

Traditional postpartum practices among Thai women

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Background. Culture is often related to notions of well-being, illness, healing and health that inform individuals in their day-to-day activities. The postpartum period is noted for traditional practices related to rest, healing and the consumption of food and drinks, but a contemporary view of these practices is needed.

Aim. To gain an understanding of the traditional practices that Thai women follow in relation to postpartum care and the rationales underpinning such practices.

Methods. This descriptive study surveyed 500 Thai women living in Ubon Ratchathani, Thailand and attending their first postpartum hospital clinic appointment. A self-completion questionnaire was specially developed and pilot tested, and then administered to women attending the clinic.

Data analysis. Descriptive statistics were used in relation to the incidence of particular behaviours. Chi-square analyses were conducted to determine relationships between demographic characteristics and traditional practices.

Results. The majority of Thai women adhered to traditional postpartum practices related to the notion of regaining 'heat'. These included 'lying by fire', food restrictions, taking hot baths and consuming hot drinks. Other activities involved not exposing the body to heat loss by keeping covered, not shampooing the hair, avoiding the wind and sexual abstinence. Younger, less educated, primiparous women were more likely to report traditional practices. Mothers and mothers-in-law were most influential in recommending these behaviours.

Conclusions. Traditional postpartum practices are still dominant in contemporary Thai culture and are perpetuated by close female family relatives. Health professionals need to be aware of clients' culture and consider the extent to which professional care complements the mothers' traditional beliefs. Nurses need to educate women about the benefits of contemporary postpartum care and to provide strategies to help them to integrate their beliefs and the practices recommended in contemporary health care practice.

Keywords: culture, postpartum care, puerperium, traditional beliefs, Thai women

What is already known about this topic

- Pregnancy, childbirth and puerperium are accorded special rituals and customs in Thai culture.
- The postpartum period is noted for traditional practices associated with 'Yue Fai' (lying by fire) and a balancing of opposing forces of Yin and Yang (hot and cold) with the five elements of the body.

What this paper adds

- Confirmation that Thai women's postpartum practices reflect an accommodation of biomedical practices and a continuation of traditional rituals.
- A list of twenty postpartum activities as reported by Thai women.
- Conflict is likely if the women feel they need to comply with contemporary practices while they are hospitalised.
- Recommendations in relation to education of Thai women and the people who were reported to influence their decisions.

Introduction

Culture can be viewed as a system of socially transmitted behaviour patterns that link human groups to their environmental setting (Hastrick 1995, Leininger 1995). Individual health behaviours are embedded in cultural pattern exchanges and are usually transmitted from generation to generation. Culture is often related to notions of well-being, illness, healing and health that inform individuals in their day-to-day activities (Aamodt 1978). In all societies, health beliefs are among those held to most tenaciously and are an integral aspect of a culture (Spector 1979).

Pregnancy, childbirth and the puerperium are accorded special rituals and customs in many cultures (Manderson 1985). The puerperium is the interval from the birth of a baby until 6 weeks after delivery, starting with the first day after birth (Minett & Gunstone 1996, Burroughs 1997). The initiation of lactation and return of the reproductive organs to their approximate, prepregnancy position characterize this 6-week interval (Lawrence 1989). According to Eastern traditions, which are influenced by Chinese beliefs, women are confined to the home for at least 30 days following childbirth. This time is translated into the term 'doing the month'. Women are encouraged by Eastern traditions to follow a specific set of prescriptions and proscriptions to encourage an optimal level of health for the mother (Fok 1996, Du 1998).

Background to traditional Thai beliefs

Traditional Thai beliefs are a mixture of Indian and Chinese medicine and spiritual/animistic beliefs, although the exact origins of many concepts are uncertain. Thai mothers are influenced by ancient Chinese concepts reflecting the South-East Asian concept of balancing the opposing forces of 'Yin and Yang' (cold and hot) with the five elements of the body (metal, wood, water, fire and earth) (Orque *et al.* 1983). Diseases are defined as hot or cold and treatment is prescribed accordingly.

The postpartum period is noted for traditional practices associated with the 'Yue Fai' or 'lying by the fire'. The belief is that childbirth leaves the mother cold and wet; mothers lie by a hot fire to warm their bodies and dry out their insides (Phongphit & Hewison 1990). Some apply a heated stone wrapped in cloth to the abdomen. It is also believed that if the mother rests near a fire her uterus will return to normal faster (Esterik 1985). New mothers must restrict their activity, as well as observe food regulations. This period is normally from 3 to 15 days (Vong-Ek 1993). Today, relatively few women die in childbirth and few people believe in spirits or try to manipulate them. Thus, 'Yue Fai' to dry the uterus is seen as an optional practice for the mother's convenience (Kaewsarn & Moyle 2000). Few women practise it, but most still observe a period of 'rest at home'. This aids, it is believed, in regaining strength, physical equilibrium and in producing good quality breastmilk (Vong-Ek 1993).

Cultural postpartum food practices

Cultural factors play a fundamental role in the identification, value and use of food. In Thai culture, food is traditionally thought to play a part in the cause and treatment of disease, and knowledge of 'hot' and 'cold' foods is passed down to family members through experience (Henderson & Primeaux 1981). Thai women have traditions of food restrictions around parturition, and believe that they should have good food which is not too hot or too salty (Phongphit & Hewison 1990). Women generally are encouraged to eat very plain food, for example, rice, and one or two plain dishes or soup (Vong-Ek 1993, Mulder 1996). It is also believed that cold water should not be taken during this period. Postpartum mothers are encouraged to drink warm water and to bathe either with plain or herbal warm water. Food restrictions are frequently associated with a desire to ensure breastmilk production. Boiled water is believed to stimulate milk flow, and foods which are white in colour are thought to be symbols of good quality or correct milk concentration and Thai women are encouraged to eat these (Vong-Ek 1993, Jirojwong 1996). However, it is not clear

whether traditional postpartum dietary practices, especially food restrictions, are as prevalent today. It was reported by Vong-Ek in 1993 that most young mothers had given up such practices unless forced to follow them by an older family member.

Sexual intercourse

Other Thai postpartum practices reported in the literature relate to sexual activity. Sexual intercourse is traditionally prohibited for mothers for about 30 days after delivery in most developing countries (Rice 1994, Maher 1995, Holroyd *et al.* 1997). When the mother is considered rested, sexual relations may resume after vaginal bleeding has stopped (Rice 1994, Maher 1995).

The study

Rationale for research

There are gaps identified in the available research on cultural beliefs and postpartum care. Studies investigating the impact of culture on the postpartum period have mainly concentrated on breast-feeding and have been conducted in countries such as America, Australia, Europe and Asia (Phongphit & Hewison 1990, Chee & Horstmannshof 1996, Gorrie *et al.* 1998, Whelan & Lupton 1998). Most of these studies describe differences among people who live in those countries. Furthermore, findings from studies of Asian women mostly apply to Vietnam, China or Indonesia (Jenson *et al.* 1993, Burroughs 1997, Rice *et al.* 1999). In Thailand, two small breast-feeding studies (Vong-Ek 1993, Whittaker 1994) were considered important in informing health professional practice on breast-feeding in Thailand. However, these studies were conducted nearly 10 years ago and did not extend to postpartum care, despite the importance of this period in women's and babies' health. Therefore, the present study sought to address this gap in knowledge, and gain understanding of the traditional practices that Thai women follow in relation to postpartum care and the rationale underpinning such practices. The outcomes of this investigation will contribute to the contemporary understanding of culture-based health practices and inform health education for women and health professionals.

Aim

To gain an understanding of the traditional practices that Thai women follow in relation to postpartum care and the rationales underpinning such practices.

Methods

Sample

Five hundred Thai women living in Ubon Ratchathani, Thailand who were attending their first postpartum hospital clinic appointment were surveyed. The women were identified as potential participants by nurses working in the clinics at the request of the researchers. Ubon Ratchathani is North-East Thailand's easternmost province, and is bordered to the east by the Mekong River and Laos and to the south by Cambodia. To participate the women had to be: (1) 18 years of age or older; (2) have had an uncomplicated pregnancy; (3) 6–10 weeks postpartum; (4) in good health and have a well baby; and (5) currently or until recently breast-feeding their baby.

Questionnaire development

No existing studies of Thai women's beliefs of breast-feeding and postpartum practices were identified and so a specific survey tool was developed. Questionnaire items were drawn from a review of the breast-feeding literature and exploratory interviews with a convenience sample of Thai women in Brisbane, Australia, where all the authors were living at the time. Participants consisted of nine older Thai women and nine Thai women who had experience of breast-feeding and traditional postpartum practices. The women described feeling confused by contemporary nursing care and the conflict between hospital care and traditional practices. The interview themes, along with the researchers' knowledge and experience, as well as discussions with academic and clinical experts in the field of midwifery and childcare, informed questionnaire item development. The instrument was initially written in English, translated into Thai, and piloted with a convenience group of Thai women ($n = 9$) in Brisbane. The instrument was refined and decisions about face and content validity were based on feedback from the pilot process.

The questionnaire asked participants to respond to 39 items using a series of 'Yes/No' responses to identify their postpartum practices, the duration and reasons for these and the people who encouraged the practices.

Data collection

The main site for data collection was the postnatal clinic at Ubon Ratchathani hospital, which is the biggest hospital in the province and second biggest hospital in the North-East part of Thailand. Additional study sites included other district hospitals within Ubon Ratchathani province. To ensure that a representative sample was obtained, quota sampling was used to recruit adequate numbers of participants from

each research site to reflect the approximate proportions in the general population.

Ethical considerations

Ethical clearance was provided by the University Human Research Ethics Committee and from the Ministry of Public Health, Thailand. Staff at each participating clinic site identified eligible women to participate in the study. These women were then asked if they would be willing to speak with a researcher. Potential participants were provided with written and verbal information about the study. Consenting women were then asked to complete the questionnaire while waiting for their appointment, and to return it before they left the clinic. Data were collected from April to November 2000.

Data analysis

The Statistical Package for the Social Sciences (SPSS), version 8 for Windows, was used for all data analysis. All data were checked for completeness and consistency before analysis. Initially, the distributions of each variable were quickly scanned and were not found to be meaningfully skewed or kurtotic in distribution. Descriptive statistics were used to examine the frequency distribution for each of the variables and to describe the characteristics of the women including the percentage practising particular behaviours, while mean, range and standard deviation were used to describe continuous data. Chi-square analysis was conducted to determine if selected traditional practices were associated with demographic characteristics.

Results

Sample characteristics

From a sample of 551 women approached to participate in the study, a total of 500 (90.7%) completed the questionnaire. Most women in the sample were Buddhists, with an age range from 18 to 49 years (mean = 27.11, SD = 5.86). The majority lived with a partner and had completed primary school education. Many of the women were farmers; nearly half lived in a nuclear family and half in an extended family. The demographic profile of the sample, when compared with Ubon Ratchathani statistics (Ubon Ratchathani Health Centre 2000), was found to be representative of childbearing Thai women (Table 1).

Obstetric details

There were 52.4% ($n = 262$) multiparous and 47.6% ($n = 238$) primiparous women in the sample. The number

Table 1 Demographic characteristics of women

Demographics of women	Study sample n (%)	Ubon population $n = 281\ 326$ (%) [*]
Religions		
Buddhists	497 (99.4)	279 638 (99.4)
Christians	3 (0.6)	1406 (0.5)
Age (years)		
15–19	42 (8.4)	24 475 (8.7)
20–24	156 (31.2)	26 725 (9.5)
25–29	137 (27.4)	28 413 (10.1)
30–34	102 (20.4)	27 007 (9.6)
35–39	49 (9.8)	21 662 (7.7)
40–44	12 (2.4)	18 004 (6.4)
45–49	2 (0.4)	14 628 (5.2)
Marital status		
Married	342 (68.4)	194 677 (69.2)
Separated	15 (3)	8721 (3.1)
Divorced	5 (1)	3375 (1.2)
Widowed	2 (0.4)	1406 (0.5)
De facto	136 (27.2)	73 144 (26.0)
Education		
Primary school	353 (70.6)	203 442 (73.3)
Secondary school	63 (12.6)	41 833 (14.8)
Certificate	35 (7)	13 783 (4.9)
Bachelor	46 (9.2)	17 116 (6.08)
Postgraduate and other	3 (0.6)	– [†]
Occupation		
Labourer	73 (14.6)	37 692 (13.4)
Government officer	61 (12.2)	31 998 (11.37)
Technical	7 (1.4)	2685 (0.95)
Employed in cooperative	13 (2.6)	5820 (2.03)
Trader	49 (9.8)	37 580 (13.37)
Farmer	209 (41.8)	120 020 (42.66)
House duty	88 (17.6)	45 631 (16.22)
Type of family		
Nuclear family	241 (48.2)	– [†]
Extended family	259 (51.8)	– [†]

^{*}Indicates total Ubon population.

[†]Data not available.

of visits to the antenatal clinic (ANC) varied across the sample, with over half the women ($n = 308$, 61.6%) visiting the ANC six times or more. Around 18.2% ($n = 91$) reported visiting the clinic around five times, 12.8% ($n = 64$) made three to four visits, while relatively few ($n = 31$, 6.2%) had one to two antenatal visits or never had an antenatal visit ($n = 6$, 1.2%).

The majority of women had given birth under the supervision of a health professional ($n = 491$, 98.2%). Nurses ($n = 373$, 76.4%) predominantly provided childbirth assistance, with fewer doctors ($n = 115$, 23%) assisting at delivery. Relatively few women were assisted by traditional

Table 2 Summary of activities and hygiene practices mentioned by women

Activity	<i>n</i> (%) of women practising activity	Mean number of days practised	Range (day)	Reason		Influential person	
				First	Second	First	Second
1. Sexual abstinence	500 (100)	63	7–450	Ut	Wo	Nurse	Mother
2. Hot drink	438 (87.6)	39	1–360	Bm	Ut	Mother	Relative
3. Hot bath	416 (83.2)	14	1–90	Ut	Wo	Mother	Mother-in-law
4. Food restriction	394 (78.8)	62	2–720	Wo	Ba	Mother	Relative
5. Stay home	392 (78.4)	34	1–180	Wo	Ut	Mother	Partner
6. Stop doing house work	364 (72.8)	28	1–120	Ut	Wo	Mother	Relative
7. Breast massage	329 (65.8)	10	1–90	Bm	Wo	Mother	Nurse
8. Lying by fire	329 (65.8)	7	1–19	Ut	Wo	Mother	Relative
9. Heat lamp on perineum	319 (63.8)	6	1–30	Ut	Wo	Nurse	Mother
10. Restriction shampoo hair	305 (61)	8	1–90	Wo	Bm	Mother	Mother-in-law
11. Avoid cold, wind and rain	284 (56.8)	32	1–730	Wo	Bm	Mother	Partner
12. Exercise	266 (53.2)	19	1–120	Ut	Wo	Nurse	Partner
13. Hot compress on breasts	249 (49.8)	9	1–90	Bm	Wo	Mother	Nurse
14. Hot bag on abdomen	240 (48)	16	1–60	Ut	Wo	Mother	Relative
15. Closed dress	233 (46.6)	28	2–90	Wo	Ut	Mother	Partner
16. Squatting or kneeling	161 (32.2)	14	1–90	Ut	Bm	Mother	Relative
17. Steaming (hydrotherapy)	126 (25.2)	10	1–90	Wo	Ut	Mother	Mother-in-law
18. Hot sitz bath	78 (15.6)	7	1–21	Ut	Bm	Mother	Mother-in-law
19. Body massage	77 (15.4)	6	1–60	Wo	Bm	Mother	Mother-in-law
20. Discard colostrum	12 (2.4)	2	1–7	Ut	Bm	Mother	Partner

Ut = Uterus, Wo = Women's health, Bm = Breastmilk, Ba = Babies' health.

birth attendants ($n = 7$, 1.4%). The majority had a spontaneous vaginal birth ($n = 441$, 88.2%).

Postpartum practices

The postpartum practices of Thai women appear to reflect an accommodation of biomedical practices and a continuation of traditional rituals. There were 20 reported activities performed by postpartum women (as outlined in Table 2). More than 50% of women performed 11 or more of these activities. Nine activities were practised by fewer than 50% of women (activities 12–20). Six of the most popular activities will be discussed further and include sexual abstinence and restricted activity, taking hot drinks, hot baths, food restriction, practices to maintain body heat such as 'lying by fire', avoiding cool air and managing 'bad blood'.

Sexual abstinence and restricted activity

A period of sexual abstinence was reported by all women, with the duration varying from 7 to 450 days (mean = 63 days, $SD = 27$). Involution of the uterus ($n = 479$, 95%) and women's health ($n = 6$, 2.6%) were the most common reasons given for avoiding sexual intercourse. Nurses were commonly reported as suggesting sexual abstinence ($n = 383$, 78.7%) and the women's mothers were also influential in this practice ($n = 104$, 20.4%).

Several behaviour restrictions are common for Thai women during the postpartum period. They avoid many activities in order to rest, particularly in the first few days after childbirth. Participants reported that they walked less and performed tasks less vigorously during this period ($n = 392$, 78.4%). Heavy physical activities requiring large amounts of energy, such as carrying heavy loads of water, squatting or kneeling, and exercising were not undertaken. Travelling long distances or any heavy household duties were also avoided. These activities were believed to stop the involution of the uterus, collapse of the internal organs and a prolapsed uterus.

Taking hot drinks

Taking hot drinks was the second most popular practice among postpartum women. The period of consumption of such drinks varied from 1 day to 1 year (mean = 39 days, $SD = 35$). To improve breastmilk production was the main reason for taking these hot drinks ($n = 344$, 68.8%), and mothers and relatives had an important role in encouraging this.

Hot baths

Hot baths were the third most popular practice reported and its duration ranged from 1 to 90 days (mean = 14 days, $SD = 12$). The women's mothers ($n = 306$, 61.2%) and mothers-in-law ($n = 45$, 9%) usually suggested this practice,

Table 3 Incidence of foods consumed, reason and influences

Type of foods	Number of women <i>n</i> (%)	Reason		Influential person	
		First	Second	First	Second
Protein					
Pork	484 (96.8)	Breastmilk	Postpartum recovery	Mother	Nurse
Chicken	481 (96.2)	Breastmilk	Postpartum recovery	Mother	relative
Fish	467 (93.4)	Breastmilk	Postpartum recovery	Mother	Nurse
Egg	415 (83)	Breastmilk	Uterus	Mother	Partner
Milk	387 (77.4)	Breastmilk	Postpartum recovery	Mother	Nurse
Catfish	374 (74.8)	Breastmilk	Uterus	Mother	Partner
Internal organs	325 (65)	Breastmilk	Postpartum recovery	Mother	Nurse
Beef	310 (62)	Breastmilk	Postpartum recovery	Mother	Nurse
Shrimp	299 (59.8)	Breastmilk	Postpartum recovery	Mother	Partner
Pork maw	255 (51.1)	Breastmilk	Postpartum recovery	Mother	Partner
Buffalo meat	178 (35.6)	Postpartum recovery	Breastmilk	Mother	Partner
Vegetable					
Fresh vegetable	455 (91)	Breastmilk	Postpartum recovery	Mother	Partner
Banana flower	426 (85.2)	Breastmilk	Postpartum recovery	Mother	Partner
Lemon grass	431 (86.2)	Breastmilk	Postpartum recovery	Mother	Partner
Onion	419 (83.8)	Breastmilk	Postpartum recovery	Mother	Partner
Ginger	410 (82)	Breastmilk	Uterus	Mother	Partner
Cabbage	413 (82.6)	Breastmilk	Postpartum recovery	Mother	Partner
Hairy melon	407 (81.4)	Breastmilk	Postpartum recovery	Mother	Partner
Snake bean	393 (78.6)	Breastmilk	Babies' health	Mother	Partner
Chili	368 (73.6)	Breastmilk	Postpartum recovery	Mother	Partner
Pepper	350 (70)	Breastmilk	Postpartum recovery	Mother	Partner
Bamboo shoot	267 (53.4)	Breastmilk	Postpartum recovery	Mother	Partner
Fruit					
Orange	455 (91)	Postpartum recovery	Breastmilk	Mother	Partner
Banana (long)	73.8 (396)	Breastmilk	Postpartum recovery	Mother	Partner
Tamarind	312 (62.4)	Postpartum recovery	Babies health	Mother	Partner
Water melon	56 (280)	Breastmilk	Babies health	Mother	Partner
Jack fruit	274 (54.8)	Breastmilk	Babies health	Mother	Partner
Durian	162 (32.4)	Babies health	Postpartum recovery	Mother	Partner

which was claimed to maintain body heat as well as promote healing.

Food restrictions

The fourth most popular activity was food restriction, which lasted between 2 days and 24 months (mean = 62 days, SD = 75). There are many culturally determined practices that include consumption and avoidance of certain foods by pregnant or lactating women. Consuming particular foods and avoiding others were viewed as a prophylactic measure and commonly observed ($n = 394$, 78.8%) throughout the postpartum period. The foods readily consumed included sources of protein, vegetables, fruit, special menu and herbal drinks and medicines. The health of the mother ($n = 258$, 51.6%) and baby ($n = 70$, 14%) were the most important reasons for following this practice. Women's mothers and

their relatives encouraged a range of food restrictions (see Table 3). There was not total agreement about these foods, as some women mentioned eating foods which were considered to be dangerous by others, such as fresh vegetables ($n = 45$, 9%) and fish ($n = 33$, 6.6%). There were concerns among some that such foods could be the cause of women's sickness ($n = 258$, 51.6%) and could decrease breastmilk volume ($n = 58$, 11.6%). Some women ($n = 385$, 77%) stated that they were allowed to have these foods only by approval of their mothers and relatives.

Three groups of foods – protein, vegetable and fruit – were predominantly reported by women as being suitable foods to consume. Pork was the most common protein reported, and chicken, fish and eggs were also popular. Buffalo meat was the protein least consumed. Commonly, buffalo meat is considered to be harmful because of the traditional belief that

it is toxic and poisonous for postpartum women. There were three main reasons for consuming these types of food: to assist breastmilk production, to aid postpartum recovery and for the baby's health. The mothers of women were most influential in relation to diet, with nurses and partners the second most influential.

More than half of the women ate every kind of vegetable. Vegetable consumption was reported to promote breastmilk quality and quantity. Postpartum recovery was the second most important reason given for vegetable consumption. Improving breastmilk production and baby's health were the first and second most important reasons for fruit consumption. Mothers and partners were most often reported as encouraging women to consume fruit.

Seven special menu dishes were reported by postpartum women. These included: pork soup, Kang Leang (mostly cooked with a variety of vegetables, mashed fish or dry prawn), black chicken soup (chicken which has black meat and skin) and mashed shrimp. All of these meals were believed to be beneficial for breastmilk production. Three other kinds of food – pickled vegetables, pickled fruit and spicy food – were believed to affect positively babies' health and uterus involution. Women's mothers and their partners were influential in encouraging them to consume these foods.

Maintaining body heat

Results demonstrate that participants' postpartum practices followed beliefs originating from the *Yin* and *Yang* of Chinese medicine and that they practised a number of activities to maintain their body heat. Women accepted the practice of 'lying by fire' or *Yu Fai* during the postpartum period, and this was believed to reheat the mother's body, increase uterus involution, flatten the belly of the new mother, help to remove stretch marks and help to heal perineal tears. A small group of women ($n = 6$, 1.2%) described 'lying by fire' as also assisting with increasing in milk supply, helping them to gain strength and avoid permanent ill health due to a cold state. However, some ($n = 171$, 34.2%) considered 'lying by fire' as inconvenient and unpleasant, and some suffered minor burns and heat rashes. However, they remained convinced of its benefits as an important aspect of their health practices.

Another traditional practice was standing over a lit fire or the more modern practice of shining a heat lamp on the perineum, and a hot sitz bath for 10–15 minutes at least twice a day. A number of women indicated that heat from a heat lamp on the perineum ($n = 316$, 63.2%) and a hot sitz bath ($n = 76$, 15.2%) would heal the perineal wound quickly. Heat was also viewed able to stimulate the release of lochia. Thai nurses also recommend the practice of sitz

baths and heat lamps to the perineum. Thus, there was no reported conflict here between the women's traditional beliefs and modern nursing practice, although the latter does not incorporate of 'lying by fire'.

Cool, moving air was considered dangerous by over half of the mothers ($n = 284$, 56.8%). Thus, they avoided sitting near evaporative coolers and walking in rain. However, nearly half ($n = 216$, 43.2%) considered that they could not avoid moving air as it was everywhere. They also believed that air could harm the eyes and lead to blindness. The shoulders and breasts were also covered to prevent breast infection.

Managing 'bad blood'

As postpartum discharge or lochia is present during the postpartum recuperative period, the new mother is considered to be sick or in a state of ill-health. Postpartum discharge was viewed as bad or useless blood that was not wanted in the body. This blood, however, was seen by the women ($n = 416$, 81.2%) to hold some sort of power that could contaminate others with who they came into contact during this period. The imposed hygiene restrictions were the same for new mothers as for menstruating women. For example, new mothers did not bath in a tub, shower or shampoo their hair. A number of women ($n = 305$, 61%) mentioned that they did not shower or shampoo their hair for a range of 1–90 days after giving birth, and began showering after their recovery from vaginal bleeding. They believed that violation of these restrictions results in serious illness ($n = 140$, 28%).

Demographic analysis

Chi-square analysis was conducted to determine whether demographic characteristics were associated with selected traditional practices. The majority of women took hot drinks, hot baths and adhered to food restrictions. Younger (20–29 age group) and less educated women (primary school educated) were more likely to follow traditional postpartum practices. There was a statistically significant difference between education and food restrictions ($\chi^2 = 45.67$, d.f. = 4, $P < 0.01$). However, there was no meaningful difference between education and taking hot drinks and having hot baths. Women working in 'agriculture' and 'house duties' were more likely to follow these practices. There was a statistically significant association between women's occupation and taking hot drinks ($\chi^2 = 16.77$, d.f. = 6, $P < 0.01$) and food restriction ($\chi^2 = 71.24$, d.f. = 6, $P < 0.01$). However, there was no meaningful relationship between occupation and having hot baths ($\chi^2 = 9.99$, d.f. = 6, $P > 0.13$).

Discussion

In many cultures the postpartum period is seen as a period when new mothers are vulnerable to all sorts of illness. Not only are the women's behaviours often restricted during this period, but they also want to observe certain traditional customs in order to avoid ill health in later years (Manderson 1985, Fok 1996, Holroyd *et al.* 1997). 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 study findings show that postpartum care is a cultural construct made up of a collection of knowledge and experiences not only of the mothers themselves, but also of their significant others. New experiences are reinterpreted by individuals on the basis of their own cultural knowledge, which in turn can be based on more than one factor, including assumed past behaviours on the one hand and perceptions of postpartum care. We found that more than 50% of postpartum Thai women continued to follow a number of traditional practices in the postpartum period, particularly related to self-care, rest and the consumption of 'hot' foods and fluids as well as certain other foods. Predominantly, these practices reflected traditional Chinese beliefs of 'Yin and Yang' (cold and hot) and 'Yue Fai' or 'lying by the fire' (Phongphit & Hewison 1990). The belief is that childbirth leaves the mother cold and wet, and that certain practices are required to restore balance, aid recovery to the prepregnancy state and promote the production of breastmilk (Fok 1996, Du 1998). Several studies have also reported the need for hot food among postpartum Thai women (Vong-Ek 1993, Rice 1994, Rice *et al.* 1999, Kaewsarn & Moyle 2000).

Younger women, and those who are less educated and working in unskilled jobs, are more likely to practise traditional ways. Thus, it is important that additional support is given to this group. Cultural beliefs and practices can act as barriers to contemporary care and Thai women may undertake postpartum practices with which health professionals may not always agree. In order to develop and provide effective postpartum care, nurses and other health professionals need to be aware of and sensitive to the cultural needs of clients (Phongphit & Hewison 1990).

Rice *et al.* (1999) studied the experiences of the postpartum hospital stay and return home among Thai mothers in Australia. They found that participants were not happy with specific hospital practices or the hospital environment, as their traditional beliefs were not observed. Although we did not study women's satisfaction with maternity care, our findings clearly identified the continuing dominance of

traditional practices for Thai women and the potential for conflict between traditional and contemporary postpartum practices. While women are in the hospital they may comply with contemporary practices; however, they may experience conflict until they return home, where they may commence traditional practices. It is important that the evidence base of postpartum practices is shared with women so that they understand contemporary postpartum practice in the health care system.

Health professionals need to be aware of clients' cultural beliefs and practices and carefully consider the extent to which their care complements these. Nurses should educate women about the benefits of contemporary postpartum care and provide strategies to help them deal with conflict about their beliefs and those recommended in contemporary health care practice. For example, Thai women should be educated to understand that there is no known advantage to such activities as avoidance of shampooing of hair and showering, and that there are greater risks than benefits of practices such as 'lying by fire'. Other activities, such as the use of heat lamps, could be recommended in place of these to help them adjust to changes in practice. Furthermore, influential people who are involved with traditional practices should also be educated. Postnatal education and home visits provide opportunities to observe and educate women and their relatives. Home visiting may be beneficial to postpartum women after discharge from hospital. Prompt support and information should be available, perhaps via a telephone help line where home visits are difficult, or where this might cater for a large population effectively and efficiently. However, health professionals should take the opportunity when possible to educate women individually and in the presence of other family members. Women in such situations may feel less threatened and may become confident with integrating their traditions with evidence-based practice (Mulder 1996). We also recommend that cultural education on postpartum care be included in nursing, midwifery and health professional education and that this is regularly updated as new evidence comes to light.

The amount of activity that new mothers assume when they go home depends on her circumstances. Women in this study reported that their mothers, other female relatives, husbands and children assisted them with housework. However, changes in Thai culture are reducing the number of extended families (Phongphit & Hewison 1990). Thus, Thai women may not have family members to assist them with the baby and household tasks. This may have an effect on postpartum practices and the opportunity for women to rest. Such changes need to be taken into consideration in planning postpartum care.

Study limitations

A limitation of the study was the development of the questionnaire with a sample of Thai women and nurses in Australia. Further research is needed to validate the questionnaire constructed for this study with a different sample of women and for health professionals to use standardized measures to identify the needs of postpartum women.

Conclusion

The findings of the present study contribute to the existing body of knowledge by providing a contemporary snapshot of postpartum practices in Thailand. In contrast to previous research (Phongphit & Hewison 1990, Vong-Ek 1993, Whittaker 1994), the study used a large representative sample of women, explored a number of practices and discerned their relative importance in the lives of these women. Furthermore, the study endeavoured to ascertain those people who are influential in the lives of Thai women. Mothers, mother-in-law and partners are instrumental in promoting certain practices and may also require education, if certain beliefs are contradicted by research evidence. Future research could investigate the advantages and disadvantages of traditional postpartum practices and whether there is evidence to support the activities undertaken by the women. Furthermore, an examination of nursing, midwifery and other health professional curricula in relation to cultural beliefs and postpartum practices might prove useful in identifying the areas that need further attention.

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