

# **CULTURAL BELIEFS AND TRADITIONAL RITUALS ABOUT CHILD BIRTH PRACTICES IN LAO PDR**

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## ACRONYMS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARROW	Asian-Pacific Resource and Research Centre for Women
BBC	Beyond Beijing Committee
CAM	Constituent Assembly Member
EDP	External Development Partner
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
GON	Government of Nepal
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IEC	Information Education Communication
INGOs	International Government Organizations
IoM	Institute of Medicine
KAP	Knowledge Attitude and Practice
NGO	Non Government Organization
NRs	Nepalese Rupees
OPD	Out Patient Department
PNC	Post Natal Care
POP	Pelvic Organ Prolapse
PPP	Public Private Partnership
RH	Reproductive Health
SMNF	Safe Motherhood Network Federation
TBA	Trained Birth Assistant
TUTH	Tribhuvan University Teaching Hospital
UNFPA	United Nation Population Fund
UPA	Uterine Prolapse Alliance
UP	Uterine Prolapse
UVP	Uterovaginal Prolapse

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## 1.0 INTRODUCTION

Lao PDR is a low income country with the total population of 5.6 million. The reproductive health status of women and girls, especially ethnic groups who live in the remote areas remains poor. Lao PDR had one of the highest maternal mortality rates in the world (405/100,000 live birth) according to the Lao Reproductive Health Survey, 2005 (National Statistic Centre, 2007). The total fertility rate was 4.07 children per woman aged 15-49 years old during the period of 1-36 months before the survey. In rural areas, women and adolescent girls have shorter interval between births, many young women have a higher fertility rate compared to those living in the urban areas (National Statistic Centre, 2007). According to MDGs, Lao PDR should strive to affect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. Lao PDR with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births (POA, 8. 21).

Maternal and perinatal mortality and morbidity levels are key indicators of public health in each country (Urassa et al., 1995; World Health Organization, 2000). The Safe Motherhood program in Laos was initiated in 1998 in order to reduce maternal mortality and morbidity. Maternal mortality is still high in low income countries (Starrs and Interagency Group for Safe Motherhood, IAGSM, 1998) and lack of access to maternity services is a main contributing factor (Nasah et al., 1994). The problems within the high maternal problems were due to poor health services, including poor human and financial resources; inadequate maternal health services; low awareness on reproductive health, safe motherhood and modern contraceptive methods

The National Reproductive Health Survey in 2005 showed that there was a low coverage (28.5 %) of antenatal care (ANC) in which about 15.7% obtained ANC from doctors, 8.7% from a nurse, 4.3% from midwife, and 1.6% from health worker. Only 0.8% received ANC from traditional birth attendants. Among children born in the last 5 years, approximately 85 % of births occurred at home. Whereas of the 12.8% of birth took place at a health facility, 1.8% were delivered at the central hospitals, 5.1% at provincial hospitals, 4.8% at district hospitals and less

than 1% at health centers and 0.3% at private clinics. Women living in the urban areas were more likely to deliver at health facility compared to women living in the rural areas (51.2% versus 2.1%) The reasons for delivering babies at home are because more than 75% of mothers felt there was no need to go to a health facility, 34% because of the distance, and 5-6% because of the health care costs (National Statistical Centre, 2007).

In the Reproductive Health Survey (2007) most deliveries were assisted by relatives or family members (63.4%) and traditional birth attendants (12.1%). Health personnel assisted only 18% of births - 8% by doctors, 3% by nurses, 3% by midwives and 4% by others health workers (National Statistical Centre, 2007). In urban areas, medical doctors delivered 63.2% of births compared to 15.3% in rural areas with roads and 5.3% in rural areas without roads. The question to ask is why many women deliver at home and the answer might be related to socio-economical and cultural factors. Mothers generally have a social support person to assist them during delivery and during the postpartum period. Three main delay factors which cause maternal mortality such as the delay of decision among pregnant women, the delay of transportation and delay of treatment had been identified. In Laos, the delay of decision and transportation are still major factors (MOH, 2002).

It is crucial to identify the underlying causes of MMR since 85% of births occur at home and not with trained birth personnel, it is important to find out the attitudes and practices that influence pregnant women to think that it is unnecessary to come to health centers and hospitals for ANC, delivery and postnatal care (PNC). Moreover, the traditional, cultural and social context of Lao women from the rural tribes regarding this delay is still not clearly explained. In accordance with the previous information about the high proportion of home delivery and traditional child birth practices in Laos, a further study using qualitative methods should be conducted, in order to gain better understanding about the socio-cultural and gender perspectives regarding cultural childbirth practices and the influence of women relatives in rural areas. This information would help us understand the reason behind these traditional practices which could be incorporated into the health intervention programs in order to reduce the high IMR and MMR within the country.

## **2.0 OBJECTIVES**

### **2.1 Objectives**

1. To gain a better understanding about the socio-cultural background of Lao ethnic women on issues pertaining to home delivery and traditional child birth practices.
2. To explore the gender perspectives influencing home delivery and traditional child birth practices.
3. To explain the reasons for giving birth at home and carrying out traditional child birth practices among Lao rural women.

#### **2.1.1. Indicators for Outcome Measures**

- What are the socio-cultural beliefs and practices on child births that the women and their relatives hold onto? (The indicators to explore cultural meanings and beliefs and practices around pregnancy, childbirth and postpartum held onto by the women and their relatives (husband, mother-in-laws); and birth attendants (traditional birth attendants and trained persons).
- What are the gender aspects of child birth practices in Laos? The indicators for power relations on: i) the difference between the women's decision making on child delivery and postpartum practices from their husbands or male relative and older female relatives, ii) the sexual health and rights of women with regards to gender, to explore women's experiences on unwanted sexual intercourse during birth practices.
- Why do Lao women still give birth at home? The indicators for reasons include accessibility, availability of staff and equipment, affordability, lack of privacy and confidentiality.



## **3.0 METHODOLOGY**

### **Research Methods & Locations**

Qualitative research methods were used in this study including focus group discussion and in-depth interviews in order to explore and gain better understanding about the reasons for choosing home delivery, the patterns of traditional child birth practices and rituals, and the influence of women relatives on home delivery and traditional child birth practices.

### **3.1 Study Site**

The study was conducted in the rural communities of two provinces; one in the Central and one in the Southern parts where there are many ethnic women. The Khammouane and Champasack provinces were purposively selected for the Central and Southern parts respectively. Two districts were selected for each province.

The Khammouane province consists of 333,487 population, 61081 households and 9 districts and the average household size is 5.7. The population is made up of lowland and upland Lao groups: Phuan, Tahoy, Kri, Katang etc. The estimated total fertility rate is 5.0 and the number of children born is 4.6. The infant mortality is 103 (112 and 94 per 1 000 live births for boys and girls respectively) and the maternal mortality is 420 per 100,000 live birth (National Statistic Centre, 2007). For the Khammouane province, the Thakhek and Mahaxay districts were selected because one has an ‘intermediate’ connection to health facilities and the other is ‘remote’ and away from health facilities, thus both can provide useful socio-demographic indicators (literacy rates and proportion of population belonging to socially marginalized groups).

The Champasack province encompasses 593,839 population, 104,249 households and 10 districts. The average household size is 5.5 and the estimated total fertility rate is 4.2; the number of children born, however, is 4.8. Infant mortality is at 70.5 (75 and 60 per 1 000 live births for boys and girls, respectively) and the maternal mortality is at 320 per 100,000 live birth (National Statistic Centre, 2007).

### **3.2 Study Population**

The key informants included women who experienced home delivery during the last year, their family members (husbands, mothers (in-laws), grandmothers or relatives), head of villagers, and the Lao Women's union of traditional birth attendants (TBAs) and health officers at the district health offices and centers. The inclusion criteria were women who had past experiences delivering at home but with different pregnancy outcomes. For example, women, particularly the ethnic groups from the Southern and Central parts of the rural areas, who had an obstructed labor, whose relative experienced complications or died during child birth or postnatal period, whose relative played a substantial role made decisions during the antenatal/delivery/postnatal periods), were selected.

### **3.3 Sampling Method**

The key informants were selected purposively from the community after discussion with the district health offices and hospitals, health centers and head villagers. Women were recruited through the network of health centers and head villagers as well as snowball sampling technique that women were asked to nominate or to contact their friends or relatives, who had experienced home delivery with or without complications, and who would be interested to participate in the study. In addition, TBAs, health staff, head villagers and Lao women union who are responsible for maternal and child health (MCH) were also interviewed.

Seven FGDs with 42 participants were conducted by recruiting women who have had experienced home delivery in the last year. Twelve in-depth interviews with selected women who had past home delivery with different pregnancy outcomes, eight husbands and eight mothers of women who delivered during the past year were interviewed. In addition, eight TBAs and twelve head villagers and six Lao women's union representatives at the provincial and district levels were also interviewed. Data collection took place from December 2008 to January 2009.

### **3.4 Data Analysis**

The qualitative data were analyzed using content analysis. Information from the interview consists of the women's description and explanation of their cultural childbirth practices and reasons for giving birth at home. Raw notes and tape recordings were used to generate transcripts in the local language. The investigators read the transcripts many times in order to gain better understanding of the context, and then coding, identifying categories and major themes.

### **3.5 Ethical Considerations**

This research proposal was submitted to the ethical committee for health research of the University of Health Sciences, Ministry of Health for review and approval. A verbal consent was obtained from the women and their families, head villagers, Lao women's union and TBAs for in-depth interviews (IDIs) and FGDs before participating in the study.

## **4.0 FINDINGS AND DISCUSSION**

### **4.1 Socio-demographic Characteristics**

The age of the participants ranged from 18 years old to 37 years old for IDI and 17 to 38 years for FGDs. Three women from IDI and 10 women from FGDs were illiterate. One case from IDI and one case from FGD had a history of stillbirth. Two cases from IDI had complications such as collapse and bleeding: a woman who when collapsed was assisted by TBA but she recovered and did not go to the hospital and a woman with bleeding was referred to the provincial hospital and was safe. The babies lived and there were no cases of birth deformities.

Eight TBAs from four districts were part of the IDIs. Two of them were medical professionals who used to be auxiliaries and worked at the obstetric section at a provincial hospital before they retired. One TBA was a medical assistant and one was a midwife. Most of them have practiced and experienced birth attending for more than or at the least 10 years. A few of them (n=2) had

only received training on birth attending at the district level and the topic of the training was about the technique of birth attending.

The majority of village heads were male (11 males and only one female). The age ranged from 35 to 61 years. All of them were literates, at least primary school. Most of them were Buddhists, some were Christians and the rest followed other spiritual beliefs.

## **4.2 Attending Antenatal Care (ANC)**

### **4.2.1 Attending ANC at the Health Facilities**

The majority of women attended antenatal care at the public hospitals. The reasons for attending ANC at the health facilities were to prevent complications from occurring during pregnancy, to be safe under the supervision of medical doctors and to ascertain that both mother and baby are fine.

*“During pregnancy, my wife attended the ANC at the district hospital because my wife was not so healthy, and she often got sick and to prevent the difficult labor.”*

*(Husband, 38 years old)*

Some pregnant women refused to attend ANC even though their husbands or mothers advised them to obtain ANC. However, because the pregnant women were healthy and not at risk, hence there was no need for them to attend ANC. The reasons of not attending ANC include the following: no time, lack of money, lack of means of transport, and long distance.

*“...My husband and mother-in-law also suggested I attend ANC, but I did not go, because I think that I was healthy and had experience in childbearing.”*

*(Women who had delivered, 24 years old)*

## **4.2.2 Attending ANC with TBAs**

Some of the women who had delivered reported that they attended ANC with TBAs. The TBAs provided ANC services by examining the fetal position and offering consultation to the pregnant women. If some pregnant women have an abnormal fetal position, TBAs advised them to go the health facilities.

*“Most of the pregnant women came to my house for their antenatal visit. I advised them to take care of themselves during their pregnancy, especially wearing comfortable clothes and not drinking alcohol because of the negative health consequence on the baby and suggested they prepare some stuffs for delivery. In addition, I also advised them to attend ANC at the health facilities more frequently, especially during the last trimester.”*

*(Female TBA, 67 years old)*

The other reason cited was because the mobile health care team came to do vaccination at the villages, thus the husbands recommended their wives attend ANC with TBAs. This is because it was easy and they did not need to go to the health facilities and it involved no transportation cost.

## **4.3 Care and Support**

### **4.3.1 Physical Activities**

Most of the women during pregnancy reduced their daily physical activities, especially hard work was prohibited. Similarly, their husbands and mothers or mothers-in-law were also concerned with the physical activities of these pregnant women carried out. Rigorous activities were seen as harmful to the pregnancy because the activities may lead to miscarriage or abortion. The heavy activities prohibited include lifting heavy objects such as carrying water, gardening, working at the rice fields, carrying charcoal; however, they can do light works such as cooking and cleaning their houses.

*“When I was pregnant, my husband shared my daily housework such as cooking, farming, gardening, clothe washing.”*

*(Woman who had delivered, 18 years old)*

Ongoing activities during pregnancy will help the women to have enough energy to push when in labor. However, the women were prohibited from sleeping during day time due to their belief that they would experience difficulty in labor, in retaining the placenta and the baby would contract jaundice.

*“It was suggested by the elderly that I should not sleep during the daytime because the baby would have jaundice after birth.”*

*(Woman who had delivered, 24 years old)*

#### **4.3.2 Psychological Support**

In addition, the women would like their husbands to take care of them and provide some psychological and emotional support as the pregnant women might get angry easily.

*“I would like my husband to take care of me and guide me to the hospital and I did not want my husband to go out socializing with other girls or even drinking and smoking during my pregnancy.”*

*(Woman who had delivered, 25 years old)*

#### **4.4 Sexual Intercourse during Pregnancy**

Any sexual act during pregnancy was thought to be dangerous to their baby as it could cause high contractions of the uterus and miscarriage. In addition, sexual intercourse could injure the baby and cause congenital malformation as well as preterm labor. The women and their husbands perceived that having sexual intercourse during pregnancy is harmful to the baby and they were afraid of miscarriage or abnormality of the fetus. They were also afraid that the delivery would be

prolonged or obstructed. Some of them mentioned that they avoided having sex starting from the third trimester until birth.

*“I did not have sex with my wife during her pregnancy starting from the third trimester because it would cause the health of my wife and fetus to decline, plus the sperms will have a negative effect on fetus and there would be a lot of lochia.”*

*(Husband, 34 years old)*

#### **4.5 Health Risk during Pregnancy**

Most of the women, their families and TBAs knew about the health risks that might occur during pregnancy, including abortion, vaginal hemorrhage, and premature delivery, still birth or death of fetus. If the pregnant women work hard, it would have some effect on the baby such as the loss of fetal movement.

*“The health risks during pregnancy include collapsing (fainting), vertigo, abortion, which could endanger the fetus. To prevent this, the pregnant women have to take care of themselves and not work too hard.”*

*(Mother of women who had delivered, 54 years)*

If TBAs found cases of at-risk pregnancies, they suggested the women rest and not work hard, and if the women did not get better, they advised them to go to the health facilities. Some TBAs advised the women to go to hospitals, directly.

*“If I found an at-risk case, I suggested they go to the hospital, because I did not have the equipment to handle the case, especially if it involves the mal-position/presentation of the baby because I have never assisted in delivering babies by myself. I just told them to go to the hospital.”*

*(TBA, 56 years old)*

Some of the women, their husbands and mother-in laws were not aware of the health risks of pregnancy. However, they knew that there were some risks during delivery, when the labor is prolonged.

*“I know that there was no risk during pregnancy; however, there were some risks during labor when the labor is prolonged and there is no early prognosis for this kind of risk.”*

*(Husband of a woman who had delivered, 32 years old)*

## **4.6 Traditional Beliefs and Practices during Delivery**

### **4.6.1 Birth Preparedness**

Most of the women who had delivered reported that their husband prepared some things for childbirth such as money, sarong, nappies, baby clothes, rope, ginger, herbal medicine, boiled water, wood, and bamboo bed. Some women mentioned that their mothers prepared these things for them.

*“My husband prepared wood for fire, boiled water, a bamboo bed and charcoal for roasting.”*

*(Woman who had delivered, 24 years old)*

*“I prepared some hot water and nappies for the baby.”*

*(Mother of woman who had delivered, 50 years old)*

However, some women and their mothers were afraid that advance preparation of these things, especially baby clothes would cause the death of the unborn baby.



*“I did not prepare anything for my baby. I was told by the elderly that I do not need to prepare anything in advance for my baby. It is believed that it will be a stillborn or death of the uterus.”*

*(Women who had delivered, 25 years)*

Some TBAs did not prepare anything for child birth assistance because the relatives of the pregnant women were the one who were responsible for preparing the necessary things for child birth, for example, a razor blade or sharp bamboo piece to cut the cord. But some TBAs prepared the childbirth essentials themselves or brought their delivery kits with them, especially TBAs who have been trained at the health district office. Some TBAs also prepared gloves, soap and other materials used during child birth.

*“For birth preparedness, I prepared soap, gloves, candle and magic water (Nam Mon) to blow and spray on the mother in case of a difficult delivery. For the cutting of the umbilical cord, I prepared the sharp bamboo piece (Mai Kase) as I think it is clean enough, and I have never used a razor blade to cut the cord because I am afraid the baby will get umbilical tetanus.”*

*(TBA, 56 years old)*

## **4.6.2 Birth Assisting**

### *4.6.2.1 TBA Assistance*

Most women in the FGDs and IDIs reported that the person(s) who assisted during delivery was either TBAs, husbands, mothers or relatives. TBAs supervised the deliveries at the women's home. Some husbands mentioned that they are the ones who assisted in the delivery, in addition to the TBAs. They helped their wives to deliver because if the TBAs assisted during delivery, the family had to prepare some gifts for the TBAs as a token of appreciation for their assistance. It is believed that if the family did not give gifts to the TBAs, it considered as a sin.

*“After the delivery, I had to prepare some gifts for the TBA, such as clothes, light, flowers, and perfume to compensate and as a sign of respect to the TBA as they helped my wife during delivery and they apologized because they had to touch blood and waste the woman’s clothes tainted with blood. Thus giving the gifts mean my family is sinless and the baby will grow up well.”*

*(Husband, 45 years old)*

The predominant role of TBAs was to give traditional medicine and some magic water during labor. The herbs and magic water (Nam Mon) were used to relieve pain during labor, treat abnormal discharges, and provide the women with strength to push during labor. TBAs advised them to walk, and compress the abdomen during labor pains.

*“During labor, I suggested the pregnant women to walk in order to engage the head of the baby to the mother’s pelvis and make it easier for delivery. I have never suggested that they should restrict their activities; they can carry on with activities they need to do.”*

*(TBA, 56 years old)*

#### 4.6.2.2 Family Assistance

During labor, the women’s mothers and husbands also provided them with care and support. Their mothers applied herbal medicine and eggs on the abdomen which could lead to an easy delivery. In addition, the women drank coconut milk during labor in order to facilitate the labor.

*“I used a herbal medicine called “Wane” which I put in the water, and I used this water to put on the head of my wife which could lead to an easy labor and reduce the pain during labor.”*

*(Husband, 32 years old)*

Family members also mentioned that family support is important during child birth. The pregnant women would like their husbands and mothers to be close to them for psychological support. Participants also mentioned that women had to drink water that has been blessed with sacred

words known as “*Nam Mon*”, take a bath with this water or put it on the abdomen in order to experience an easier child birth.

*“I used the water “Nam Mon” when I take a bath and it is believed that my wife will have an easy birth.”*

*(Husband, 27 years old)*

TBAs also provided consultation and different approaches to women during labor in order to facilitate the child birth.

*“To support and assist women during labor, I suggested she lie down and hold a rope, and I pushed her abdomen in order to position the head of the baby downwards. Then, I did a vaginal examination to check the cervical dilatation, when it was fully opened, I told her to push with energy.”*

*(TBAs, 38 years old)*

## **4.7 Cultural Practices and Beliefs during Postpartum Period**

### **4.7.1 Umbilical Cord Cutting**

According to the traditional beliefs and culture, most of TBAs cut the umbilical cord by using a bamboo called “*Mai Ka See*” or razor blade. Some key informants mentioned that they used alcohol to wash the razor and they used a black or white rope to tie the umbilical cord. After giving birth, the baby was given a bath and then placed on the bamboo plate beside the mother.

*“I used to cut the umbilical cord using a sharp bamboo piece (tew may phai) because I did not have a delivery kit. I think it was clean and safe, and it was easy and available in our community. Based on my experiences, there were no cases of umbilical tetanus with the use of “tew mai phai”.”*

*(TBA, 58 years old)*

#### **4.7.2 Mother Roasting – “Yu Kam” or “Yu Fai”**

After delivery, the women were guided to lie down on the bamboo bed which was prepared as a hot bed by starting a contained fire under the bed. This is traditional child birth ritual or practice known as the hot bed – “Yu Kam” or “Yu Fai” which literally means “on fire”. Mothers put salt on the fire and guided the postpartum women to lie on the hot bed. Before staying on top of the fire (“yu kam” or “yu fai”), another ritual is conducted in which the water taken from a traditional healer is blown at to the women and a black and red cotton is tied to the wrist, ankle and neck by the elderly in order to ward off bad spirits. Then, the women are told to stay on the fire. During the hot bed ritual, the women had to take hot baths, and drink hot water between one to two weeks. The reason for the hot bed was to strengthen the health of the women and accelerate the contraction of the uterus.

*“According to the ritual practice, the postpartum women had to sit on the banana leaf with salt for about 40 minutes in order for wounds to get heal quickly. After that, the women had to take a hot bath with herbal medicines before staying on the hot fire, drink about four pots of hot herbal medicine mixed with water, and also, take hot baths early in the morning without cleaning the skin for two weeks.”*

*(Mother, 50 years old)*

#### **4.7.3 Placenta Disposal**

The placenta was buried deep down into the earth by the husbands beneath house because it was dirty and they could not just throw it away. In addition, they also started a fire around the buried area in order to prevent spirit and animals from reaching the placenta. If any of them touches the placenta, it is believed that the lochia might dry up, the child could be inflicted with diarrhea or it could even cause neonatal death.

*“I buried the placenta in the ground floor near the stairs and made a fire near that place. It is believed that if we bury the placenta far from the house, the child would go away. The fire is related to the belief of expelling the umbilical cord quickly.”*

*(Husband, 32 years old)*

Due to the fear of scavenging animals dragging out the buried placenta, some bury the placenta in the hilly places and when they bury it, they are not allowed to look to the left nor right.

#### **4.7.4 Care of Newborn**

The newborn baby was given water after delivery because they were afraid that the newborn would be thirsty. Some key informants mentioned that they dripped boiled water on the mouth of the newborn, some used a water bottle. The other reason was that some mothers would not have breast milk yet. In some villages, they put a needle in the water and gave the water to the child to drink because they believed that if the children drank that water, they would be clever.

*“After delivery, I suggested they feed the baby water or honey using clean cotton soaked with water or honey, which is then softly pressed onto the lips of the baby because the mother was ready to breast feeding yet.”*

*(TBA, 58 years old)*

It is believed that the baby should drink water immediately after birth. If the baby is not given water, they believed that the baby will have jaundice and conjunctivitis. Some TBAs suggested giving colostrums to the baby and also breast milk immediately after delivery.

*“After delivery, I did not suggest they give the baby any food or drink, but I advised the mother to breast feed in order to stimulate lactation and make the uterus contract.”*

*(TBA, 38 years old)*

## 4.8 Decision Making on Places of Delivery

### 4.8.1 Husband as Main Decision Maker

Most of the women mentioned their husbands and mothers or grandmothers influenced their choice on the place to deliver their baby. Most of the husbands mentioned that they are the one who made the decision that their wife should deliver at home or the hospital.

*“My husband decided where I should deliver. However, he also mentioned that it is up to me and I decided to deliver at home.”*

*(Woman who had delivered, 28 years old)*

*“I would like my wife to deliver at home because it is convenient, cheap and our relatives can stay with us. In addition, I could like to be close to my wife during labor and delivery.”*

*(Husband, 32 years old)*

It is suggested that the women are powerless when it comes to making a decision within the household, even the place of delivery. Women had to ask their husbands first to get an agreement and their husbands would then bring them to the hospital when the need to deliver in the hospital arises.

### 4.8.2 Joint Decision

Some of them reported that both husbands and wives made a joint decision to deliver the baby at home or the hospital. Most of them decided to deliver, first, with the assistance of TBAs. If the TBAs could not help them, they would go to the hospital.

*“I used to consult my husband where to deliver our baby and we decided to deliver at home because my previous delivery was also done at home.”*

*(Husband, 35 years old)*

### **4.8.3 Influence of Others**

Even though the women and their husbands may prefer to deliver the baby in a health care center, others like the women's mother or mother-in-law, aunt or neighbor, could also influence their decision. The women's mother or mother-in-law who had delivered at home would advise their daughter or daughter-in-law to do the same.

*“My mother used to deliver at home, so she advised me to deliver at home. When I did, nothing bad happened.”*

*(Woman who had delivered at home, 25 years old)*

### **4.8.4 Influence of TBAs and Health Care Providers**

Advice from TBAs, health care providers during ANC also influenced the choice of the place of delivery. Some health providers did not directly advise the women where they should deliver their baby. Eventually, it still depended upon the women to make their own decision.

*“The nurse did not advise my wife to deliver at the hospital when my wife attended antenatal care. She said that my wife could deliver at home.”*

*(Husband, 27 years old)*

## **4.9 Sexual Health and Rights of Women**

The frequency of sexual practices among couples expecting a baby decreased because the libido of the pregnant women was suppressed and they still thought that talking or expressing about their sexuality is a taboo, thus they lacked communication skills to express their sexual desires. Most women who had delivered mentioned that they never did anything to express their sexual desire. If they did, it is deemed as an unusual practice by their husbands. This is because the female libido is still critiqued as a bad thing in the social and cultural construction of the sexuality of women. Hence, they try to control themselves and forget about it. One of the

common perceptions about the sexual health and rights of the women and their husbands during pregnancy is as follows:

*“I did not express my sexual desire with my husband as it depends on the sexual desire of my husband. Sometimes, I felt tired and did not have the libido. However, if my husband would like to have sex, I can’t refuse him.”*

*(Woman, who had delivered, aged 30 years)*

## **4.10 Reasons for Place of Delivery Preference**

### **4.10.1. Home Delivery**

#### *4.10.1.1 Easy and Convenient*

The factor that it was easy and convenient was cited as the reason for delivery at home. Most of the family members reported that it is easier to deliver at home as they did not need to move from one place to another. Plus, their family and relatives did not need to visit them at the hospital.

*“I would like my wife to deliver at home because it is easy and cheap. In addition, I can help my wife during labor by massaging her abdomen when she’s in pain...”*

*(Husband, 34 years old)*

#### *4.10.1.2 More Experience with Home Delivery*

The factor – previous habit was taken into account when selecting the place of delivery. Most of the key informants from the FGDs reported that they had some experiences delivering at home from their first child to their current pregnancy. If the previous place of delivery was good, then they are more likely to go back to that place in their next pregnancy. The child birth experiences of their mothers, mothers-in-law, mothers, aunts and grandmothers, also influenced on where



they should deliver the baby. One common perception among women discovered during the FGDs was:

*“Our mother or grandmother used to deliver at home with the assistance of TBAs and nothing bad happened.”*

*(Woman, who had delivered, 25 years old)*

#### *4.10.1.3 Family Support*

Family support is another important factor that the women and the family members brought up. It is explained that the presence of family members such as the women’s mother and husband, is vital because their closeness provide these women with the psychological support and physical touch like a back massage, the gentle touching of the abdomen. Hence, the women felt better through the warmth of their family members. Most women and their husbands prefer to have the baby delivered at home because at the hospital the husband could not enter the delivery room when his wife goes into labor.

*“I would like to deliver at home because I would like my husband to stay with me during labor and I could feel his warmth and not be afraid. My husband would hold my hands, and the TBA would also stay with me.”*

*(Woman who had delivered, 29 years old)*

*“I provided psychological support to my wife when she delivered by holding her hand in mine, and I was there to give her emotional support when pushing during labor.”*

*(Husband, 31 years old)*

#### *4.10.1.4 Affordability*

Most of the family members reported that pregnant women would like to deliver at home due to lack of money to pay for delivery, transportation and food. Home delivery did not cost too much,

while the cost of an institutional delivery was higher, as the cost included food, medicine, rooms, and transportation. A common opinion among FGD and IDI participants is:

*“I could not afford to deliver in the hospital due to the high cost compared to a home delivery. If I gave birth in the hospital, I would have to pay for the rooms and medicine, while a home delivery I did not have to pay anything except the gift for TBAs who assisted in the delivery.”*

*(Woman who had delivered, 29 years old)*

#### *4.10.1.5 Accessibility*

The lack of transportation was reported, in all villages, as a contributing factor for choosing to deliver at home. In the rural areas, there was no public transport from the district to their village. Therefore, they had to use their own vehicles such as motorbikes and small trucks as means to get to the health centers.

*“Because my daughter was delivering for the first time, I wanted her to deliver at a health facility. However, I had to wait for the bus or pick-up-truck for 2 hours, and still there was no transport. Moreover, I did not have my own transport.”*

*(Mother, 50 years old)*

Sometimes, labor would start at night and they did not like to travel at the night. They were afraid that labor would occur during the journey because of the long distance to the health facilities.

#### *4.10.1.6 Acceptability of Medical Interventions*

Delivering a baby in the right position was also an important factor in choosing to give birth at home. Some women mentioned that when they deliver at home, to be in a sitting position, the women had to hold a rope from the ceiling so that they can be in knee-chest position. Delivery at the hospital, however, the women had to lie in the horizontal position on a labor bed with their legs strapped onto the metal stirrups or on the women’s back.

Some women who had delivered mentioned that they were afraid of some of the medical procedures such as the cutting of the major labia (episiotomy) and doing suture during delivery at the hospital, plus they cannot stay on the fire (hot bed) during the postpartum period.

*“I did not like to deliver at the hospital because I was afraid that the health staff would cut the major labia and I could not stay on the fire or hot bed and I was afraid of bleeding and...The other medical procedure was the frequency of the vaginal examination at the health facilities compared to the delivery at home where there was no vaginal examination.”*

*(Woman who had delivered, 24 years old)*

#### *4.10.1.7 The Value of Child Birth Rituals and Practices*

In addition, women also reported that they could not take a hot bath and stay on a hot bed immediately after delivery at the hospital. If they delivered at the institutional places, there were many difficulties and they could not do as they like if they stayed at home.

*“After delivery at home, I can take a hot bath so the wounds would heal quickly and bleeding would stop, therefore I can stay on the hot bed. If I delivered at the hospital, I could not stay on the hot bed immediately after birth and I was afraid that the stitching would be teased.”*

*(Woman who had delivered, 28 years old)*

Some key informants mentioned that health staff did not counsel them about the place of delivery during ANC and some health workers told them they could deliver at home if they would like to do so.

*“The health staff at the health center did not advise me where to deliver during ANC.”*

*(Woman who had delivered, 24 years old)*

#### *4.10.1.8 Poor Quality of Health Care*

The women or their mothers, who had bad experiences with the health staff due to low quality services, did not want to deliver at the hospital.

*“My daughter did not want to deliver at the hospital because I had a bad experience with the health staff. The last time I was ill, I went to hospital and the health staff gave me some injections. Then, I got worse, so I did not want my daughter go to the hospital.”*

*(Mother, 50 years old)*

#### *4.10.1.9 Lack of Privacy and Confidentiality*

The lack of privacy and confidentiality was also reported by the women, their mothers and husbands as the reason for giving birth at home. Because there were many health staff present during delivery, the women felt shy and uneasy having to expose themselves to the staff. Hence, this is one of the contributing factors for delivery at home.

*“In health facilities, there were many health staff during delivery and I was shy, so I preferred to delivery at home.”*

*(Woman who had delivered, 25 years old)*

#### *4.10.1.10 Absence of Female Birth Attendant*

The gender of birth attendants also influenced the decision to deliver at home. If the birth attendants are male, most of the women could not accept it due to shyness and embarrassment. However, their husbands could accept it if the gender of the health care provider is male.

*“I did want to delivery at the health facilities but I was shy because of the presence of the male health care providers.”*

*(Woman who had delivered, 25 years old)*

Although these reasons clearly favor home delivery over hospital delivery, sometimes there was just no time to decide where one should go to delivery because of the quick progression when in labor. Some mothers said that their labor progressed so quickly, so they cannot go to the health centers or other health facilities on time. A key informant mentioned that:

*“Because the labor was easy and quick, a short labor, so I could not go to the health facility on time.”*

*(Woman who had delivered, 26 years old)*

#### **4.10.2 Institutional delivery**

##### *4.10.2.1 Skilful medical staff*

The reasons for choosing an institutional delivery were because it was safe and there was close supervision by trained health workers. The doctors were skilful and had medical knowledge to assist women in childbirth if any complications arose.

*“I would like my daughter to deliver at the hospital because I was concerned for my daughter’s health and I would like the health staff supervise and examine her. So, good quality assistance is at hand to help the mother and baby on time.”*

*(Mother of women who had delivered, 54 years old)*

##### *4.10.2.2 Handling complications*

The delivery at the health facilities was the alternative choice. If the delivery is prolonged or if there were some complications during delivery such as bleeding, breech presentation, or vaginal tears, they would like to deliver at the hospital because the health providers can handle the complications.

*“For the first child, I delivered at the hospital because there was some bleeding.”*

*(Woman who had delivered, 19 years old)*

#### **4.11 Discussion**

To our knowledge this study is the first attempt to describe the cultural and traditional belief of pregnancy and child birth practices. The findings revealed that most participants practiced traditional child birth rituals and practices during the pregnancy, delivery and postpartum periods. Our research supports the view that cultural rituals are important in pregnancy, childbirth and puerperium (Phongphit & Hewison, 1990; Fok, 1996; Du, 1998; Kaewsarn & Moyle, 2000). The pregnancy, delivery and postpartum periods are important in the women’s life and the knowledge and experience are a collective one, not only for the pregnant women but also others close to them, their husbands and mothers.

The study findings show that from the majority of mothers who attended ANC, only a few of them delivered at the hospitals. Firstly, pregnant women needed to be assured that their pregnancy is fine. If the pregnancy is fine, the mothers decided to deliver at home (Neema, 1994). In the last 5 years, the Lao Reproductive Health Survey (2005) found that 28.5% of births were from women who received ANC and 84.8% of children were born at home.

The traditional and cultural beliefs and decision making within the household influence the child birth practice and choice of the place of delivery. In Laos, the cultural and traditional beliefs related to pregnancy and child birth are aimed to preserve the life and well being of the mother and her baby. This is similar to the biomedical mode, but differs in terms of the immediate social context in which they act upon, and of the cultural values that they espouse (Muecke, 1978). In the Lao culture, child bearing is a normal event in women’s life. Lao ethnic women still practiced traditional child birth including birth preparedness, umbilical cord cutting, and the roasting of mothers and so on.

The findings also provided evidence that women's decision making about the place of delivery were influenced by socio-economical, accessibility, and socio-cultural factors. Advice from their husbands, parents and care providers are important factors influencing the choice of the place of delivery which was similarly to previous research carried out in rural Tanzania (Mrisho et al., 2007). Even though women are responsible for the health status of their households, the decision making of the choice of health service utilization was made by their husband and parents (Tanner & Vlassof, 1998). Women have to consult their husbands, mother-in-law and the elderly before seeking care. According to previous researches, the decision about the place of delivery was made by nurses, while husbands and parents made the decision regarding the place of delivery when complications arose (Urassa et al., 1997).

This study also revealed that the main reasons for home delivery were because it was easy and convenient and also due to the experience of previous home deliveries, the lack of money to pay for delivery, transportation and food which were similar to previous studies (Ensor & Cooper, 2004). Compared to the National Reproductive Health Survey in Laos (2007), about 75.7 % of women who did not giving birth in the hospitals stated "Not necessary" as their reason. This reason was cited by a large majority of respondents irrespective of their background such as place of residence and level of education. Other reasons less frequently cited included "Distance" (33.7%) and "Cost" (5.5%). Most mothers also reported that they delivered at home because the labor started earlier than expected or at night, which mean that delivery could be unplanned or inconvenient. Our findings were similar to previous studies (Amooti-Kaguna & Nuwaha, 2000; Chandrashekhar, Hari, Binu, Sabitri & Neena, 2006). Numerous barriers including access to health facilities and transportation to health services were identified as the reason for home delivery. Several studies also found that the lack of accessibility to health services was the main barrier to delivering at hospitals (Borgi et al., 2006; D'Ambruso et al., 2005; Amooti-Kaguna & Nuwaha; 2000). The factor - previous habit, was identified as the reason for delivering at home. Habit means one's "previous behavior" which is expected to influence one's current expectations (Godin & Shephard, 1990). A repeated behavior could turn into a habitual behavior. Ajzen (1991) also argued that a previous experience could result into a habitual one instead of a seasonal behavior. Similarly, Bandura (1986) suggested that the habitual choice of delivery may be a

result of modeling which was proposed as an indispensable aspect for learning behavioral patterns.

About 28 out of 53 women who had delivered at home only completed primary school, while 13 out of the 53 were illiterate. Most of them were mainly farmers and they were from the middle and poor socio-economic statuses. Similarly, in the National Reproductive Health Survey (2007), women with at least a lower secondary education were by and large more likely to deliver in a health facility compared to women with less or no education. The low percentage of women who delivered their babies at a health facility is of concern since skilled delivery and emergency obstetric care are the only interventions which can substantially lower maternal morbidity and mortality.

Among the women who had delivered at home during the last year, a majority of them delivered without the assistance of skilled TBAs; only husbands and grandmothers helped the women during delivery. Similarly, the National Reproductive Health Survey revealed that in the last 5 years, most births were delivered with assistance of relatives (63.4%) and traditional birth attendants (12.1%). Health professionals assisted in 18.5% of births – 8.1% were assisted by a doctor, 3.5% by a nurse, 3% by a midwife and 3.9% by a health worker. In urban areas, health professionals delivered 63.2% of births compared to the 15.3% in rural areas with roads and 5.3% in rural areas without road.

The cause of maternal mortality may be direct or indirect. Direct maternal death resulted from complications during pregnancy, labor or puerperium, or from intervention, omission of, or incorrect, and treatment; while the indirect maternal death resulted from the interaction between pregnancy with unrelated medical conditions which may predate conception or may first appear during pregnancy, labor or the puerperium. Given the large percentage of deliveries that take place in the home, it is believed that the great majority of maternal deaths occurred in the home, and that many of these deaths go unreported (WHO, 1997). Previous studies have reported that perinatal mortality in births delivered without a trained TBA was three times higher than that for births in a hospital or dispensary with trained attendants (Walraven et al, 1995). In addition, a study in Papua New Guinea also demonstrated a high rate of obstetric complications amongst pregnancies delivered at home (Garner, Lai, Baeca, 1994). According to the National



Reproductive survey in 2005, 85% of pregnant women delivered at home which led to a high number of maternal deaths due to complications. However, we could not link this directly to traditional child birth practices with high maternal deaths as measuring maternal mortality is notoriously difficult for both conceptual and practical reasons. Maternal deaths are hard to identify precisely and a maternal death is a relatively rare events.

## **5.0 Conclusions and Recommendations**

This study provided an evidence-based research to advocate the taking into account of the socio-economical and political contexts of child birth practices and highlight the traditional child birth and postpartum beliefs and practices on child birth among rural women. The findings also provided a deep understanding of the reasons for delivering at home by considering the complexity of certain frameworks such as the socio-economy, accessibility, traditional belief, and gender relations. This information will assist in planning interventions and focused on reducing maternal mortality. In addition, the result of this study underscores the gender perspective of Lao women regarding child birth practice. This information should be discussed among policy makers, and planners to guide and develop skilled birth attendants.

### **Policy implication**

From the findings pertaining the perceptions and attitudes of women about child birth, comparisons can be made on the framework of MMR reduction policies and programs, and recommendations for advocacy can be suggested accordingly.

For Government and Community Members

1. Empower women to make decisions on how to take care of themselves during ANC, delivery and PNC as well as a safe place of delivery.
2. Husbands and relatives who can influence women's child birth practices should be made aware as to how they can help deconstruct the notion that child birth is only a woman's issue. One of the ways is by integrating male involvement into safe motherhood programs

(during pregnancy, delivery and postpartum practices) as well as advocating overall reproductive and sexual health and rights. Men do seem to be very much involved in both decision-making and assisting in child birth.

#### Health Care Providers

3. With an understanding of the cultural beliefs and practices of women from Laos, health care providers can develop maternal education that is culturally specific, provided with the involvement of key people from the community. For women, effective programs which provide information, education and communication on safe motherhood programs should reach women and their relatives. Safe motherhood packages (ANC, delivery and PNC) should be made accessible so that positive perceptions toward child birth practices can be established, promoted and sustained. This should enable them to make an informed decision about their choice of delivery.
4. The provision of mobile maternity services might be an alternative solution for unplanned home delivery due to lack of transport and precipitate delivery.
5. Establish a skilled workforce with the capability and capacity to reduce maternal and newborn mortality and morbidity (i.e. adequate numbers of competent skilled birth attendants), including developing a cadres of midwives (rural and community midwives).
6. Emergency obstetric care screenings for women who are at risks and refer them to the hospitals on time.
7. Adopt cultural sensitive programs on ANC, child birth and PNC. For example, attending ANC will not be in opposition but a combination of the cultural/habitual practices for pregnant women and their family. The involvement of the husband and family members to care and support in preparation prior, during and after child birth would be selected and incorporated into the program, ultimately for the pregnant women's health and well-being. Proper care, rest and healthy nutrition should be given to mothers and their newborns.
8. Suggest standard quality package for the continuum of safe motherhood programs. After analyzing the negative attitudes of mothers and family members, the myths and concerns about health facilities and the skills of health care providers, a recommendation to train

health care providers at the grass root level and provide health facilities reaching underserved women in their community.

#### Ministry of Health

9. Advocate the safe motherhood policy nationwide.
10. The midwifery curriculum should be revised by taking into account the positive aspect of cultural child birth practices.

#### NGOs

11. Provide safe delivery kits for trained TBAs and strengthen the capacity of health care providers working in the safe motherhood programs.

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