Maternal Health Care in Thailand in Post-MDG Framework – Learning Points & Pressure Points

Deborah Kelechi Mbakwe
LSE Asia Research Centre - Thailand Government Scholarship
November 2014
### Abbreviations

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IMR</td>
<td>Infant mortality rate</td>
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<td>KPI</td>
<td>Key Performance Indicators</td>
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<td>MCM</td>
<td>Maternal Child Mortality</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>M2M</td>
<td>Mother to Mother</td>
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<td>PPP</td>
<td>Public private partnership</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV and AIDS</td>
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<td>UNDIO</td>
<td>United Nations Industrial Development Organization</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNMDG</td>
<td>United Nations Millennium Development Goal</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. **Introduction – Thailand & Maternal Health**

Globally, half a million women die each year during pregnancy and delivery. Also, 7 million children aged less than five years die, mainly due to limited access to basic but effective health interventions (WHO, 2012).

“Until the 1960s, Thailand had maternal mortality rates well above 400 per 100,000 live births” (WHO, 2005). Over the past 50 years that maternal health statistic has been transformed and the number of deaths has dropped significantly. Whilst there has been an immense national effort, this transformation must be contextualised globally in order to properly understand why Thailand’s success in this area is so significant. Against the background of The Safe Motherhood Initiative (1987), UN year for women (1975), International Conference on Population and Development and ICPD, Cairo (1994), Investing in Health (World Bank) includes maternal health as a “Best buy” in global health. After the publication of the now famous article “Where is the M in MCH?” (Rosenfield & Maine, 1985) maternal mortality reduction has garnered more attention than before.

After the introduction of Millennium Development Goals (MDG) in the year 2000, 189 nation states came together to ratify the Millennium Declaration. This specified eight goals to be achieved by 2015 with specific targets and indicators for each goal. The Millennium Development Goal (MDG) 5a & 5b deal with improving maternal health:

**MDG 5 Targets**

TARGET 5.a: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Indicators: (5.1) Maternal mortality ratio, and (5.2) Proportion of births attended by skilled health personnel.

TARGET 5.b: Achieve, by 2015, universal access to reproductive health. Indicators: (5.3) Contraceptive prevalence rate, (5.4) Adolescent birth rate, (5.5) Antenatal care coverage (at least one to four visits) and (5.6) Unmet need for family planning (WHO).
The MDG goals 5a and 5b interact with a range of other MDG goals, namely goal 6 (HIV/AIDS, malaria and other diseases) and goal 3 (promoting gender equality and empowering women), not only as a healthcare concern / maternal healthcare concern but as a development concern that is linked to human well-being. Due to advances made in this sector in Thailand these goals were met achieving the United Nations Millennium Development Goal for maternal and child health (MCH). Thailand has outperformed the vast majority of developing countries in improving health outcomes, achieving all the health MDG by the early 2000s and subsequently moved towards ‘MDG plus’.

**MDG+ - Thailand has set MDG-Plus targets for poverty reduction, education, health, gender equality, and environment accordingly.**

**Targets and Indicators**

Reduce by half the Under 5 Mortality Rate (U5M) in highland areas, selected northern provinces and three southernmost provinces between 2005-2015.

The move towards MDG plus not only represents progress, but also an eventual phasing out of these goals. As such the rapid progress made in this area means that there are valuable lessons to be learnt. As the MDG goals phase out and Thailand moves towards a much more advanced status in the maternal health field there are a range of victories, issues, and concerns that have emerged as a result of the attainment of these goals. Thus, this study discusses/presents the learning points and pressure points that emerged in this research. Globally, maternal health related MDG’s have remained one of the hardest to reach as annual maternal deaths have not shown a large change globally in the last 20 years. Thus, Thailand’s story is an extremely important one to tell.

**1.1. Priorities for Research and Evaluation**

For the purpose of this report three main areas for exploration were identified prior to engaging in fieldwork. The identified three stood out from the existing body of literature (WHO 2002, Say & Raine 2003) available concerning Thailand as priorities for research and are discussed below.
Research priorities

Priority (1) to understand the social and cultural factors that have resulted in some improvements in the maternal mortality ratio and the attainment of MDG 5a & 5b.

Priority (2) an examination of the most potent pressures that affect existing improvements in the maternal health infrastructure.

Priority (3) discuss gaps and the ways to improve current gaps in the policy at a national level in light of the findings from research priority 2.

The body of this work will be split into three sections and each section will do the following: the first part of this report will consider the “how” of the process. This section serves as “lessons-learned” not only for Thailand but also for other nation-states that wish to emulate the success of Thailand in maternal health. These social factors will be based on the findings from research conducted as well as existing literature.

The second part of this report will examine thematically the multi-layered issues that have emerged out of the attainment of MDG 5a and 5b and the improvement of maternal health.

The final part of this report will examine current gaps in policy, namely where improvements can be made, bridges built and gaps filled in light of the discussion of “Priority 2”.

1.2 Methodology

The methodology that has guided the bulk of this research project is primarily qualitative as the emphasis on this research project endeavors to provide insight into the topic at hand. In design, the focus was to reveal the perceptions and opinions of the research subjects concerning research priorities highlighted in the previous section. The evidence cited in this report is limited to who the author believes are significant contributors to the maternal health process in Thailand and includes extracts from a limited number of interviews conducted from September to October 2014 (Appendix I). It is on this basis that many of the conclusions and hypotheses that underpin the second and third section have been constructed.
Participants in this study were six health workers, two specialist doctors, one academic, and three key stakeholders in international organisations in Bangkok and Chiang Mai. Since the methodology is qualitative in nature, there is a degree of subjectivity that underpins this work (Bogdan and Biklen, 1992)

Thus, the findings of this research are based on the persons interviewed and their opinions. Steps have been taken to ensure the reliability and validity of this research. In qualitative research the reliability and validity of a study is judged by four criteria: credibility, transferability, dependability and conformability (Trochim, 2000).

Credibility was established through methodological triangulation to ensure that the findings emerge from the qualitative data and not from personal presuppositions. Dependability was established by cross-referencing the research findings with existing data (WHO, 2011) to establish whether or not the findings were dependable. Validation was further enhanced through asking a wide range of research questions in order to gather objective information. The interviewees are all very different; the questions pertained to the nature of their roles but were streamlined where possible.

There are two main assumptions that underpin this work:

- Whilst the MDG’s are not wholly responsible for the improvements in maternal health care in Thailand they have contributed significantly on a policy level in Thailand.
- The qualitative explorations discussed in this report are expansive but limited by the parameters of the sources, the sources are from bureaux, non-governmental organisations etc. and they are not wholly representative of the entire spectrum of the maternal healthcare landscape in Thailand.

The main hospital this research uses is Bangkok Christian Hospital, a non-profit private hospital of 198 beds under Church of Christ in Thailand Foundation opened in 1949. The profile of the patients is not only Christian, but includes the wider community. As a mission hospital, it is known as a good hospital. This study focused on one hospital because of the practical issues associated with time constraints and procedural limitations of visiting other hospitals. Thus, many of the statements made in this report are based on participant observation by visiting this hospital and conducting interviews.
This report also endeavours to provide some new knowledge that will enable the parties mentioned above to deliver such a service. Thus, the research hopes to contribute not only to a better understanding of maternal healthcare services accessibility and utilisation in Thailand but also to address some gaps that could the Thai health services in the provision and delivery of a more equitable service. The layout of this report is as follows: Chapter 2 discusses the various ways in which maternal health has improved in Thailand. Chapter 3 discusses the various pressure points that have emerged that are problematic for the maternal health system in Thailand. Chapter 4 discusses the various gaps in policy that exist make subsequent recommendations and Chapter 5 will conclude.
2. The “How” of progress in maternal health – Attaining MDG 5

This section will outline the social and cultural factors that have resulted in improvements in MRM (Maternal Mortality Ratio) and the attainment of the MDG 5a & 5b based on the qualitative research that I conducted (Appendix 1) and additional materials (Appendix 2). Infant mortality fell sharply from 68 per 1000 live births in 1970, reaching under 10 in 2006 (IHME, 2010). This demonstrates that MDG 5, which targets 75% reduction in maternal mortality, is achievable, provided there is political will and financial investment (Gill et al. 2007 quoted Ronsmans and Graham 2006).

Thai lessons learned in reducing maternal mortality

2.1 Universal Health Care Coverage & Healthcare Initiatives

Generally speaking, Thailand has become a leader in Healthcare in the South-east Asian region in respect to maternal health and health. The Thai healthcare system is one of the most advanced in Asia (Bloomberg, 2014) and consecutive political administrations have committed to its improvement, hence Thailand has become the hub of medical tourism regionally. Using the district and sub-district healthcare system as a foundation, the “30 baht programme” was introduced in 2001. This programme delivers universal health coverage and ensures that every individual in Thailand may access registered health services. The exemption to payment categories include children under 12 years of age, senior citizens aged 60 years and over, the very poor, and volunteer health workers. Universal health care means that women who wouldn't be able to otherwise afford it are able to access essential antenatal, perinatal and post-partum care. This also ensures that skilled attendants are available at all births reducing the risk and the possibility of a higher IMR solidifying goal 5.2.

In Thailand I think for the maternal health we are relatively good, we have universal health coverage meaning that nearly 100% of Thai babies are born in hospital (Bunyarit, Ministry of Public Health, Bureau of Reproductive Health – Thailand)

As such this universal approach, which has built upon many of the vertical health programmes instituted by the Ministry of Public Health in Thailand, lays the foundation
for an advanced maternal healthcare system in the future. Whilst the current system is
not without its pitfalls, initiatives to combat these have been put in place. For example,
the “Tumbon Noummaie” Maternal Health initiative by the Bureau of Health Promotion
Maternal Health and Child Health Promotion.

_Everything is free, no charge. Every pregnant woman brings pink book. She
comes to the hospital with the pink book and she has important access to health
knowledge. Through health practice we integrate better care, we integrate
nutrition_” (Mrs Chaweewan Tonputsa, Bureau of Health Promotion- Maternal
Health and Child Health Promotion)

Pink books that are available in multiple languages (Appendix III) facilitate the
betterment of maternal healthcare in Thailand operationally and structurally as women
have on average four visitations before they give birth.

2.2 Overcoming the “Three Delays Model”

The Delay Model by Thaddeus and Maine provides a suitable conceptual framework for
understanding risk factors associated with maternal mortality at tertiary referral
hospitals. The "Three Delays" model proposes that pregnancy-related mortality is
overwhelmingly due to delays in:

(1) Deciding to seek appropriate medical help for an obstetric emergency;

(2) Reaching an appropriate obstetric facility;

(3) Receiving adequate care when a facility is reached.

In respect to the first of the three delays, an obstetric emergency includes, but is not
limited to, haemorrhage, sepsis (infection), obstructed labour, hypertensive disorders of
pregnancy (including preeclampsia) and other pre-existing medical conditions that are
exacerbated by pregnancy. Complications such as these can increase MMR and the
chances the baby will survive.

In respect to the second delay all provinces in Thailand have hospitals with trained
medical personnel. Receiving adequate care has also been a legacy from the 1960s
when village birth attendants were substituted with village midwives and traditional birth
attendants begun to play an ancillary role. Additionally, across the public sector, care is
somewhat standardized. Standardized care has been achieved through the introduction of universal healthcare in 2002.

2.3 Agency

*I would not claim that it’s the entire success because of family planning but because of the women’s status in this country has changed significantly in the last two or three decades. (As) women become employed, they can make decisions about their own reproduction, how many children they want to have and when they want to have the babies and all that so this has changed the future of the country (Assistant Representative of UNFPA Thailand Country Office, Dr. Wassana Im-em)*

A more equal society, increases in educational attainment, the movement of women from rural to urban environments, an increase in the social acceptability of women in the labour force, and the higher participation of women in the labour force all ensure that women are able to exercise agency in ways that were previously not possible. Maternal health is invariably related to agency. As women are able to exercise more choice in all areas of their lives it has an effect on their reproductive choices, if and when they have children, how many children they have and their inter-pregnancy intervals. The level of agency and the position in society has also contributed to a declining birthrate and the Total Fertility Rate (TFR) stands at 1.8 (Bhakta B. Gubhaju, 2003). This can be attributed to a high contraceptive prevalence rate (CPR) amongst consenting adults. However, for this to take hold in this society women must first and foremost have a measure of choice and be able to exercise a measure of agency concerning their own bodies. This can perhaps be attributed to changes in Thai society at several levels. Both migration from rural to urban contexts and urbanization have transformed the family-structure (Mishra, 2010). Women’s place within this structure has consequently changed.

2.4 Social & Cultural Attitudes of Women

Traditional Thai medicine was dominant up until the last century. Moreover, obstetrics was met with a degree of scepticism by women and traditional midwives who had practiced their medicine for centuries (Power, 1997). Since women already had “Hmor tamyae” (the traditional birth attendants) that assisted during births and utilised traditional Thai medicine. Their presence remains in rural locations, however, over the
past 50 years their role has changed and they now play a more auxiliary role supporting women through the process from a socio-cultural perspective as opposed to a purely medical one.

Also, the social and cultural attitudes of Thai women are a key variable in the attainment of MDG 5. This is rooted in Thai culture. Thai women themselves have been open to advances in modern medicine and new social practices in pre-natal and post-partum care. This can also be attributed to the high literacy rate in Thailand, which currently stands at 96% (World Bank).

2.5 Trans-governmental Commitment

_The ministry of public health achieves goals mainly through Key Performance Indicators (KPI) in maternal health. There are many KPI's such as maternal mortality, neo-natal mortality and the percentage of adolescent pregnancy, the percentage of infection in women, the percentage of anemia in women. The strategy is to make these KPI's achievable for pregnant women and ensure how they can go to hospital to receive quality care. (University of Chiang Mai – Medical Faculty, Associate Professor, Anonymous)_

Irrespective of the government of the day there has been a continual commitment, enshrined in the public bureaux and the civil service. Whilst the current KPI's exemplify the determination for success in this area small steps were taken decades ago through for example, compulsory birth registration for new-borns. This set the foundation for improvements in maternal health. Without this specific commitment by the Ministry of public health the attainment of MDG 5 would not have been possible.

2.6 Development in other areas

_Thailand became an upper-middle income economy in 2011. Notwithstanding political uncertainty and volatility since 1970, Thailand has made remarkable progress in social and economic issues, moving from a low-income country to an upper-income country in less than a generation. (World Bank, 2014)_

There is a high level of infrastructure; good roads, transportation networks, functioning electricity grids which all facilitate improvements in healthcare. Thailand simultaneously developed economically and socially thus this has enabled the improvements in maternal health. For example, over the past 50 years government expenditure in
transportation, especially in remote areas, has facilitated good road networks enabling individuals to get to hospitals etc. The creation of an enabling environment in all sectors has contributed to higher living standards as poverty has reduced (ADB, 2015). With this in mind a holistic effort, through high capital investment in other sectors, has also contributed to the achievement of MDG 5.

2.7 Family Planning

“Put simply, if a woman does not get pregnant, she will not die in pregnancy or childbirth. Therefore, increasing access to methods of fertility control can have a significant impact on the number of maternal deaths, by reducing the number of times that a woman runs the risk that a fatal obstetric complication will occur.” (UN Millennium Project, 2005, 72)

The introduction of family planning has been crucial to the attainment of MDG 5. Through community and hospital based family planning, the training of midwives to distribute oral contraceptives and the National Family Planning Programme family planning became a pillar of Thai healthcare services (Rosenfield, A., Bennett, A., Somsak Varakamin and Lauro, D. (1982). Since 1976, Thailand implemented a family planning program concentrating on four groups—remote rural villages, the southern Muslim communities, ethnic minority hill tribe groups, and unmarried adolescents. Whilst family planning can be understood as ground gained in another area, it has contributed towards the attainment of MDG goal 5.3 as when women have less children it puts less stress on the system as whole.
3. Pressure Points

3.1 Teenage pregnancy

“22.1% of women aged 15-19 or more than 530,000 women are married or living with their partner” (UNFPA, Motherhood in Childhood in Thailand)

“I think you have to look at both demand and supply side in terms of demand we need to really empower youth / young people, really hear more about their needs. Youth-friendly services, we need to know what kind of services they want, we need to decide what they need so they can come out for services, the government has a lot of services available but teenagers won’t come for services and often time when you have those services it’s only the women who come not couples. Service for boys, there are almost none.” (Dr. Wassana Im-em, Assistant Representative of UNFPA, Thailand Country Office)

“In Thailand we don’t have the exact data about the prevalence of teenage pregnancy that are intended or unintended. We assume that nearly all the teenage pregnancy are unintended, this is not all true because in some rural areas we still have agricultural people may have early marriage.” (Dr. Wassana Im-em, Assistant Representative of UNFPA, Thailand Country Office)

Teenage pregnancy is a major pressure point for the Thai maternal healthcare system. In recent years, teenage pregnancy has become quite problematic (Reuters, 2013). The issue is that teenagers place pressure on the existing system as health practitioners are sometimes ill-equipped to deal with their complex needs, the quality of care they receive, and how quickly they are able to absorb certain maternal health practices due to their age. Teenage pregnancy has a negative effect on maternal health outcomes, and the life chances of the surviving babies (BBC, 2007).

“if she is still a student, still studies in school and if she pregnant in her teenage years it’s the high risk for her too because sometimes they have the premature babies (Malinee Jalanant, Instructor of First Aid and Health Care Training Centre)

Notwithstanding issues such as this, the low CPR amongst teenagers resulting in higher teenage pregnancy also makes young people vulnerable to HIV/AIDS. This is also an issue in Thailand with 440,000 living with HIV (UNAIDS, 2013).
3.2 Variations between public and private sector
In any healthcare system there is bound to be a gap between public and private in respect to aspects of service delivery.

Maternal health facilities in Thailand offer good medical services, but government hospitals are often crowded. There is a general level of expertise that exists in the public sector that is quite high but the private hospitals in Thailand have a reputation of excellence due to their excellent facilities and staff.

“The problem in the government sector are the low socio-economics of the patients mostly, second the manpower is limited with lots of patients at a time so it’s totally different from the private sector where the socio-economics of the patients is much better and the ratio of the manpower compare to patients is much better, more standardised. The ratio is one-to-one especially in Intensive Care Unit, one nurse per one patient but the government sector sometimes you have four patients per one nurse per shift.” (Dr Wiwat iem sawasdikul, Bangkok Christian Hospital).

3.3 Regional disparities – mountainous areas and lowland provinces
As with most global cities, the best healthcare is in the capital as transport links tend to be better and educational levels tend to be higher. In Thailand the MMR is higher in the highland areas of some northern provinces with ethnic hill tribe populations, and three southern provinces with predominantly Muslim populations (UNFPA, 2006). According to the WHO “Except for low birth weight, all undesirable MCH indicators were more concentrated in rural than in urban areas.” (WHO - Limwattananon, Viroj Tangcharoensathien & Prakongs).

Risks vary by how rural many parts of the country are, thus the problems in the rural south are not necessarily the problems in the rural north (WHO, 2010). From a more general perspective, access to health care for rural residents is complicated by patient factors as well as those related to the delivery of care. Rural residents are more likely to be poor (due to rural and urban disparities in overall development).

In the North we have an issue with logistics and it takes a long time to come to the hospital” (Bureau of Health Promotion- Maternal Health and Child Health Promotion, presentation by Mrs Chaweewan Tonputsa)
In highland northern areas, the mountainous terrain impedes progress and also the provinces that border with Burma have their unique culture and language thus creating difficulty in communicating maternal health. In some provinces there is a cultural and religious conservatism that impedes trust being built between women and men that are a part of the maternal health process and health practitioners (IRIN, 2008)
4. Policy gaps and Recommendations

Based on the findings of this report there are three main gaps that exist at a national level that could be applied at a provincial level that could assist progress.

4.1 Teenage Pregnancy

On Education

Sexual education could have two effects. Education would have preventative effect. On the one hand it would prevent teenagers falling foul to adolescent pregnancy. On the other hand, it would also equip young people with the knowledge needed to make informed sexual decisions.

- Thai sexual education is heavily weighted towards physical anatomy and not comprehensive sexual education. Preventative measures through education, and a multilateral adoption of sex education by all ministry of public health and ministry of education would ensure that young people receive the right information in schools (Thammaraksa, Powwattana, Lagampan, Thaingtham, 2014).

- Family is central to Thai culture. Involving Thai parents in the sexual educational progress through 'home toolkits' where teachers encourage parents to speak with their children about using these informative toolkits would help to remove the taboo of sex within Thai society. This would be a pilot scheme as a toolkit such as this does not exist within sex educational discourse and practice in Thailand. Whilst it would be quite controversial to begin with this toolkit would be piloted at the digression of schools.

On facilities

Young people do not want to run into family members and neighbours when entering, utilizing, or leaving reproductive health facilities. If there is a possibility that this might happen they may reject sexual health services as demonstrated in studies by UNFPA (2005). Thus, the following recommendations are made:

- The provision of facilities outside of the hospital setting.
- Creating facilities where public transportation is available and / or close to places where young people gather, such as schools and community centres.

- Privacy in the facilities as some teenagers may not want to possibly run into people they know. If that is not possible, then hours should be set-aside just for youth, in the late afternoon and evening and on weekends.

- The creation of an atmosphere that is youthful, informal, and culturally appropriate for all the youth using the services.

On Services

- Grassroots consultation in design of these services. That is contacting young teenagers who may be in receipt of any existing services and developing ideas for improvement.

- Training former teenage parents as peer educators in the process and use education as a preventative method.

- Walk in services for teenage pregnancies within opening hours.

4.2 Variations between public and private sector

One of most potent points noticed through participant observation whilst at Bangkok Christian Hospital were the excellent facilities, the time and care taken by the staff and their attention to detail in respect to all of the patients. As one of the leading hospitals in Bangkok, one might assert that this was to be expected due to the standards in the private hospital being higher. Here this report will introduce the concept of Public Private Partnership (PPP). Through partnership with the private sector, PPPs enable the delivery of efficient, cost-effective and measurable public services with modern facilities whilst minimizing the financial risk to the public sector (Barrows, David et al., 2012). There is a need for greater cooperation between the public and private sector, especially in the area of maternal health as there could be gains in some very specific cases:

- Private health care providers’ participation in a PPP to improve access to maternal health care in complex cases for women by providing access to free obstetric care from a range of accredited private providers.
- Deploying a demand-side finance (SF) model similar to a voucher scheme, women may access the care on proof of their below-poverty-line status, while the state reimburses participating providers for care delivered to eligible women.

4.3 Regional disparities
First and foremost, in Northern most provinces of Thailand geography is the main obstacle whilst the Southernmost provinces (especially in Muslim communities) cultural conservatism still inhibits the effectiveness of many of the programmes that are instituted by the Ministry of Public Health and its subsidiary bureaux (Kijsanayotin, 2007). For this reason, this would recommend the continuation of previous and current programmes that send out health care practitioners into the community.

- Maternal health clinic on wheels: the Mobile Health Clinic is a doctor’s office and clinic on wheels. A specially outfitted truck provides examination rooms, laboratory services, and special medical tests to those in remote areas who have access to little or no medical facilities, and to patients who do not have the resources to travel to obtain care (UNICEF, 2004).

- An increased education and health practitioners presence in hard to reach groups through the appointment of community liaison officers that begin to build more trust (UNICEF, 2004).

- Health practitioners encouraging the involvement of men in the ante-natal, delivery and post-partum to process in order to break through the cultural conservatism (UNFPA, 2006) that exists in the Southern most provinces.
5. Conclusion

There are learning points and pressure points with the maternal healthcare system in Thailand. Overall there have been vast improvements and a great deal of progress made. This progress is an example of the strides that can be made when a nation-state commits to the achievement of a particular goal. Past and current government administrative policies and strategic investments have influenced the cultural and social drivers that determine overall attitudes to maternal health.

The factors that put pressure on maternal healthcare system can be overcome with the right amount of capital investment and commitment from healthcare service professionals and the government of Thailand to continue along the path of improvement (WHO, 2010).
Fieldwork

Appendix I
Interviewees

Bangkok Christian Hospital
Ms Nathasaphan Sasomsap – managerial nurse, Bangkok Christian Hospital
Mrs Tassawan – patient in Maternal Health care
Dr Pramote Praisuwanna – Neonatologist, Head of Paediatrics division
Dr Wiwat Iem sawasdikul – Head Gynaecologist & Obstetrics
Date of interviews: 23/09/2014

Thai Red Cross
Malinee Jalanant - Instructor of First Aid and Health Care Training Centre
Darunee Poosanasuwansri - Instructor of First Aid and Health Care Centre
Date of interview: 01/10/2014

University of Chiang Mai – Medical Faculty.
Associate Professor (Anonymity granted)
Date of interview: 13/10/2014

United Nations Population Fund
Dr. Wassana Im-em - Assistant Representative of UNFPA Thailand Country Office
Date of interview: 22/10/2014

Ministry of Public Health - Bureau of Reproductive Health
Bunyarit Sukrat - Deputy Director of bureau of Reproductive Health
Date of interview: 21/10/2014
Auditing/Observation

UNWG (United Nations Working group) on Adolescent Pregnancy

Participants: WHO, UNICEF, UNESCO, UNAIDS, UNDIO, UNFPA were represented at working group meeting

Date: 23/10/2014

Presentations

Ministry of Public Health - Bureau of Health Promotion

Maternal Health and Child Health Promotion Presentation by Mrs Chaweewan Tonputsa

Date: 21/10/2014
Appendix II

References

Books

Edited Books

Journals


**Reports**


**Online**


WHO (2010) Equity in maternal and child health in Thailand, Available at: [Accessed: 30/10/2014]

WHO (2014) August 18, 2014 marked the 500-day milestone until the target date to achieve the Millennium Development Goals (MDGs), Available at: [Accessed: 30/10/2014]

WHO (2011) Differences in the availability of medicines for chronic and acute conditions in the public and private sectors of developing countries, Available at: [Accessed 01/11/2014]

World Bank (2014), Thailand Overview, Available at: [Accessed 10/11/2014]

World Bank (2014), Literacy rate, adult total (% of people ages 15 and above), Available at: [Accessed 10/11/2014]

Appendix III

Mother and Child Health Handbook

Name-Surname of Child

Please do not lose this handbook

Please bring this handbook with you every time you come in for services at the government and private hospitals.

This handbook can be used as a reference for obtaining your baby’s Birth Registration Certificate, and adding your child’s name into the household record.

Ministry of Public Health 2555 (2012)
สมุติบันทึกสุขภาพแม่และเด็ก

ชื่อ-นามสกุล

โปรดอย่าทำลาย

นำสิ่งต้องหุ้นร่างที่รับบริการ ในสถานพยาบาลทุกแห่ง
ใช้ประกอบการแจ้งเกิด เพื่อออกบัตรประจำสัญชาติในทะเบียนบ้าน
กระทรวงสาธารณสุข 2557
หากผิดเก็บหรือแสวงบุญบัตรนี้ โปรดส่งคืนด่วน