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Health Services Providers and Users' Opinions on Maternal Health Services in Bangkok Metropolis

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Introduction

Concurrent with a secular decline in mortality, measured by the crude death rate[1], during the last three decades from 1960 to 1990, the maternal deaths, measured by the maternal mortality rate[2], also showed a declining trend. In 1960, there were approximately 3,855 maternal deaths with the maternal mortality rate of about 4.2 per 1,000 live births. In 1970, the number of maternal deaths was below three thousands and the maternal mortality rate was reduced to 2.3 per 1,000 live births. In 1990, the number of maternal deaths was as low as 237 persons with maternal mortality rate of only 0.4 per 1,000 live births (Division of Health Statistics, Ministry of Public Health, 1990 and 1992). The maternal mortality rate was much lower in Bangkok with 0.2 per 1,000 live births in 1980 and as low as .04 in 1988 (Department of Policy and Planning, Bangkok Metropolis Administration, 1989). Although the number of maternal deaths is believed to be an underestimate either because of underregistration or miscategorization, the decreasing trend in maternal mortality as a cause of death seems to be significant. The role of abortion, direct and indirect obstetric causes in maternal deaths showed that in 1970, direct and indirect obstetric cuases accounted for about 95 per cent of meternal deaths. In 1990, direct and indirect obstetric cuases accounted for only 82 per cent of maternal deaths. Assuming that the report on number of maternal

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deaths by three cuase groups is reliable, the decreasing role of direct and indirect obstetric causes in maternal deaths probably reflects the impact of improved maternal care services of the country.

The declining trend in maternal mortality in maternal mortality in Thailand does not necessarily entail the reduction in the magnitude of illness from causes related to pregnancy, childbirth and the puerperium, Of 42.272 million outpatients classified by 17 cause groups of illness in 1990, about .575 million outpatients or 1.4 percent of all outpatiens were in the complications of pregnancy, childbirth and puerperium cause group. About 35 percent of outpatients in this cause group received services from health service units in Bangkok Metropolis. For inpatients, there were about .561 million inpatients in the complications of pregnancy, childbirth and puerperium delivery without mention of complication category, accounting for about 19.6 percent of all inpatients in 1990. Approximately .120 million inpatients or 15.4 percent of all inpatients in this category received services from health service units in Bangkok Metropolis. Slightly over one-fifth or 21.6 percent of inpatients and outpatients of illness from causes related to pregnancy, childbirth and the puerperium received services from health service units in Bangkok Metropolis in 1990 were non residents of Bangkok. However, with about 50 general and specialized service hospitals and 18,000 hospital beds which represents about 23.1 percent of the national total hospital beds in Thailand 1990, Bangkok may be considered as being endowed with a disproportionate share of health resources. (Division of Health Statistics 1992). Outpatient health services are also available at 58 BMA health centers which are, in principle, intended to serve the urban poor, estimated to be about one-sixth of the total population of Bangkok Metropolis in 1990. However, availability of health resource does not necessarily means that the poor can have access to these resources. In a condensed urban area like Bangkok, physical accessibility may not be a problem. However, the extent of socio-economic and cultural accessibility to public health services is still unknown.

Most studies on maternal health seeking behaviour and practices to date are mostly conducted in the rural areas. Whenever such studies are conducted in urban areas, they are mostly hospital-based dealing with factors affecting abortion, direct and indirect obstretic causes of mortality. No attempts have been made to examine the predisposing factors linked to these causes. To date, the study on maternal health seeking behaviour of the urban women is practically nonexistent. Two most recent studies are confined to identifying socio-economic and demographic characteristics of pregnant women which affects the utilization of antenatal care services. It was found that younger women, women with higher educational attainment and women of higher family income visit ANC clinics either the BMA health centers or at the general hospitals more often than older women, women with less education and women of lower family income (Kanavacharakul, 1989; Jintanothaithavorn, 1993). It was also found that women with more time of antenatal care had less complications at labour than those with fewer times of antaenatal care (Jintanothaithavorn, 1993).

Objectives of the Study

This study aims to evolve a culturally appropriate participatory maternal health education and information program though the partnership between women in the community and the relevant health agency. This will be done by taking a fresh look at rationality schemes of decision making as they pertain to pregnancy, delivery, and postpartum care and the extent to which these can be incorporated in the maternal health education program. The specific objectives are as follows:

1. To examine and analyze local customs and traditional practices as they pertain to pregnancy, delivery and postpartum care;

2. To assess the factors --- cultural, programmatic and socio-economic accounting for the selective utilization of health services for prenatal care and delivery;

3. To determine the prospects and nature of women's involvement in the planning, implementation, and evaluation of an education and information program for maternal health.

Study Site, Data and Methodology

The study was conducted in Bangkok as a part of joint study undertaken in poor communities in five cities of Asian region. These cities had been categorized into economic grids with Korea at the helm having reached a high stage of industrial development although mortality level remained high followed by Kuala Lumpur and Bangkok, which represent under going rapid industrilization. The third level is constituted by Jakarta and Manila, wherein the population problem acts as a deterrent to economic growth. The interest in this economic delineation is the extent to which industrilization, modernization and technological changes could interact with culture to effect behavioural modifications in pregnancy and postpartum care and how such behavioral change can influence the formulation of relevant maternal care programs.

A community survey was first conducted in May 1992. Two low-income communities in Bangkok Metroposlis with approximately 1,900 households and 9,000 population were selected for data collection. A sample of 526 ever married women aged 15-40 years and have ever experienced pregnancy were interviewed, using a structured guestionnaire. From the community survey, the information on various types of ante-natal services which respondents receive was collected. These services can be categorized into two types, hospital services and public health center services. This report will present in-depth information acquired from general hospital and health centers regarding ante-natal, delivery and post-natal services. Two general hospitals and three BMA health centers which respondents stated they had attended were selected. For the purpose of identification, hospitals will be called hospital A and hospital B, while BMA health centers will be refered to only as center one, center two and center three.

Both hospitals provide ante-natal, delivery and post-natal services while the health centers provide only pre-natal and post-natal services and patients here are referred to hospitals for deliveries. Due to the exploratory nature of our study we administered an in-depth semi-structured questionnaire to the hospital and health center personnel.

The interview was also supplemented by tape recording the entire discussion in order to acquire more meaningful interpretation of the discussion. The information presented in this chapter on hospital and health center services represents and analysis based on the in-depth interview schedule and the tapes.

In addition to the above, focus groups were conducted in two of the communities in which the community survey was conducted. The objective of conducting the focus group was to acquire community opinions concerning hospital and health center services from the acceptors point of view. Knowledge of health care and practices was also discussed. Participants were selected of whom were pregnant at the time or who had given birth for not more than three months prior to the discussion. The first community focus group was conducted on the second floor of a large community center. The second floor was semi-open air and there was good air circulation since the discussion was carried out in the late morning. The second community focus group discussion was conducted on the second floor of the community's library. Since heat was a problem to be considered we were able to begin the discussion at 9:00 a.m.

Both group discussion were moderated by one of the co-investigators following focus group guidelines of the project. Three days prior to the discussion participants were screened with the help of the community leader and invited to join the group. The second focus group had eight participants, the first focus group was attended by nine participants.

The focus groups were tape recorded with two tape recorders use in each group, one as the main tape recorder and the second as a back up. Upon completion of the focus group the tapes were transcribed and entered into a word processing package. The objective of the transcription process is to get 100 percent of what was said, however, noise restrictions and participants talking at the same time limited this to around 90

percent. Contextual information acquired from the focus groups will be presented at the end of each section, where appropriate.

Findings

1. Ante-natal Services at the Hospital

A. Ante-natal hospital services from the administrative view Hospital A and Hospital B are large general hospitals situated in Bangkok and serve a significant population of the Bangkok population. Both hospitals operate an pre-natal clinic five days a week from 8:00 a.m. to 12:00 noon. Hospital A has a special clinic for 'difficult births' two days a week in the afternoon as well as a 'mother class' which teaches infant rearing and voluntary breastfeeding.

Both hospitals are able to accommodate a relatively large number of patients daily. Hospital A has 220 old and 80 new pre-natal patients daily while Hospital B accommodates 130 old and 50 new pre-natal patients daily. With the on-going construction of a new building Hospital A expects to accommodate, in total, more than 400 pre-natal patients a day. Both hospitals note that on Mondays and Tuesdays there are particularly large numbers of patients because of three main reasons. One, a back-log of patients from the previous week are re-appointed again on either Monday or Tuesdays, two, the beginning of the week there are a lot of new patients because there are no pre-natal services during the weekend, three, because of the first two reasons medical personnel, especially obstetricians, prepare themselves for the large number of patients in the early part of the week and generally work more quickly. Towards the end of the week the number of patients, especially new patients, decreases, this was stated by both hospital administrative officials.

Both hospital officials stated that they desired more nurses but this was not seen as a serious drawback in the services provided (i.e. 1 to 2 nurses). With the

AIDS epidemic prevalent in Thailand additional services provided by these nurses include pre-counselling for HIV as well as general health education. With regard to medical equipment, medicine and other hardware, no problems were discussed. Both hospitals, in fact, were quite proud of the 'modern facilities' which they had, up to date medical equipment and supplies and the personnel informed us of the on-going construction of a new building and equipment which they were going to have in the near future. Various manuals were also available for reference in pre-natal examinations such as toxemia of pregnancy; hypertension; pre-eclampsia as well as possible crisis or critical situations which may occur during pregnancy.

Hospital A reports that services provided to patients are adequate and sufficient with little complications. However, Hospital B requires additional nurses because existing working conditions require nurses to do more than one job at the same time. The lack of nurses are due to the 24 hour monitoring of patients conditions as opposed to doctors who come in only on appointed times to do the rounds, both hospitals would want more nurses because of this fact. At present number of beds for patients are inadequate at Hospital A though with the construction of a new wing they feel that this problem will be overcome. Hospital A notes that, in their view, major obstacles in providing a good service are not due to a lack of facilities or personnel. The 'major problem', in their view, is lack of empathy of doctors towards nurses. This communication problem arises for example in doctors scolding nurses in front of patients and other hospital personnel. (This topic was also discussed in focus groups presented in a subsequent section.) Frequently mentioned was an air-conditioned lounge for doctors but none for nurses. This seemingly small issue has resulted in a lot of ill-feeling by the nurses. Doctors are seen as only periodically attending to patients and then quickly going off to play golf or opening the doors of their private clinics (in-depth discussion with hospital nurse administrator). Yet, as discussed, the role of nurses is to provide 24 hour monitoring of patients. It is undoubtedly possible that minor mistakes may be made in their activities but these result in open scolding by doctors to nurses. The existence of the air-conditioned lounge for doctors and not nurses

is a possible symbol for nurses to vent their stress upon. In Hospital A at least, nurses have a saying when they begin their duties each day. They ask the nurse on the previous duty whether today is an 'easy' or 'difficult' day meaning if it is 'easy' it means that doctors whom have good inter-personnel communication are on duty. If it is 'difficult' tnen doctors who have bad personal communications are on duty.

B. Ante-natal hospital services from the nurses perspective This section provides a discussion on actual practices and working conditions by nurses in the ante-natal clinic. Both informants had about 15 years of working experience in the ante-natal clinic. They were asked to discuss their own experiences as well as venture opinions concerning other nurses in the ante-natal clinic where appropriate.

Only one of the two nurse had attended a seminar/training session during this time and that was in nursing the elderly. She obviously felt that this seminar was of little importance to her work in the ante-natal clinic. However, she did use this knowledge in caring for her elderly parents at home. It is unclear whether such little attendance at seminars and training sessions is widespread among other practising nurses.

Ante-natal services were relatively comprehensive at both hospitals, these include urine and blood test, weighing; pregnancy check-up; vaccinations; health education; counselling on checking for ovulation to assist in conception; breastfeeding and case referrals. Both practising nurses did not see any major obstacles in providing services to their patients.

In the ante-natal clinic general health problems of patients included minor levels of malnutrition, syphilis and hepatitis at Hospital B and diarrhea, high blood pressure, D.M. at Hospital A. Though not frequently encountered, patients with complications were given advice and treatment and in certain cases referrals for special treatment made. For venereal disease patients referrals were made to the STD clinic

which also provide counselling services. Health and nutritional education and counselling were provided for malnourished patients at both hospitals. In both hospitals ultra-sound services are provided when necessary.

Interestingly, both providers voice similar opinions concerning service provided. That is, a severe lack of medical personnel at both hospitals in relation to the 'extremely large' number of patients. In regard to this both providers have to take on multiple roles of nursing, janitor as well as computer expert. Work structure, communication flows and conflicting opinions regarding job responsibilities seem to abound in both ante-natal clinics, from the health providers point of view. Hospital B emphasizes that providing health education to patients with a low level of education and income creates numerous obstacles for effective self-care for expectant mothers. Appointments, for example, at time are not kept because patients, though wishing to come and have the money at the time the appointment is made do not do so because on the day of the appointment they do not have enough money. At the same time, they may have felt that their health is good and thus do not have to keep the appointment. Nurses note that high risk patients are appointed to a high risk clinic on Wednesdays at Hospital B. Higher frequencies of appointments are made for high risk patients, health education is provided for expectant mothers and close relatives and appropriate referrals to specific wards are given.

Technical nurses at both hospitals informed us that most patients were receptive to the advice given by medical personnel in the ante-natal clinic. Reasons given were that if patients did as they are told and found it to be effective they continued to do so and this reinforced their confidence in further advice given. This has implications for medical personnel to provide detailed diagnosis and complete health education during the early stages of ante-natal care. Good advice can also be supplemented by clear examples of what had happened in previous cases to a patient who did not follow the advice given and subsequent complications which occurred to her. Hospital B state further that they do not force or coerce patients concerning

maternal health care but explain the benefits and adverse effects of correct and incorrect practices and allow the patient to decide for themselves.

The minority of patients who do not follow the advice given was explained as mainly due to a low-level of education contributing to difficulties in communication between medical personnel and the patient, low income which result in, as mentioned earlier, patients not keeping the appointments; incorrect beliefs regarding proper health care such as controlling one's weight for fear that the baby would be too large and woould result in problems during delivery; incorrect knowledge on sex education and a fear that one will not be able to lift relatively heavy objects (i.e. manual labor) after sterilization. Hospital B further notes that some mothers cannot make appointments because of child-rearing duties at home which necessitate them to remain at home. Yet in other cases even when post-term occurs, patients refuse to be admitted because they do not feel any pain yet.

In addition to reasons mentioned earlier for not keeping the appointments. Nurses state that some patients were migrant wage laborers, mostly in the construction industry and thus move around a lot not enabling thems to come and receive service. Though few in number, the lack of money, frequent migration and most important, the lack of understanding of the importance of regular pre-natal check-ups are the main reasons for patients not making their appointment at both hospitals.

Both ante-natal nurses are of the opinion that their hospitals are well received and accepted by the surrounding community which they serve due to their ability to accept large numbers of patients, low costs, especially at hospital B, adequate facilities, especially at hospital A, good and friendly service with a longer time spent for new patients.

Incorrect practices noted by the nurses were those of the belief that mothers should not eat taboo food (khong salang) resulting in nutritional deficiencies.

Consumption of traditional medicine which are fermented with rice whiskey resulting in a high alcohol content in breastmilk; the discarding of mother's first milk which is high in protein. Other incorrect practices include bathing at night which may cause colds or accidents and fears that breastfeeding will make the mother less physically attractive.

2. Ante-natal Services at the Health Center

A. Ante-natal services from the administrative view Information presented here was collected from the three major health centers which survey respondents stated they attended. These centers were center one, center two and center three of the Bangkok Metropolitan Administration..

The three health centers have between one and three doctors providing pre-natal services. These doctors only treat patients who have complications or are at high risk. Thus, a large proportion of patients are provided service by nurses. There are between 4 and 7 professional nurses at the health center. Nurses vary in their duties, in addition to providing pre-natal services. These duties include general health check-ups, home visits (including primary health care) and mobile clinics. Center three also provides health check-ups at primary schools under its jurisdiction. None of the health centers have midwives. Depending upon each center's individual needs additional personnel are included. Cente two, for example, has a technical nurse and two nurse assistants because of their limited number of professional nurses. At health center three nurse assistants and family planning personnel are also hired to serve the large low-income community surrounding the center.

All three centers provide ante-natal service one day each week on Monday in the afternoon for three hours. This time period seems adequate to serve the community, according to all three centers. On average between 20-30 patients are provided ante-natal service, of these 10-20 are old patients and 7-10 are new patients. Because ante-natal services are given only on Monday, comparisons on day of preference

were not possible. However, two health centers remarked that if a public holiday fell on a Monday the number of patients would increase the following day. Similarly, on national holiday such as New Year day or long weekend (which private companies close but government offices do not) number of patients reduce considerably. All health centers state that they need more nurses, particularly for home visits which take up a large part of their time. Home visits must cover all areas under the centers jurisdiction. Some centers, thus, are not able to cover areas with a large population with home visits. In addition to home visits other time consuming activities include providing health education; blood tests and blood pressure checks for every patient. No medical equipment or medicine was seen to be lacking in any of the three centers interviewed.

Services additional to ante-natal provided at each of the health centers include provisions for shock treatment; iron deficiencies; high blood pressure, family planning; home visits for infants with complications such as infectious umbilical chords and consistent fever. There is a referral system for all centers for complications not provided there. Such complications, for example, include delivery, caesarian, blood transfusions and pre-mature births. Center three states that they receive referrals also from social welfare agencies and private and public hospitals indicating that there are also a large referral network beyond public health agencies.

All centers have access to diagnostic manuals in their service provision , such as nutrition, home visits vaccinations primary health care. However, Center one stated that they did not have a specific ante-natal manual whilst Center three stated they did. It seems that a standardized published manual on pre-natal care is not widely distributed to all public health centers.

Pregnancy complications reported by the three health centers can be considered as minimal and part of the routine service provided by the health center. Major complications encountered included swelling; high blood pressure and vaginal bleeding. These complications were given appointments to the doctor at the center and

if the condition does not improve are referred to the hospital. Other complications encountered, but much less frequent included diabetes; abnormal blood test results, low weight and HIV positive cases. Similarly, these were referred to appropriate channels i.e. low birth weight to nutrition services of the hospital; HIV+ for further specific counselling.

All centers state that they are able to provide ante-natal services under their jurisdiction. This was stated inspite of the centers' lack of license nurses. For example, Center two states that though they are able to manage all processes of ante-natal from weighing, monitoring blood pressure, blood and urinal tests, tetanus shots, pregnancy checks, medication and administrative work, they are working under a certain amount of stress because of a lack of personnel.

With regard to obstacles in provision of services to their community the three health centers replied in similar ways. The lack of nurses was again emphasized. Other obstacles encountered were not the lack of equipment or money but a lack of communication between center and hospital officials and center and patients. Referral networks encountered problems when certain 'low-level' hospital personnel refused to accept delivery cases informing the patient that they should acquire delivery service at the place where they received ante-natal service. This resulted in tremendous misunderstanding by many patients of whom informed other expectant mothers in the community not to come and receive pre-natal service from the center.

Another important obstacles identified by the administrator was a problem of communication between the center and individual patients with little education. Center personnel stated that in some situations patients did not understand their health status as explained to them by nurses or doctors. Patients were not able to comprehend the reasons for taking certain medication continuously, for example, because of their special circumstances. This lack of comprehension resulted in further pregnancy complications by such patients.

Possible solutions to overcome obstacles were also discussed. Health centers state that formal meetings should be organized on a regular basis for integration of work between health centers and hospitals with regard to referral networks. They also state that high ranking officials at the ministry of public health and hospitals should discuss possible ways to overcome such obstacles. However, it is not clear to the researchers whether introducing regular meetings between hospitals and health center personnel would result in a positive outcome considering the existing heavy workload of public health personnel as stated by health center administration. Center one states that another alternative may be to consider printing monthly circulars providing information on referral systems from various health centers in which a particular hospital can accept. A possible variation is to print a small poster showing various hospitals and health centers and private clinics which can be referred to by them. These small posters can then be appropriately placed in pre-natal and delivery wards of hospitals. The problem which health centers say they cannot overcome is the lack of personnel. They feel that it is beyond their means to ask for more due to obvious budgetary constraints. All centers though stated that administrative work occupied a significant proportion of their time. Consideration of the type of administrative work which health centers are involved in and possible avenues in streamlining, cutting down duplication and increasing efficiency is a potential avenue for future research. With regard to communication problems between health center personnel and patients, Center one's personnel states that home visits to provide IEC should be stressed for such patients.

Another interesting issue which was considered as a major problem by Center three personnel was impoliteness of nurses towards patients. Such impoliteness may occur at all stage of the ante-natal service, from asking patients about the personal history to actual conduct during physical check-ups. These problems were considered by the Center three official as an individual and attitudinal problem which would be difficult to overcome and which the best they could do was to remind individual personnel from time to time. From our study's perspective, we have heard about

attitudinal problems between medical personnel and patients at all levels of the medical system from senior physicians to nurse aids. When a person's job involves continual long-term interaction with others from a position of advantage or given the likelihood that the inter-action process may be routinised and the patients considered not as an individual but more as a product. Humanism and the process of healing and caring must be somehow re-instilled on a regular basis for this to be overcome.

Out of the three centers, Center two did not provide any post-natal service because of lack of personnel. They only provide family planning service. The other two centers provided similar post-natal services which include check-ups on cervical cancer or receiving referrals from the hospital, contraceptive advice, including sterilization, breast feeding, home visits to weigh infants, checking umbilical chords and nipples and supplementary feeding advice.

Health center officials were not able to state specifically complications in post-natal check-ups of mothers but mentioned that a large proportion did not return after child-birth for check-ups. A major reason stated was that many mothers did not see the necessity for a check-up since they had a successful birth and their own health seemed normal. Some mothers also told them that they did not have any time and that if they came someone would have to look after their child at home. Low awareness of the importance of post-natal check-ups, as mentioned by Center three, are likely due to low education of mothers compounded with the migratory status of many low income dwellers. Many are construction workers who move from site to site depending upon the building contracts which their company acquires. Health center personnel can only minimally overcome this obstacle by conducting home visits to some of these mothers.

There is a program on knowledge and information provided on ante-natal and post-natal care which ranges from once a week to every day. Such information was given in various forms such as videos, pamphlets and manuals and the community loudspeaker network given to mothers. Health centers one and three state that

individual consultation to mothers was also provided. Information given at the center during this time included, for example, nutritional needs during pregnancy and psychological changes which expectant mothers go through for first births. However, Center three states that a major problem during information dissemination is that mothers rarely have the concentration to watch the video program because they bring their children with the. Many mothers are also in a rush to return home because they worry about leaving their home unattended. Because of this need to return home, health center personnel provide quicker service to such mothers thus reducing even further the time available to provide pre-natal and post-natal knowledge.

All health centers have a mobile unit to visit communities under their responsibility. Center one states that, in fact, their main work emphasizes dissemination of knowledge and information to the community rather than in the Center. In addition to home visits which are an extension of check-ups at the center, all centers put up posters about child care and maternal health about once a month. General health check-ups to the community such as inoculations communicable diseases, pre and post natal care as well as nutritional and psychological information for expecting mothers. Center one states, quite interestingly, that certain diseases such as dengue fever, cholera occur seasonally and information is provided during the beginning of that season. Such a program is conducted once a week depending upon what is 'booming' at the time. Booming issue also may not necessarily be seasonal but also what is 'up to the times' as seen by the personnel, thus the AIDS campaign is presently being heavily promoted.

B. Pre and post-natal services from nurses' view This section will discuss pre-natal services from actual health providers' perspective. A semi-structured interview was conducted at the three health centers with providers. The discussion was also tape-recorded to assess not only what was said but how it was said. The semi-structured interview guide and transcripts from the tapes provide the basic data set for analysis in this section.

All three providers were female, married, each had a bachelors degree equivalent education and aged in their mid to early 40s. Ante-natal experience ranged from three to five years. The providers at Center two with the least ante-natal experience, three years, also had eight years experience in a delivery ward in a large Bangkok hospital. The most experienced practitioner, at Center three, had eight, seven, and 15 years experience in pre-natal care, delivery and post-natal services respectively. Together, the providers are seen as experienced, both in terms of professional qualifications and work years. The level of experience of those providers does not seem to be atypical to the three health centers as discussed informally during our in-depth interviews.

In addition to the services mentioned above, the provider also did home visits (three years), nutritional education (one and a half years) at primary schools; and ran a 'well-baby' clinic (six years). These additional services are conducted in conjunction with pre-natal services.

All providers had attended, past and present, a wide variety of workshops and training courses related to various aspects of child and maternal health care such as high risk pregnancies; nutritional requirements of mother and child; home visits, breastfeeding courses, etc. However, because of memory recall problems of exact titles of workshops, direct comparisons between the providers cannot be made. It seems however, that the providers at all three centers have attended, and continue to do so, many workshops directly related to their occupation.

As a result of this, providers emphasize even more strongly than those in the hospital that these workshops benefited them directly in the quality of their work. Reasons stated included:

> I think it [workshop] is very useful, especially that which is related to pre-natal care, primary school nutrition and breastfeeding. Sometimes I think that I

> have enough knowledge but when I had the chance to attend the training course I found out that there was much more I did not know about. I learnt more about the principles and procedures in conducting my job.
>
> It [training courses] can be adapted to [my] work. It complements my existing knowledge because it came directly from the master plan of the ministry health office, such as courses on AIDS, primary health care and the training given is directly related to our job such as home visits disease prevention, well-baby clinic.

Our topic of discussion on workshop and training received one of the most important and positive verbal responses from the health providers. In addition to training related to their specific jobs providers were also appreciative of additional knowledge on AIDS, STDs and drug abuse as these were often problems associated with the communities which they work in.

> I have learnt about AIDS and HIV and how to prevent it and protect myself as well as my patients who are addicted to drugs. [From such workshops] I have learnt about treating drug abuse patients, about psychological states of drug addicts and its causes.

All providers were involved in almost all procedures in the pre-natal clinic. The center three nurse had additional administrative work on expectant mothers. Duties undertaken at the pre-natal clinic range from weighing, pregnancy checks, blood and urinal tests, tetanus shots, breast and teeth checks as well as general advice. Post-natal duties were also undertaken with the exception of Center two which does not have a post-natal clinic.

General health complications encountered at the health centers were quite similar such as calcium deficiencies and anaemia. Some patients were referred to dentists, especially new patients. In cases of anaemia, Center two provides nutritional advice as well as medication as many of their patients are construction workers with

little knowledge on nutritional. Center three does a follow-up on anaemic cases with home visits. Center one has encountered some cases with positive blood tests for venereal disease, hepatitis B and HIV. For these cases married couples are given counselling, provided with education and referrals to the hospital.

Pregnancy related problems encountered were also similar and included low blood pressure, bleeding, low weight, incorrect position of infants, calcium deficiency (especially at Center two). These again were provided with advice, medication and referrals to hospital when necessary.

Post-natal services received much less discussion at all health centers. Center two as referred to earlier does not provide a post-natal service but patients have been incorrectly referred to them by the hospital, a further indication of referral system problems. Part of the lack of discussion partly stems from much less attention given by parents in post-natal care. Center one has provided advice on improper nutritional care for infants but only rarely because not many people come to the center. Center one's providers had not encountered any general health problems of mothers but did mention one case of syphilis and another of block milked flow which was given medication and treatment.

In summary, post-natal services received was given much less attention to by others resulting in fewer services being provided. This seems to imply that if Center two did have a post-natal service it would not be attended by many mothers. Further implications for emphasis on post-natal care are obvious here and would necessitate a rather large campaigning effort by public health centers. For patients who migrate such as construction workers or even the general population, referral systems are even more important during post-natal care. Thus, in addition to a possible post-natal care program being emphasized referral systems between health centers within Bangkok hospitals as well as the provinces must first be established.

Obstacles to effective provision of service provided further interesting discussion. A common obstacle mentioned by providers was a lack of personnel. This resulted in one medical personnel having to do numerous jobs at the same time. A lot of the work deals with duties as a result of new administrative policies though these additional duties were not seen as insurmountable, it was felt by Center two that increased personnel would allow for more individual attention to patients. Such attention as providing one-to-one health education rather than as a large group and for each personnel to be responsible for specific duties. Increased work load and higher responsibilities resulted in many acquiring work at private schools as a school nurse which has good pay and privileges, according to the Center two's nurse.

Interestingly all three health providers stated that actual service provision was not convenient to patients. Various check-ups such as blood pressure, weight, internal, etc. were held in different rooms and at times also different parts of the building creating confusion to many patients. Center three health provider further states that their ante-natal check-up rooms are very inconvenient because of its small size, hot and humid and the check-up bed is quite high, making it inconvenient for women in latter stages of pregnancy. It is quite likely that other centers would also have such standardized check-up beds such as this and with no air-conditioners and situated in a high density area. Patient inconvenience regarding ante-natal check-ups thus, may be more widespread than just this particular center.

With high risk cases all providers at the three centers have two major steps in which they take. The first is to diagnose what type of high risk a patient has. The second is to decide whether to refer the case to the hospital or provide treatment at the health center.

Cases which are referred directly to hospitals include swelling, very high blood pressure, high albumin, high protein levels in the urine and excessive bleeding. For young patients whom are also considered a high risk group health education is

provided. Other non-serious cases are also provided with health education and periodic home visits to maintain their health status. The health provider at Center two further states that their doctors do not provide any services to patients but refer cases to either the hospital or the nearby health center number 16 for treatment. It is unclear why there are numerous difficulties with regard to inefficiencies, as stated by the Center two health provider. Some seem to be specific to the center such as doctors referring too many cases while others seem to indicate a widespread problem at health centers such as too much responsibility placed on any one personnel.

In general, all the nurses stated that a large majority of patients heeded the advice given to them. Reasons stated for this are because the health provider tried to create a positive atmosphere during consultation by providing example during their explanation, giving one-to-one consultation whenever possible and did not attempt to rush any kind of answer to questions from patients. However, as discussed earlier, pre-natal health education advice is heeded much more than post-natal. As mentioned earlier, attention given, though good, is hampered by the size of the group and the infants which mothers bring along. With regard to pre-natal advice, though, direct benefits are clearly seen more than Maternal and child care after child birth.

The nurses did not think there were any major problems of patients not listening to their advice. Similar comments arose concerning the lack of education and problematic communication resulting in the information not coming across clearly to many mothers. In such cases, some patients felt that to attend pre-natal clinics is only a place to ultimately give birth to her child rather than a place to begin a process of a safe birth leading to a birth of a healthy child.

The minority of patients who do not make their appointments are due to their migratory status. Construction workers, for example, come to pre-natal clinics but because they move to find work such mothers miss the regular check-ups and it is presumed that they give birth back in their home provinces. In other cases some

patients miss quite a few pre-natal check-ups because they are visiting their home province. Such cases seem to occur rather frequently as stated by Center two and Center three. Center one's health provider mentioned that there were a number of cases, though few, who came to the health center just to find a place to deliver their baby and afterwards did not come until they were about to deliver. Similarly, some came to the health centre only at the latter stages of their pregnancy because they felt it not necessary to come earlier. These above points emphasize that early and continuous as well as community health education is important if pre-natal service is to be more effective.

Problems related to pre-natal services are also linked to post-natal services, i.e. the migratory status of mothers and their families. Construction workers and labourers as well as street vendors move around within the city as well as the provinces. Some thus give birth in their home province and remain their to recuperate and care for their child.. Such cases result in problems of follow-up by the health center.

With regard to general services other than maternal and child health provided to the community practising nurses stated that they had good relations with the community due to their daily house visits and mobile health center services. These visits create a sense of friendship between the center and the community. Coupled with the centers convenient location they stated that those community members who do receive services, mostly low to middle income families, come quite regularly. Center two states that their childrens vaccination program is quite popular because of the center's convenient location and low cost.

All three centers state that households with a high income generally do not come to receive service at the center. Reasons are mainly because these people feel that the center provides a lower quality of care than the hospital. Cost of medication is also low and which makes these people think that the medication is of inferior quality.

In addition, the nurses state that since health centers do not provide a delivery service many higher income households prefer to receive services directly from the hospital which provides pre-natal and post-natal service. Center two's particular problem, according to the health provider, is that they have one doctor who has bad interpersonal communication with patients. The doctor yells and is rather impolite to many patients causing some not to return. Center two has an additional doctor whom the provider says is quite polite and many patients like. Center two's provider highlights a particular problem in that professional doctors cannot be told what to do or not to do such as nurses. Doctors are not seen as under a specific line of command as are nurses and thus personal characteristics, behaviour and mannerisms are more subject to lesser control by the establishment.

Beliefs, traditional customs and practices seemed to play a minor role in either promoting correct or incorrect health practises. Beliefs and practices which nurses felt were of at least no harm or may in fact be beneficial consisted of not watching horror or violent movies and not attending funerals. Doing such activities is felt to affect the expectant mothers emotions which may affect her physical health and ultimately her baby.

Dietary customs mentioned by nurses included chicken and ginger which some patients felt would increase milk flow. Consumption of a lot of warm water was also felt to ease blood circulation. 'staying by the fire', a common customary practice for many Thais in the past but less presently is supposed to assist in healing the mothers womb and allow it to be 'put back in its proper place'. There are many variations of 'staying by the fire' in Thailand and other parts of Southeast Asia. One variation is to heat rocks over a fire underneath the mother's bed thus acting like a very strong sauna room. This practice usually carries on for approximately one month.

Possibly harmful practices which providers noticed included consuming alcoholic medicine which would affect the mother's milk. Some mothers also give

bananas to their new-born resulting in undigestable food and if given in large amounts some babies may have to be operated on to remove the undigested food. Another customary practice is for the mother to consume only salt or salted fish and rice or to refrain from eating eggs in the belief that it would heal the womb. This practise will ultimately result in a lack of nutrient in the mothers milk.

In spite of the above incorrect practices all nurses were of the opinion that they were a rare occurrence nowadays compared with the past. Our discussion on this matter did not seem to spark immediate examples and concern on the part of the nurses. The practising nurses, rather, took some time in recalling such incorrect practices as they were not seen as a major problem of many patients who received service at the center.

C. *Focus group findings on pre-natal service* Reasons for attending a certain hospital were considered to be its physical convenience to one's household. Discussions from both groups mentioned that knowledge of services was not known and the choice taken to go to a particular hospital depended mainly on the physical distance, the nearer the hospital the more the convenience.

Participant 1:	Vachira hospital is good because it is close to my house....
Moderator:	So why did you go there?
Participant 2:	I also went to Vachira hospital. I told my husband I was going to go to Klang hospital but he was afraid that I could not travel that far.
Participant 1:	Afraid that you could not bear the pain for that long [a ride in a taxi].
Participant 3:	And also because her husband works at night.
Moderator:	And what about Ramathibodhi hospital?
Participant 4:	That is also not far.
Participant 5:	I even think it is closer than Vachira hospital.
Participant 3:	Ramathibodhi hospital is closer if you take the direct route.

Such discussions, centered mainly on queries regarding how close a hospital is to one's house implying that the closer it is the more convenient.

For mothers who had already given birth to one child at a particular hospital they went to the same hospital not because of good or bad service but rather because of the convenience in not having to fill out forms all over again. It was discussed that they could just inform hospital personnel to bring out their file. Some participants did mention however that Ramthibodhi provided all clothes for mothers and the infants so that they would not have to prepare anything when they go to deliver their child. This was considered as one reason why the chose this hospital. Thus, convenience was one overiding factor in hospital choice rather than positive or negative information acquired concerning a particular hospital.

Opinions concerning pre-natal services can be categorized into straightforward categories from findings of the focus groups, positive and negative opinions.

Positive opinions It was clear during the discussion in both groups that mothers had a reasonable knowledge about health care practices during pregnancy. A lot of the discussion centered on procedures taken during ante-natal check-ups and how these procedures were beneficial to themselves and their children. Discussion centered on information pamphlets given during initial ante-natal check-ups which were explained to the mothers with many in the group able to recall the information provided in the pamplets.

Moderator: I would like to know if whether women in this community would read the pamplets which were distributed. I think there must be some who did not read it or do according to what the medical personnel said?
Participant 1: Well, like this I really don't know.
Participant 2: But what I do know is that those that are sitting here all have read the pamphlets.
Moderator: All of you read the pamphlets?
Participant 3: The first day I went to the clinic I read it (read the pamphlet).
Participant 1: They told us to read it. They distributed it and told us to read and understand it.

Some in the group were able to discuss information given to them during the group education class on breast-feeding practices as well as the importance of taking vitamins during pregnancy . Medical personnel also informed them what injections they are about to receive such as for measles and tetanus and why these are necessary. Ramathibodhi and Vachira hospitals seemed to involved mothers in ante-natal check-up procedures, at least to a limited extent. Mothers were told to weigh themselves on each check up and to inform hospital personnel what their weight was.

Participant 1: At Ramathibodhi hospital they have a computer scale. .....
Participant 2: We go and stand on it and we write our weight down on a piece of paper....write on our own file. .....
Participant 1: I would know my weight because it is my own file.
Participant 3: But at another hospital they tell us to stand with our back facing the scale. After they weigh us they tell us to get down, so we don't know our weight. .....
Participant 4: But at Vachira, [though they don't let us write down our weight] they tell us our weight.

Many in the group discussion felt that this made them more conscious of the importance of their weight gain during each month of pregnancy. Thus, the discussion on weight gain was relatively detailed. Participants were also able to discuss their monthly weight gain.

Negative Opinions Negative opinions were varied and extensive. These opinions can be seperated into two categories: firstly, the human factor of stress resulting in bad services; secondly, and to a lesser extent, bad hospital administration.

It was apparent that participants realized the amount of work and stress involved in working in a busy hospital or health center. Some remarked throughout the discussion that working in a hospital where many people come and go is a rather stressful environment. However, they were of the opinion that this should not mean that hospital or medical personnel at certain hospitals should be rude and provide bad service to patients.

Participant 1: They [at Hospital A] are very rude and provide bad service not like the Police Hospital. .....
Participant 2: Some [personnel] are good and some are bad. ....
Participant 3: It depends on the doctor (medical personnel).
Participant 4: I have been to receive service many times [at Hospital A].
Moderator: In what way do they speak?
Participant 4: Like, well...like they only want their own way.
Participant 1: (cutting in) Like they are in a bad mood and speakly harshly.

An example was also given of a stressful doctor who yelled at the nurse for working slowly thus making all the waiting patients in the pre-natal clinic very nervous and afraid. Scolding the patients who did not answer questions correctly or, not looking at a patients face during consultation also contributed to a certain amount of criticism by the participants.

Participant: Harsh in a way that makes me scared. Like the nurse called in the next patient slowly, and the doctors said 'what are you doing out there, why haven't you called the next patient in!' And so the patient is afraid and some [ofthe sepatients] area fraid to go in....the voice carries all the way out of the room and the rest of us are afraid.

Participant: And when I go into the room I am afraid and when I speak my voice shakes, something like that. And so the doctor gets mad and the doctor begins to ask questions quickly and so loud that the voice travel outside the room and so the people outside must also be afraid.

Negative remarks regarding the hospital administration concerned the extremely long waiting periods commonly encountered when attending the ante-natal clinic. A bad referral system was also discussed though it was not considered a major problem. It was felt that one contributing reason to this was the occurence of queue jumping.

Participant 1: Suppose it is our turn in the line. We are about to get our check-up. But someone else knows the personnel and gives them money to cut in the queue, so they get a check-up before we do.
Participant 2: They cut in the queue.
Participant 1: So we have to wait because they cut in the queue... I went to the hospital at 6:00 a.m. and got my check-up at 4:00 p.m..

Perhaps what may be most disconcerting from the discussions is the remark that money seems to change personnel behavior and that if one is admitted into the special check-up clinic, by paying more money, these same personnel seem to display a more helpful attitude.

Participant 1: If we don't have enough money then it will be bad (will receive bad service).
Participant 2: If we have enough money then the service will be a bit better, [they] will not scold us like this.
Participant 1: Like if it is my turn in the queue, I am about to get my check-up and somebody knows someone or has money to give and so cut in the queue. On that day I was able to go home at 3:00 p.m. (meaning very late).

Another important category of negative opinions is the lack of communication between hospital personnel and patients. We have termed this lack of communication as conflicting diagnosis between patients and hospital personnel.

Participants stated that in some instance they did not feel normal and were worried that they may have pregancy complications. However, after visiting the pre-natal clinic they were informed only that there was nothing wrong. Yet, they were certain that their body was telling them that something was abnormal.

> Participant 1: I went to get a checkup at the health center (because she thought she was preganant)....the doctor said he/she was not sure....checked my urine. I thought I was pregnant because I did not have my period (she was actually pregnant) .
>
> Participant 1: The doctor told me to get ultra sound check...I did not know what for. The doctor just said there may be some complication so we should see if there is something wrong with the baby...because I was two months [pregnant] and the baby did not move... But I felt I was okay and normal.

In contrast another participant stated that she felt completely well but was informed that she had a complication in her pregnancy which required some medication . It is likely that the process of ante-natal check-ups does not allow enough time for consultation between personnel and patient. Patients should be given as much information as possible, even if it means an 'I don't know answer' and it is likely that the hospital process, as a routinesed one does not allow for this. Physical facilities seem adequate, though some waiting time is obvious. Thus, ante-natal services are seem to be relatively sound, from the particpants view but its dehumanization factor may be the one important criteria which needs to be addressed.

3. Delivery Services at the Hospital

A. Delivery services from the hospital administrative view Hospital B has 28 physicians, 26 nurses and five auxiliary nurses attending the delivery ward. Hospital A has 31 physicians, 74 nurses and six midwives in its delivery ward. The higher number of nurses in hospital A is most likely due to its expansion program seen in the almost completed delivery ward currently under construction.

All delivery services are provided at the hospital, there are no delivery services provided at any government health center in Bangkok. However, as mentioned earlier, all health centers provide a referral system in which expectant mothers are able to give birth at a government hospital.

After giving birth mothers stay at the hospital between three to seven days for both hospitals depending on their health. Hospital A charges approximately 700 Baht for their services, 200 Baht of this goes to the costs for the actual delivery with the remaining going to medical and room costs. Hospital B charges approximately 500 Baht for their service. For both hospitals, payment is mostly by the mother herself. Patients who want a special or private room or who need a caesarian will have to pay additional costs. For both hospitals medical personnel undertaking the delivery include nurses, interns and student nurses. Medical physicians are directly involved only in complicated deliveries such as caesarians, awkward postioning of the child and prolonged labour. Hospital provides a complete range of post-natal service which is situated in a different building from delivery services. Hospital B also provides a wide range of post-natal services. Post-natal services provided at both hospitals include check-ups, family planning counselling and services, difficult birth clinics and breast cancer check-ups.

Health education is provided to all mothers who come for service by both hospitals. The services provided by both hospitals include cleanliness practices, handling birth pains, delivery, caring for stitches, breastfeeding, nutritional supplement for expectant mothers. Hospital A's personnel state that their consultation is done on a one-to-one basis for the objective of a successful delivery and cooperation of mothers. Hospital B holds daily Mother Classes for groups of 12 expectant mothers, poster and video presentations are shown and pamphlets are distributed. Both hospitals do not visit communities as this job is for health centers. Hospital A only sends out student nurses on occasional community visits. It would obviously seem beneficial that the services provided at the hospital, regarding health education, be developed with some

knowledge of the community context. The current health education programs may encounter difficulties in their actual practice within the community. Knowledge of these difficulties or obstacles would be helpful in developing the program to be able to overcome them. It is likely that occasional visits by Hospital A student nurses are undertaken only for the personal experience of the nurses rather than in any way related to the development of the health education program.

B. Delivery services from the nurses view Our in-depth discussions were carried out with two nurses who worked in the delivery ward. The nurse at hospital A had 25 years of service experience compared to eight years for the nurse at hospital B. Additional activities beyond deliveries included teaching student nurses for the nurse at hospital A and for the hospital B nurse, occasionally conducting community visits for health awareness. Both nurses attended the occasional training and seminars. These seminar arrangements last from one to five days. The hospital A nurse, having more experience, attended much more seminars, on the average two seminar/training sessions per year. The hospital B nurse attended only one seminar/training session per year. The seminars attended include topics on developing efficiency of nurses; caring for AIDS patients; early child care; hospital administration, etc. Both nurses were of the opinion that the content of the these courses were rather useful and that they gained more knowledge from attending them. They also felt that the courses made them better nurses as it contributed to their personal development. However, work constraints at times do not alllow them to put the knowledge to practise. The Hospital B nurse, for example, felt that the breastfeeding seminar she attended was useful but she was unable to put this knowledge to practise because there were not enough nurses to do other activities such as administrative and paper work which kept increasing every day. She felt she had very little time left to put this knowledge to practice. The Hospital B nurse, however, stated that the training course for caring for AIDS patients was quite useful because she actually put this knowledge to use. This is not surprising, given the importance and money spent on AIDS research and training by the MOPH and other related agencies.

With regard to delivery service procedure both nurses were involved in all activities immediately prior to, during and after delivery. These include pre-delivery washing and check-ups; delivering, recording vital signs and observation after delivery. Problems encountered during delivery did not seem to be an obstacle at both hospitals, according to the nurses view. Being a large general hospital both Hospital A and B have an extensive referral network within which enable them to handle various obstacles encountered during childbirth.

Obstacles to providing efficient services mentioned include an insufficient number of nurses due to a large number of patients. Hospital B nurse mentioned that births occuring between shifts made their work inconvenient, contacting medical physicians in time of emergency was difficult, implying an inadequate intra-hospital communication system. In addition, cases where there is a lot of blood lost need to be moved into a different room causing inconvenience and possible danger to the patient. High risk cases in both hospitals are seperated out and given closer monitoring. Abnormal indications are reported directly to the physician on duty.

Both nurses were of the opinion that most patients in the delivery ward heeded their advice. Reasons for this was because patients wanted to have a safe birth and had a high level of trust, as stated by both providers and the medical personnel at the hospital.

Nurse state that their service is well accepted by the community because it has a good reputation with a qualified staff. Hospital B states that they are accepted by the community because of their low cost for delivery, close access to many inner city communities and a staff which is generally quite friendly. Unsatisfied patients at hospital B, according to the nurses, were minor and included cases where patients complained about not receiving anasthesia injections when they were being sewn up or patients who lost their child during childbirth. Both nurses mentioned only certain negative practices of patients some of which were not beneficial to mothers and their

children. Some of these practices included eating only rice and salty fish resulting in high blood pressure, hair washing prior to birth and consuming herbal remedies in alcohol. Cultural practises not directly affecting deliveries was seen in patients bringing in holy water and sacred string into delivery rooms in the belief that it would result in a successful birth of a healthy child.

C. Focus group findings on delivery services Discussion on delivery services centered mainly on implementation of services by hospital personnel. The major issue of discussion was on differences between male and female personnel and not on availability of medical equipment or hospital facilities.

Though it was mentioned throughout both focus groups that some personnel were helpful and some were not and that this depended upon individual personalities. Doctors were seen to scold a lot during deliveries, especially when patients were crying out loud with labor pains. This resulted in some in the focus group to bear the pain quietly.

Moderator:	Why are you afraid of the doctor scolding you? Can you tell us how you felt at the time?
Participant 1:	It was like...even though it hurt I had to bear it. The woman on the bed next to me was in pain and was crying. The doctor yelled at her that "when you were doing it (having sex) you did not cry so why are you crying now?...and if you are in pain why do you have to cry?" He told her to go home and give birth at home.
Participant 2:	I was also afraid of crying...The doctor said to the women in the bed next to me that he would cut the baby out of her if she kept on crying. That she was screaming all day and that she had no strength.

It was also discussed that senior doctors tended to be much nicer with warm and encouraging words. Though not discussed often it was mentioned that the senior is the ones who every other personnel gathers around upon his/her arrival in the clinic. That this person showed up only very infrequently to say a few kind and

encouraging words. It was also mentioned that their warm and friendly attitude might be because they had lesser working hours and visited patients only occasionally.

Nevertheless major differences were discussed between male and female medical personnel. Generally, male personnel were seen as more helpful than female personnel. Participants stated that female doctors had a tendency to scold and lacked empathy and used rough language.

Participant 1:	Well for women doctors oh! when they come.
Participant 2:	Sometimes they scold you if you cry out in pain a lot. Some people say that some of these female doctors are like this.
Participant 1:	I am so afraid of crying out, I never cry out loud.
Participant 3:	When I cry out the female doctor comes to me and says "how many times have you given birth?" I told her it was my second birth. "your second birth and why are you still crying?"
Moderator:	Were these male or female doctors?
Participant 1:	Female.
Participant 3:	Female.

Conversely male medical personnel were seen to have a much better temperament, to be patient and displayed a much more empathetic attitude during deliveries. Reasons given for this was that it might be due to a better psychological strategy used by male doctors.

Participant 1:	Usually male doctors are kind.
Participant 2:	When I push and the baby comes out he says its a boy!
Participant 1:	I feel that male doctors have a good temparament.
Participant 2:	They are very patient.
Participant 3:	It is like when a male doctor comes to check on me during delivery I feel like I have a lot of energy.
Participant 4:	He uses encouraging words.
Participant 3:	When the male doctor comes he reassures me that "in only a few moments the baby will come out, don't be afraid, don't be afraid just be patient." He talks like this, the words are so different (compared to a female doctor).

Participant 1: For male doctors hard [to tell their real feelings] They may just be saying words just to give one a sense of encouragement. [Inside] they may be tired of all the noise and confusion but say things just to make us quiet down. Their are of speaking is much better [than women].

Participant 3: It is very important for a medical doctor to be able to use psychology to talk to patients. The doctor should not let their own personal feelings out.

4. Post-natal Services

Both hospitals have a relatively small post-natal staff. Hospital B have six midwives, Hospital A has five nurses and three physicians. It is likely that at least some of this number are also working in other wards and thus not full-time post-natal staff. Post-natal services are provided five days a week on week days during working hours at Hospital A. Hospital B's services are seven days a week. Both hospitals provide check-ups for infections of the womb, breast cancer and promote an extensive family planning advice and service on IUDs, injections, sterilization Norplant and the condom.

At health centers post-natal services are provided once a week for three hours at Center three and Center two. Center one provides two days a week in which mothers can come to the center for post-natal care and advice on each of these days. Other services include health check-ups for children twice a week at health Center three and mobile health units for vasectomies, family planning, counselling and service for Center two. Due to a lack of health personnel Center two has temporarily closed its post-natal clinic for the last six months prior to our visit. However, consultation is still provided in child care practices and family planning advice. At Center three and one services include physical check-up for pep smear for cancer of the womb, such cases can also be referrals from the hospital. Urine test and breast checks are also provided. Consultation on family planning and possible contraception methods to be used are included. Sterilization cases are first interviewed and if considered appropriate are

referred to the hospital. Breastfeeding information and procedures are also provided. Center one stresses home visits to the community to weigh children, check umbilicial chords, supplementary nutrition and breast checks.

Only one in ten mothers make their appointments for post-natal check-ups at health Center three. At Center one a higher proportion (around 80 percent) make their appointments. At Center three, the nurses states that there is a large number of households who are construction workers at various construction sites throughout the city whom have little spare time. This coupled with their low level of education accounts for a lack of importance by them to come for post-natal check-ups and monitoring. Perhaps, just as important is that construction workers are a very mobile population and post-natal visits to the health center may not be possible if some move out to another site after the birth of a child. The large number of construction site workers situated near the Center three may likely account for higher number of mothers who do not bring their children for post-natal check-ups.

For those mothers that do come for check-up at Center one and three, nurses at both centers state that there were only a few cases which had health complications. Such cases include a mother who had syphilis whom was provided with treatment or another mother who was on birth control and did not have her period so she stopped take the pill to await her period for many weeks. Again, as mentioned, such cases of complications were so few that nurse providers were able to identify and discuss them.

5. Conclusion

From the in-depth discussion and focus group findings, problems with medical equipment and hospital infrastructure were not evident, either from medical personnel or the focus group participants point of view.

A major problem from the nurses point of view is the lack of nurses working in ante-natal and delivery wards as well as health centers. Interestingly, this lack of personnel was not seen as a major problem by hospital administrators. The lack of personnel, however, was brought up and discussed rather extensively in the focus group discussion with various examples given. A tentative conclusion can be made here that a lack of personnel or overworking existing personnel should be seriously looked at in both hospitals and health centers.

A second major problem is the human factor involved in daily hospital activities and services to patients. The scolding of nurses in front of patients was discussed as a major problem by nursing staff, both nurse at administrative level and at working level. Very importantly, the context of scolding in front of patients was also highlighted in the focus group discussions. Nursing personnel explained how this affected their work and focus group participants discussed how this made them fear doctors. Our information on this topic are somewhat limited in that we did not conduct any in-depth discussions with medical doctors concerning the topic of scolding or social interaction within the hospital. It seems, however, that humanism and the process of healing should be continually instilled to a certain proportion of medical doctors.

Two potential problems are identified with regard to effective post-natal care. Firstly, an efficient referral network both within Bangkok and the provinces are necessary to refer cases and monitor maternal and child health. Secondly, mothers must be instilled a value of the importance of getting their file from the health center before they move away because they and their baby may encounter certain illnesses which could be easily overcome if they monitor their health by regular ANC visits at any health centre around the country.

The opinions stated by both providers of 'not enough time' seems to be a recurring pattern throughout our in-depth discussion, in both hospital and health center activities. It would seem useful that importance be given to a seminar programme on

assessing and managing work activities of nurses from the providers point of view. A seminar of this kind would be able to address whether or not there is a heavy workload being placed on nurse providers in the pre-natal, post-natal and delivery wards and its effects on work efficiency. An issue seems to emerging here is that administrators are explaining the activities that their ward is undertaken and of its seemingly complete and efficient coverage. However, nurse providers seem to highlight the heavy workload being placed on themselves and its negative impact on their efficiency. Its seems unlikely that subordinates would complain without any basis. It also seems likely that strains do exists in the daily work activities and avenues to constructive criticisms seem very limited.

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Note

1 Crude death rate is the member of deaths per 1,000 population in a given year.
2 Maternal mortality rate is the number of deaths due to deliveries and complications of pregnancy and the puerperium (within six weeks after delivery) per 1,000 live births.

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