Cultural Perceptions of Maternal Illness among Khmer Women in Krong Kep, Cambodia

STEPHANIE MONTESANTI

ABSTRACT

Cultural impacts on health are profound in the area of maternal health. Cultural beliefs shape a range of factors that affect reproductive health, including fertility patterns, contraceptive use, and maternal health-seeking behaviour. Traditional knowledge and medicine and childbirth in the home continues to be important to some cultures and especially in rural environments where there are social, economic and political barriers to accessing medical treatment. Here, I focus on the cultural dimensions of pregnancy and postpartum care and women’s use of traditional healing practices, traditional birth attendants and midwives in Krong Kep, Cambodia. I also discuss the role of midwives and traditional birth attendants in pregnancy and birthing.

Introduction

Cambodia’s high maternal mortality and morbidity rate remains a pervasive concern at both the village and national level (CDHS 2005). Maternal deaths and illnesses associated with pregnancy and childbirth are rising in the country and are highest in Asia, with a reported maternal mortality ratio of 472 out of 100,000 live births (WHO 2005). Examining the socio-cultural context of pregnancy and childbirth is important to understanding maternal mortality. Contextual factors that affect maternal health in the south-western province of Krong Kep, Cambodia include the age of the mother, the availability of health facilities, the quality of health services, time, household income, gender norms and cultural beliefs regarding illness and health. An anthropological perspective on reproduction has explored pregnancy and childbirth within the context of culture, social organization, political economy, and the organization of health services (Ginsburg & Rapp 1991; Maternowska 2000; Laderman 1984; Treymane 2001). Here, I focus on the cultural beliefs and practices of pregnancy and

STEPHANIE MONTESANTI, Health Policy PhD Program, McMaster University
postpartum care, and women’s use of traditional birth attendants, midwives, and traditional healing remedies in managing pregnancy and postpartum health, based on interviews in rural Cambodia.

Cultural beliefs shape a range of factors that affect reproductive health, including fertility patterns, contraceptive use, maternal health-seeking behaviour, and choice of birth attendant (Helman 2001). An emic perspective - a perspective that analyzes women’s choices using their own cultural concepts and categories - helps to elucidate women’s own understandings of pregnancy morbidities and postpartum complications (Brown 1998). In Cambodia, traditional birthing practices remain strong, especially in rural areas where the availability of health care services is scarce. A survey conducted by the National Reproductive Health Programme in Cambodia in 2006 reported that “traditional practices are being adapted to suit modern times, but are not being abandoned” (NRHP, 2006). Traditional beliefs surrounding pregnancy and childbirth inform local women’s understanding of pregnancy or postpartum complications and they also influence their health-seeking behaviours (White 2002).

Obermeyer (2001) posits that behaviours related to health seeking are associated with symbolic meanings in a culture. Individual behaviours “express norms about appropriate social conduct, implicit views of the body, and profound orientations about life” (Obermeyer 2001:2). Decision-making and individual choices to use biomedical health services are also influenced by local perceptions of risk and prevention (Obermeyer, 2001). Biomedical models of health do not necessarily account for the impact of the cultural factors (i.e. beliefs, values, and gender) that shape reproductive behaviour and practices. People in certain cultural groups may choose to retain traditional health practices for a variety of reasons, including belief in the efficacy of traditional healing practices or due to difficulties of accessing western health care services (Treymane, 2001: 6).

In this paper, I describe the pregnancy and childbirth experiences of women in Krong Kep, Cambodia. I propose that maternal health practices in rural Cambodia are influenced by Khmer etiology of reproductive illness, the organization and delivery of medical health services in the province, and the value of midwives and traditional birth attendants in the culture in managing pregnancy and childbirth. I analyze my findings using the lens of a social constructionist theory of illness (Brown, 1998). By studying how illness is socially constructed, I examine how social forces shape the Khmer culture’s understanding of, and actions towards, reproductive health, illness and healing. Further, I explore the effects of culture in shaping knowledge about illness, disease and treatment.
Methods

This study of maternal health outcomes and experiences of pregnant women and recent mothers was explored during 115 semi-structured interviews. A combination of closed-ended and open-ended questions were asked in face-to-face interviews with pregnant women and recently pregnant women to understand health-seeking patterns during pregnancy and after childbirth, and to record in-depth explanations of cultural beliefs, values and practices that shape women’s use of health services. The open-ended questions elicited in-depth responses of cultural perceptions of pregnancy and childbirth by asking the participants to provide additional information in their own words. The qualitative analysis software NVivo 7 was used to analyze interviews for similarities, differences, and relationships.

Seven to eight women were interviewed from each village in Krong Kep province, between May and July 2008. There are 16 villages in Krong Kep province, and interviews with women in each village allowed for comparisons across villages with respect to maternal health-seeking behaviour. The objective of the interviews was to learn about the beliefs and practices surrounding care during pregnancy and after childbirth, cultural interpretations of pregnancy and postpartum morbidities, the decision to use biomedical services, and the role of midwives in the healthcare system and community in Krong Kep. A midwife female translator, who is also a trained midwife, was present at all interviews. Most of the participants were illiterate and questions were asked in Khmer, the official language in Cambodia, and translated into English.

Document sources used in the data analysis and interpretation stage included statistics from the Ministry of Health of Cambodia and The National Maternal and Child Health (NMCH) Institute in Phnom Penh on maternal health indicators in the country. I obtained records from the three health centres and the referral hospital in Krong Kep and collected data found therein on the number of women practicing birth spacing, the cost of reproductive health services in Krong Kep, the number of antenatal and postnatal visits per month, and the number of deliveries in the home or at the health centres or hospital per month. Also, through informal interviews with healthcare staff at the health centre I learned about the number of midwives practicing in the province and the types of antenatal care services provided to pregnant women.

Elders in the villages were informed of the research project and were asked permission to conduct interviews with women who met the subject criteria for the study. Convenience sampling was used to gather a sample population of women who were willing to participate. Participants ranged in age from 18 to 47 years, with an average age of 26.8 years. Interviews with participants took place in the village. The inclusion criteria for participants were that they were women i)
of reproductive age and, ii) at least four months pregnant at the time of the interview, or have a child under the age of one year.

Cambodia is a war-torn country that has begun to rebuild its health infrastructure after being involved in civil war for thirty years. Health sector reform in the 1990s involved rebuilding the healthcare system in the country, which involved the development of health centres across the provinces. Since the introduction of a national health coverage plan in 1996, the Cambodian government has been constructing and rehabilitating governmental health facilities throughout the country with the aim of providing health services to all citizens (Matsuoka et al. 2010).

Krong Kep is a small province in the southwest of Cambodia (Figure 1). The 2003 population census of Krong Kep was estimated at 35,434 (Ministry of Health, National Health Statistics 2003). There are 16 villages and 5 communes (Matsuoka et al. 2010). The main source of income for the local population is agriculture and fishing (CDHS 2005). By visiting the villages and the homes of the participants I learned that few people have electricity, safe drinking water and proper sewage disposal. The Operational District Office (OD) located in Krong Kep, and the Ministry of Health (MoH) located in Phnom Penh direct the health policies and health services available to the population in the province, which include maternal and reproductive health services. Funding for maternal health services is low throughout Cambodia (Ministry of Health, National Health Statistics 2003). There is one referral hospital and three health centres in the province. The distance to a health centre differed by the villages where the women lived. Some villages were as close as two or three kilometres from a health centre, while some villages were approximately ten kilometres from a health centre. Through informal interviews with health staff and records at each health centre I was able to learn about the types of maternal health services offered at the health centres, and the constraints that the staff experience in administering maternal care to women. Each health centre is responsible for delivering health services to approximately 10 thousand people and provides services through a user-fee system. Maternal and reproductive health services are offered at the health centres and the referral hospital. The services include antenatal and prenatal care, family planning, and a delivery room with medical supplies and resources for childbirth. Antenatal care can play an important role in reducing maternal morbidity and mortality, however the province does not have an adequate laboratory facility or the necessary equipment to test blood samples of pregnant women for symptoms such as hypertensive disorders (including pre-eclampsia and eclampsia). Antenatal care offered to pregnant women in this context has primarily included the provision of iron tablets, monitoring the heart rate of the mother and the fetus, and managing pain symptoms during pregnancy. The health staff at the health centres explained that there is a lack of qualified
staff and health providers in the health centres, and the staff available is for the most part primary health nurses. The health centres also have a small number of staff with midwife qualifications.

A majority of women in the villages prefer to deliver their baby in their home (NRHP, 2006). Therefore, midwives and traditional birth attendants have played an important role in facilitating delivery in the home. The healthcare staff at the health centres reported that there are currently 16 midwives practicing in Krong Kep, who are employed at the health centres and also assist with delivery in the home. Midwives (cha-mop) in Cambodia have not been recognized as prestigious professionals, and this is reflected in the government’s financial and technical support of midwives. Given the low salary provided by the government, many skilled midwives work for non-government health organizations (NGOs) in Krong Kep or in Phnom Penh to supplement their incomes. Traditional birth attendants have also been important in assisting in childbirth in the home (NRHP 2006).

Figure 1: Krong Kep is located at the coast of Cambodia, approximately 40km from the Vietnam border.
Results

Almost all women interviewed sought health care for any symptoms experienced during pregnancy (96 out of 115). Only 19 participants reported to not visit a health centre during their pregnancy. Symptoms described by the respondents in which they sought medical attention were swelling in their legs, cramps, fatigue, headaches, abdomen pain, high-blood pressure or antepartum bleeding. Only two respondents experienced antepartum bleeding which did not lead to any serious complications or termination of pregnancy. For pregnancy symptoms, women visited the health centre, referral hospital, private clinic outside of Krong Kep, or a local pharmacist\(^1\) or shop keeper in the village. Very few respondents (3 out of 115) were visited by a healthcare provider (e.g., doctor, nurse or midwife) in their home. For those who did seek health care (96 women out 115), eight women indicated that they visited a hospital and clinic outside of Krong Kep, in Kampot province\(^2\). The average number of antenatal care visits reported by participants during their last pregnancy was 2, with three participants reporting up to six antenatal care visits to a health centre. Nineteen respondents reported that they had not received antenatal care during their pregnancy. The explanations offered by the participants for not seeking health care (more than one explanation was offered by some participants) varied from the distance to a health centre (13 respondents), responsibilities in the home (3 respondents), perceptions of symptoms experienced during pregnancy as normal (18 respondents), dislike of health care staff at the clinic (2 respondents), and cannot afford the cost of antenatal care services (3 respondents). Two responses from participants illustrate their difficulties with accessing care at the health facility. One participant reports that she “never visited the health centre to check my pregnancy because it is so far and the road condition is too bad.”(Interviewed by Stephanie Montesanti, June 9, 2008) Another participant demonstrated the effect of gender roles in the community on women independently seeking health care: “It is difficult for a woman here to go to the health centre on her own because of money and household work. We can’t always make our own decisions about our

\(^1\) A local pharmacist in this context does not refer to a trained or licensed pharmacist. Local pharmacists are those who sell western medication at a stand in the village.

\(^2\) Kampot is a larger and more developed province near Krong Kep. Many Cambodians in Krong Kep believe that the health care staff, health care facilities and services are better in Kampot. Women in Kep who were more concerned and frightened about pregnancy, and who also had the financial resources to travel to Kampot province did so during pregnancy.
health” (interview by Stephanie Montesanti, June 9, 2008) The participants who sought four or more antenatal care visits during their pregnancy varied among older and younger women (15.6 percent of women in their thirties and forties vs. 84.3 percent of women younger than 30 sought antenatal care). These older women in their thirties and forties who sought care during their pregnancy (15 out of 96) expressed concern about their health and difficulties with carrying their pregnancy to term because of their age as reasons for having regular antenatal care visits.

One factor that may lead to fatal delays in seeking medical care is local understandings of pregnancy-related changes in the female body. In their analysis of women’s use of reproductive health services, Thaddeus and Maine (1994) assert that the delay in the decision to seek care is a result of the failure of women to recognize symptoms or any problems as potentially serious, and that this failure sometimes stems from culturally specific interpretations of pregnancy-related symptoms. Similarly, White’s study of Khmer mothers demonstrates that perceptions of normal or abnormal symptoms during pregnancy and—or after delivery are culturally variable, and she argues that these perceptions influence health-seeking behaviour, which in turn can affect maternal mortality (2002:239). Culturally informed perceptions of symptoms can differ significantly from their biomedical implications.

In much of southern and southeastern Asia, humoral theory guides Cambodians women’s perceptions of the causes of illness and the practices for maintaining and promoting health (Hourn 1999; White 2002; White 2004). In humoral theory, the physiological process of giving birth is described using the hot–cold distinction. Generally speaking, the mother is “hot” before giving birth, loses heat through childbirth, and is “cold” afterwards. The “cold” condition of the mother who has just given birth is associated with weakness and vulnerability, and postpartum care in this context is devoted to restoring a woman’s ‘heat,’ primarily through physical heating and through a diet consisting of “hot” foods (White 2004). After delivery, 69 percent of participants (79 out of 115) reported to practice “roasting”, known in Khmer as Ang Pleung, which is important to the mother’s recovery after delivery. During Ang Pleung a woman is lies on a bamboo bed that is elevated over a fire. Women who have delivered will immediately “roast” for three to seven days, and will not breastfeed during this time. Wet nurses may be used to breastfeed the newborn while the mother diligently roasts for the recommended duration (White 2004). Participants reported that roasting was practiced in order to heat their bones and tendons, to prevent coldness and blood from clotting inside their uterus, to ensure good skin in their old age, and to rejuvenate their energy after childbirth. Ang Pleung is also important for protecting women from toas chamney, which refers to any illness resulting after childbirth. Khmer women believe that raising a woman’s
temperature after birth can help to fight post-birth infections (White 2004; Hourn 1999). Furthermore, it is believed that heating the body after delivery is important for recovery and helps to restore and balance the internal heat that was lost from delivery (White 2004; Hourn 1999). Women who practice postpartum roasting are not allowed to step outside of their home for several days after delivery. One participant describes her experience with Ang Pleung after childbirth: “I am told to roast because roasting could help with blood circulation so I will not have toas chamney (illness), and to push the blood out soon. I roast on the abdomen and I turn on the back when I feel chest pain...I roasted for a couple of days with the TBA [tradition birth attendant] beside me.” (interview by Stephanie Montesanti, June 12, 2008)

In addition, participants described other practices to restore their internal heat in the body and to improve their health, including placing hot stones on the abdomen, and the injection of western medications such as vitamins, antibiotics and pain medication, administered through a syringe. These medications are described by Khmer women as “hot injections” because of the stinging sensation when injected underneath the skin. Therefore, the humoral theory in this culture has incorporated modern medicine into the humoral classification of illness, and practices of care and treatment.

All the participants reported eating “hot” foods to restore heat to their bodies after birth. Foods considered “hot” include, beef, pork and fish braised with pepper, salty foods, wine, and spicy foods. These foods are believed to provide a woman with internal heat and to increase breast milk production. Some examples of food described by participants that are eaten after birth are: eggplants, banana flowers, and chilli peppers. Similarly, there are certain foods that are believed to be harmful to eat during pregnancy. For instance, Khmer women and their families believe that a pregnant woman should avoid consuming coconut milk and porridge as these foods will make the baby fat and cause a difficult delivery for the mother.

Respondents were asked to describe any special foods considered important to eat during pregnancy in the Khmer culture. Women (34 out of 115) in the study reported that coconut water directly from the coconut is desirable during pregnancy. They explained that coconut water is “good for the baby’s skin”, “makes the skin smooth”, “allows for an easy delivery”, and “gives the woman strength during pregnancy.”(reference) Other foods that were described as particularly suitable to eat were sour foods, sweets, ice water, and durian fruit. Humoral theory also informs women’s understanding of the effects of certain western medications on the body. Eight participants reported using western medicine during and—or after pregnancy. After delivery, women reported using only western medicine that fit within humoral constructions of the body (e.g. intravenous fluids, antibiotics, pain killers, or vitamins). In the Khmer culture,
western medications that are perceived to generate heat in the body are popular among postpartum women. For instance, these participants described injections to alleviate pain as “hot injections” because of the stinging sensation when injected, and are often desired because they are believed to produce heat in the body.

Participants also reported using traditional Khmer medicine during pregnancy and after delivery. The type of traditional medicine included Khmer rice wine and a liquid concoction made from either the bark or roots of trees. Eleven women reported to have taken only Khmer wine after delivery to regain their strength. Khmer rice wine in Cambodia is used as a traditional healing remedy during and after pregnancy to improve women’s health by maintaining their strength during pregnancy or regaining their strength after childbirth. It is believed to make pregnant women strong before delivery, and also help them to regain their strength after the loss of blood during delivery. One woman mentioned that: “I am told by my mother to drink boiling herbal drink for five to six months so that I will get good looking and increase breast milk production. By drinking the traditional medicine it will be very good for me in terms of beauty and health.” (interview by Stephanie Montesanti, June 13, 2008) In addition to roasting and drinking Khmer rice wine, placing hot stones on a woman’s abdomen after delivery was also described to aid in restoring the women’s health after childbirth. Thirty-five women reported using hot stones after childbirth.

Furthermore, humoral theory shapes taboos surrounding pregnancy and childbirth in Cambodia. Similarly to Carol Laderman’s study of Malay mothers, she explains that the “biological changes taking place inside the mother’s body are given meaning by the dialogue between empirical perceptions and a system of symbols that takes place in every culture.” (1984:549) These symbols are elaborated on and accompanied by behavioural changes intended to protect pregnant women from harm. Laderman (1984: 549) refers to these behavioural changes as ‘the taboos of childbirth.’ Humoral theory identifies taboos of pregnancy and childbirth in Cambodia, such as acceptable foods to eat and places women can and cannot go. These taboos provide an explanation for the causes of maternal morbidity and mortality among Khmer women. Khmer women are expected to follow the taboos associated with restricted foods during pregnancy and immediately after delivery. It is generally understood and believed that consuming any of the restricted foods - that should be avoided during this time - will lead to illness or health-related complications during pregnancy or post-delivery. Women stated that food taboos for women after delivery should be practiced for the duration of breastfeeding. Although there was some variation in the responses on food ideologies, most women expressed the benefits of a specific maternal diet to the health of the baby and the mother. For instance, foods perceived as “hot” are considered dangerous to eat during pregnancy and should only be consumed after childbirth. In addition, talking about the deceased in the
presence of pregnant women and/or newborn baby was also described as taboo by the Cambodian custom because of the fear of spirits of the dead harming the unborn fetus or newborn baby. Fifteen women reported that ceremonies of the dead and homes of the sick should be avoided by pregnant women and for some time after childbirth.

The Ministry of Health (MOH) in Cambodia stated that most Cambodians prefer to visit pharmacies and traditional healers for health advice and medicine, especially for sexual and maternal health to avoid discrimination from health staff (Health Sector Reform Strategy, 1998). This also includes the use of traditional birth attendants (TBAs) to assist in the delivery of babies. This may be reflective of the negative experience that women have in referral hospitals and/or the health centres, along with structural determinants such as transportation and economic barriers for families in the village (Maternowska, 2000). What was also learned through interviews and visits to the health centre and referral hospital is that the unavailability of health care staff in rural areas like Krong Kep deters women from visiting a health facility. Limited health care staff might impede the quality and access to care that women receive. One participant stated: “I deliver at home because health staff is not available at the health centre for most of the time.”(interview by Stephanie Montesanti, June 10, 2008)

The difference between traditional healing practices and biomedical treatments also influences a woman’s decisions to use reproductive health services at the health clinic or hospital. Biomedicine has been critiqued for ignoring the personal and social aspects of birth, and treats pregnancy and childbirth as an isolated medical event (Helman 2001). Kleinman (1992) notes that physicians and nurses centre their medical gaze on the individual and his or her pathology, instead of understanding the local world and social reality of the patient. However, traditional birth attendants have been reported to provide a positive birthing experience for women by offering emotional and personal support (Hunt 2002). The women respondents who delivered their baby with the help of a midwife or trained traditional birth attendant (TBA) (30 out of 115 delivered with a midwife vs. 19 out 115 delivered with a TBA) explained that the absence of health care providers at the health centres shaped their decision to deliver their baby at home. Some women, however, stated their preference for a non-medicalized childbirth. A woman who delivered her baby with a doctor in the hospital tended to be younger women between the ages of 18 and 22 years. These women (29 out of 115) reported that they felt that the biomedical model of birth was safer. However, the use of traditional medicine was still reported in the postpartum period from women who delivered and received care from a doctor in the hospital (13 out of 29). The decision to use medical services at a health facility was also shaped by the onset of complications during pregnancy and after childbirth: “The elderly women in the village say that if my physical condition
during pregnancy after birth is good I can have the TBA look after me. If my health is good I use traditional medicine so that I will have a safe delivery.” (interview by Stephanie Montesanti, June 16, 2008)

Discussion

There have been few studies about the basis on which women in developing regions evaluate and choose between traditional and western birthing options. In the interviews, most women expressed choosing a practitioner (midwife, doctor, or TBA) based on the suspected etiology of the problem. Numerous studies have examined the differences between care provided by midwives or TBA’s versus that provided by medical personnel (e.g. Sakala 1993; Hunt et al., 2002). The medical personnel treat childbirth as a dangerous process that should take place in a hospital (Hunt et al. 2002). By contrast, midwifery has been associated with a “natural” and “normal” birthing event that takes place in low-technology environments (Hunt et al. 2002). The home can be seen as the most comfortable and supportive environment for a woman who can manage her childbirth according to the values and meaning that her and her family attaches to the event.

Postpartum healing practices were similar across the villages in Krong Kep, Cambodia with respects to practicing Ang Pleung and special dietary behaviours. The decision to use a TBA or midwife is shaped not only by cultural beliefs surrounding pregnancy, childbirth and the body, but external factors such as distance to a health centre, quality of care in the biomedical health system, shortage of staff and the cost of health services. This study has shown that humoral theories of health and illness continue to shape reproductive and maternal health practices among women in Krong Kep, Cambodia. This is evident by the high number of women practicing traditional healing practices such as Ang Pleung, or using traditional medicine or remedies during pregnancy and after childbirth. Whether women accept or reject biomedical care is not determined solely by humoral etiology. Poor patient-provider interaction in health facilities is a common dissatisfaction experienced by the participants interviewed in the study. The quality of care provided to patients in health facilities thus also influences the decision to seek health care. These barriers are not confined to rural Cambodia, but common in several low-income countries (Abou-Zahr & Wardlow 2003).

This study in Krong Kep, Cambodia demonstrates that the lack of resources and availability of quality services, and distance to a health centre in the rural province may be linked to the continued use of traditional birthing practices and medicine. Furthermore, cultural beliefs and practices surrounding pregnancy and childbirth are important not only because of Khmer women’s affiliation and
identity to their culture, but because such cultural beliefs allow women to make sense of their maternal experiences, and to care for their health when other options of care and treatment are limited by their economic circumstances. Traditional pregnancy and postpartum practices are perpetuated by close female relatives, usually the mother as well as elderly women in the village and TBAs.

The women who reported to use the health centres for antenatal or postnatal care described that they were aware of the life-threatening risks associated with pregnancy and childbirth, and they wanted to prevent any risks or complications from occurring. The women in the villages had some knowledge and understanding (in a biomedical sense) of risky health behaviours and the benefits of medicine. The health centres and the referral hospital in Krong Kep display several posters which illustrate a pregnant woman walking towards a health facility, a pregnant woman receiving a routine check-up by a health provider, and illustrations of nutritious foods that pregnant women are encouraged to eat. Therefore, managing pregnancy and risk of illness or complications from a medical perspective involves self-surveillance of a woman’s body during pregnancy. Traditional practices and remedies that are described in this study were reported to be important in the Khmer culture, and allowed the women to give meaning and value to their pregnancy and childbirth experiences. In a situation where serious complications may arise during childbirth, the women recognized that medical attention is important.

Conclusion

Different cultures understand and manage birth in their own ways (Tremayne 2001 Obermeyer 2001). The findings of this study are consistent with other medical anthropology studies which report childbirth to be a social and cultural event, rather than a medicalized process. Cultural etiologies of illness explain the causes of maternal illness and death, and are central to an understanding of reproductive health practices in Cambodia. Local belief systems - particularly constructions of the body and of health that are based on humoral medicine - shape women’s understandings, and therefore use of, “modern” health services. While these cultural practices during pregnancy and childbirth are used to prevent reproductive illness, biomedical experts often associate these cultural practices as risky behaviours that result in negative health outcomes. For instance, Ang Pleung or “roasting” and food restrictions are perceived by medical professionals as risky behaviours and dangerous to a woman’s health (White 2004). An important difference to note from the findings from the interviews is the use of the western medical system by younger and older women participants. Younger woman were more likely to use reproductive health services, while still incorporating traditional health practices during and after pregnancy. Among the
older women who sought healthcare at the health centres, they expressed concerns about their age and viewed the medical system as useful for managing complications during pregnancy and delivery.

While biomedicine can improve maternal health, a medical model of childbirth ignores how pregnancy and childbirth is experienced, understood and practiced in a particular cultural context (Maternowska 2000). Nonetheless, contextual factors such as socio-economic status, gender norms and cultural beliefs can also be important in determining maternal health-seeking behaviours and the acceptance or utilization of medical services. Anthropologists are able to observe and chronicle birthing practices and knowledge from a woman’s perspective. This emic knowledge can provide insight into the reasoning behind the decisions and choices women make with respect to their reproductive health. Biomedical techniques during childbirth can reduce morbidity and mortality, however, and an understanding of and cooperation with cultural pregnancy and birthing practices can increase patient satisfaction and the number of deliveries at a health centre or hospital with skilled attendants. The involvement of TBA’s in health centres, clinics and the hospital can improve women’s experience with childbirth by providing social and emotional support along with modern obstetric procedures to reduce maternal mortality and morbidity. Political actors in the global maternal health agenda should attempt to envision a model of care for mothers that bridges the gap between the availability of maternal services and access to those services. A midwifery community model in the villages, where pregnancy and postpartum care visits are offered in the home, can ensure that pregnant women and recent mothers receive the care they need and can increase women’s knowledge of reproductive health risks. Home visits by a health worker can be important in this context, since women practicing post-partum roasting in these communities are not allowed to step outside of their home for several days after delivery. A current issue in Cambodia is that fewer women want to become midwives because of the insufficient salaries and the amount of time spent away from their rural homes. If the government offered incentives (e.g. training and financial) young women might be more inclined to choose midwifery careers.

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White, P.  
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World Health Organization  

Author contact information  
Stephanie Montesanti  
Health Policy PhD Program  
McMaster University  
1280 Main Street West CRL - 201  
Hamilton, Ontario, Canada  
L8S 4K1  
montessr@mcmaster.ca  
http://fhs.mcmaster.ca/hpphd/current_students.html  

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