



Safe Motherhood Practices - Knowledge And Behaviour Among Women In Bangladesh

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ABSTRACT

Pregnancy and childbirth are essential for existence of the entire human race but maternal death is a twofold misfortune affecting both the mother and child. "Safe Motherhood Initiative" enlisted four pillars of safe motherhood but even after the launch of such and other initiatives maternal, infant and fewer than 5 mortalities remained unacceptable. Assessing the level of awareness about safe motherhood practices among pregnant women thus becomes necessary to plan interventions to further empower them to avail these services. Objective the research is to assess the level of knowledge and behaviour about the safe motherhood practices among women in Bangladesh. A cross-sectional type of study conducted among the mother of reproductive age who are pregnant & having more than one children attending in Obstetrics & Gynecology Out Patient Department in Mymensingh Medical College & Hospital to assess the present level of knowledge on safe motherhood practices. The sample size was 170 were selected purposively, and the study area was selected for easy access. In this study, socio-economical, educational & occupational characteristics of mothers, ever received ANC, PNC were found. In this study, most of the mothers 38 percent were in age group of 21-25 years, followed by 30 percent in 26-30 years, then 24 percent were below 20 years and only small number 8 percent above 30 years, all of them mean age was 24.62 (SD ± 4.515). The literacy rate was 42 percent. The majority of women were homemaker 92 percent; only 21.18 percent had the knowledge on ANC visit 4-5 times & rest of them no adequate knowledge of ANC visit. In this study most of the respondent about 62.35 percent had knowledge about medical care is required during pregnancy and rest 37.65 percent of them had no knowledge about medical care. This study also revealed that 51.20 percent respondent got information from health care provider, and rest of them knew from other sources. There is significant association with socio-demo-cultural factors and its variables like religion, education, age at marriage, and place for safe delivery P values are: $p < 0.025$, $p < 0.000$, $p < 0.001$, $p < 0.001$ which is < 0.05 . Worldwide emphasis is given on safe motherhood to reduce the high prevalence of maternal morbidity and mortality. A large segment of the mother was found illiterate, and the similar segment was found to have a financial hardship. Among pregnant women knowledge about Safe Motherhood Practices was average and behaviour was poor. There is a necessity to increase the knowledge which will in turn bring about a good behaviour and empower women to use the safe motherhood services.

Keywords: Safe motherhood, pregnant mothers, knowledge, behavior, reproductive age

INTRODUCTION

Most mothers enter pregnancy with the expectation that their pregnancy and delivery will involve nothing but happiness. Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Most maternal deaths are due to five major medical causes such as severe bleeding, infection, unsafe abortion complications, a hypertensive disorder of pregnancy, and obstructed labor (Okereke et al. 2013). In every minute of everyday somewhere in the world a mother dies as result of complications arising during pregnancy, unsafe motherhood practices, MMR in Bangladesh is being 3.2 per/1000 live birth. One of the globe, every hour 2 mothers die due to pregnancy related complication and unsafe practices (Lowdermilk et al. 2008).

There are some elements in safe motherhood such as 1. Antenatal care, 2. post natal care, 3. safe delivery including emergency obstetric care 4. prevention of unsafe abortion and management of complication of abortions 5. Family planning 6. Neonatal care. Preventing maternal death and illness is a human right. Safe motherhood requires women's rights to be guaranteed and respected. These include their rights to good quality services and information during and after pregnancy and childbirth; their right to make their own

decisions about their health freely, without coercion or violence, and with full information; and the removal of any barriers that contribute to maternal mortality. Maternal deaths are caused by unequal access to employment, finances, education, basic health care, and other resources. These negative conditions set the stage for poor maternal health even before a woman becomes pregnant, and can worsen her health when pregnancy and childbearing begin (Lowdermilk et al. 2008).

There is an inverse relationship between education of mother and maternal mortality.. Knowledge among safe motherhood practice and Utilization of medical advice and services is also likely to be higher among mothers with formal education than their counterparts with no formal education as the former is likely to read and follow medical instructions more carefully than the latter. MMR is likely to be higher in rural than in urban areas, keeping other factors constant, because the latter has the disproportionate concentration of health facilities with midwifery services including EOC services. These facilities are few and far between in rural areas.

For this safe motherhood practice is the most important to reduce the risk of unsafe mother hood practice, means creating an environment in which women is enable to choose whether she wants child or not and services requires to support her decision. Failure to provide accessible, affordable, quality services during pregnancy and childbirth is a violation of women's human rights. Almost 35% of women in developing countries receive no ante-natal care during pregnancy (Islam et al. 2006) in some countries; ante-natal coverage is as low as 26%. Approximately half of all deliveries in developing countries take place without a skilled attendant, with rates in some countries as high as 85% (Lowdermilk et al. 2008).. Distance from formal health facilities, lack of transport, hidden costs (transport, drugs, medical supplies, food and lodging), interaction with providers, and socio-cultural factors (lacking decision making power, tradition, family role, law) often limit women's access to receive care for safe motherhood (Lowdermilk et al. 2008)

The international "Safe motherhood initiative" launched in 1987 to improve maternal health and cut the number of maternal deaths by half by the year 2000. However, centered on high risk screening and traditional birth attendant training, the initiative proved to be futile in reducing the high level of maternal mortality in the poor developing countries. It happened because it ignored two crucial aspects of pregnancy-related complications: their frequently unpredictable and unpreventable nature, and their requirement for prompt medical interventions. The importance of a functioning health system for addressing issues related to the mother and child health is also emphasized by the Task Force on Child Health and Maternal Health of the UN Millennium project. This is to be achieved through building a functioning primary health care system from first referral facilities to the community level, and would ensure equitable access to safe delivery and essential neonatal/child health care services.

It was reported that every year globally at least 500,000 women die from pregnancy related causes and 99% of them are in developing countries and it is expected to increase to about 600,000 in 1999 if appropriate measures for women during child bearing age are not taken (Lowdermilk et al. 2008). Concern about continuing High level of MMR in Feb. 1987, the World Bank, WHO, UN FUND organized a meeting of health experts from 30 countries in NYROBI. This is known as NYROBI international safe motherhood conference, initiative for safe motherhood, over view of safe motherhood in developing country presented together with recent programmatic level (WHO, 2001).

OBJECTIVE

To assess the level of knowledge and behaviour about the safe motherhood practices among women in Bangladesh.

SIGNIFICANCE OF THE STUDY

Safe motherhood can be achieved by providing high-quality maternal health services to all women. Services to help make motherhood safe include:

- Care by skilled health personnel before, during and after childbirth
- Emergency care for life-threatening obstetric complications
- Services to prevent and manage the complications of unsafe abortion
- Family planning to enable women to plan their pregnancies and prevent complications related to too many, too close, too early and too late pregnancies
- Health education and services for adolescents, community education for women, their families and decision-makers.

There is a global effort that aims to reduce deaths and illnesses among women and infants, especially in developing countries. This effort is called Safe Motherhood Initiative. The global safe motherhood initiative was launched in 1987 to improve maternal health and reduce the number of maternal deaths by half in the year 2000. It is led by a unique alliance of co-sponsoring agencies that work together to raise awareness, set priorities, stimulates research, mobilize resources, provide technical assistance and share information. When the initiative was launched, the extent of deaths from the complications of pregnancy and childbirth was little known. During the initiative's first decade, these safe motherhood partners developed model programs, tested new technologies and conducted research in a wide range of countries and settings.

METHODOLOGY

A descriptive cross-sectional study was conducted to assess the level on safe motherhood practices in outdoor department of Mymensingh medical college & hospital, most of its patients are referred from rural area for better management & improved healthcare. The target population in this study was mothers of reproductive ages who are pregnant & having more than one child, attending in OBS and GYNAE outdoor department in Mymensingh Medical College & Hospital, Bangladesh. The hospital was purposively selected for research. Sample size was 170. Sampling technique was used purposively who are pregnant and having more than one child. Data collection tools: An interview questionnaire is the most commonly used instrument for obtaining information by self report. It could be used to obtained different types of information on safe motherhood practices. So the data was collected from the mother of reproductive age by using structured questionnaire according to the objectives and different variables of this study through face to face interview. All interviewed questionnaire were checked for its completeness and consistency to exclude missing or inconsistent data. Data were checked, verified and summarized in master sheet to facilitate for proper analysis. The study was based on primary data with descriptive cross-sectional design filled directly with the help of respondent. The data was sorted and analyzed by using the software SPSS. The analyzed data was presented according to the variables of the study showing percentage and relationship between variables and appropriate statistical method in tables, graph, charts and bars. Descriptive statistics was used for the interpretation of the findings. Cross tabulation and association was determined by using the chi-square test where applicable. The standard guideline was followed for report writing provided by the University for Better Quality of research work. Pre-test of the questionnaire were taken in the place Obstetric & Gynae outpatient department of Mymensingh Medical College Hospital. Double entry data systems were following for better quality. Data analysis was done by SPSS. The data were noted very carefully and systematically. Each respondent were given their own cod and inter separately with coding different variables, so as to conceal their identification.

RESULTS

The basic characteristics of study revealed that the total of 170 samples included in this study of knowledge on safe motherhood practice. This study was descriptive cross sectional study conducted in Mymensingh medical college and hospital. The results are being planned to present in tabular form graphical form and narrative form as following:

Table 1 shows that maximum number of respondents 38.15 were in age group 21-25yrs, followed by 30% in 26-30yrs, 24.11% were below 20 yrs and small 7.64% were above 30 yrs. All of them mean age was 24.61 and SD \pm 4.515. The age range from 17 to 38 years. Among 170 respondents 84.11 percent were Muslim, 14.71 percent were Hindu & only 1.18 percent was Christian.

Table 1: Distribution of Socio-Demographic factors of the respondents

Socio-Demographic Factors	Frequency	Percentage
Age in years		
<20 years	41	24.11%
21-25 years	65	38.25%
26-30 years	51	30%
>30 years	13	7.64%
Religion		
Islam	143	84.11%
Hindu	25	14.71%
Christian	2	1.18%

Occupation		
Housewife	156	92%
Govt. Service	9	5%
Others	5	3%
Educational Level		
Illiterate	44	25.88%
Primary	79	46.47%
S.S.C	28	16.47%
H.S.C	12	7.06%
Graduation	7	4.12%
Having Children		
Two children	103	60.59%
More than two children	67	39.41%
Monthly Family Income		
< 5000	134	78.82%
(5000-8000)	31	18.24%
>8000	5	2.94%
(n=170)		

Majority of respondents were housewife 92 percent, only 5 percent was in service & 3 percent others. Educational status of respondents, half of them 46.47 percent had primary education, 25.88 percent were illiterate, 16.47 percent had SSC level, 7.06 percent had HSC level & only 4.12 percent had graduate level of education. In the number of child revealed that 60.59 percent had two children & 39.41 percent had more than two children out of 170 respectively. Maximum 78.82% had income less 5000 taka, 18.24% were 5000-8000 taka and only 2.94% had income more than 8000 taka. Mean of monthly family income was 2400 and SD \pm 899.704.

Table 2 shows most of the respondents 69.41% had an opinion for pregnancy and delivery check up in Govt. hospital followed by 15.88% MCWC, 11.18% TBA and remaining only a few of them said about 3.53% private chamber. By making decision for check-up in pregnancy, husband was the decision maker in family in 80.59% cases, then mother-in-law 13.53% and only 5.88% self decision maker for check-up in pregnancy. Most of the respondents, 82.35% had knowledge that the first feed of newborn was colostrums, 7.65% bottle milk, 4.70% honey and 5.30% others.

Table 2: Distribution of socio-cultural factors of the respondents

Socio-Cultural Factors	Frequency	Percentage
Place for pregnancy and delivery check-up		
Govt. Hospital	118	69.41%
MCWC	27	15.88%
TBA	19	11.18%
Private chamber	6	3.53%
By making decision for check-up in Pregnancy		
Husband	137	80.59%
Mother-in-law	23	13.53%
Self	10	5.88%
First feed of new born		
Colostrums	140	82.35%
Bottle milk	13	7.63%
Honey	8	4.70%
Others	9	5.30%

Table 3: Distribution of access to health service related and information factors of respondents

Factors	Frequency	Percentage
Distance of health facility		
<2 km	42	24.70%
2 km	46	27.06%
>2 km	82	48.24%
Frequency of ANC visit		
4-5 times	36	21.18%
Don't know	128	75.30%
Others	6	3.52%

Table 3 shows in maximum cases 48.24% health facility was far from house more than 2 kilometer and 27.06% was 2 kilometer and 24.70% was less than 2 kilometer. Majority 75.30 % respondents did not know about the ANC visit, only 21.18% told that ANC visit must be 4-5 times and 3.52% others out of 170 respondents.

Table 4: Religion of the respondents with knowledge

Religion	Knowledge	
	Had knowledge	Had no knowledge
Muslim	84 (58.7%)	59 (41.3%)
Non-Muslim	22 (81.5%)	5 (18.5%)

Table 4 shows there is significant association between religion and knowledge of the respondents.

Table 5: Education of the respondents with knowledge

Education	Knowledge	
	Had knowledge	Had no knowledge
Illiterate	60 (48.8%)	63 (51.2%)
Literate	46 (97.9%)	1 (2.1%)

Table 5 shows there is significant association between education and knowledge of the respondents. Those who are literate 97.9% had knowledge and 2.1% had no knowledge. Among illiterate 48.8% had knowledge and 51.2% had no knowledge on safe motherhood.

Table 6: Age at marriage of the respondents with knowledge

Age at marriage	Knowledge	
	Had knowledge	Had no knowledge
<19 years	87 (51.2%)	63 (37.1%)
>19 years	19 (11.2%)	1 (0.6%)

Table 6 shows there is significant association between age at marriage and knowledge of the respondents.

Table 7: Place for safe delivery with knowledge of respondents

Place for safe delivery	Knowledge	
	Had knowledge	Had no knowledge
Home	53 (52.5%)	48 (47.5%)
Hospital	53 (76.8%)	16 (23.2%)

Table 7 shows there is significant association between place for safe delivery and knowledge of the respondents.

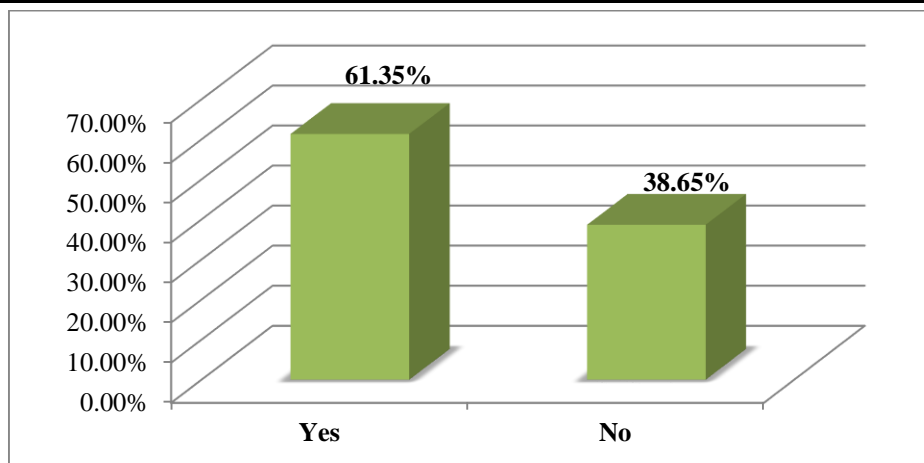


Fig. 1: Distribution of respondents by knowledge of medical care during pregnancy

Fig. 1 showing about 61.35 percent respondents had knowledge about medical care & rest 38.65 percent of them had no any knowledge of medical care in pregnancy.

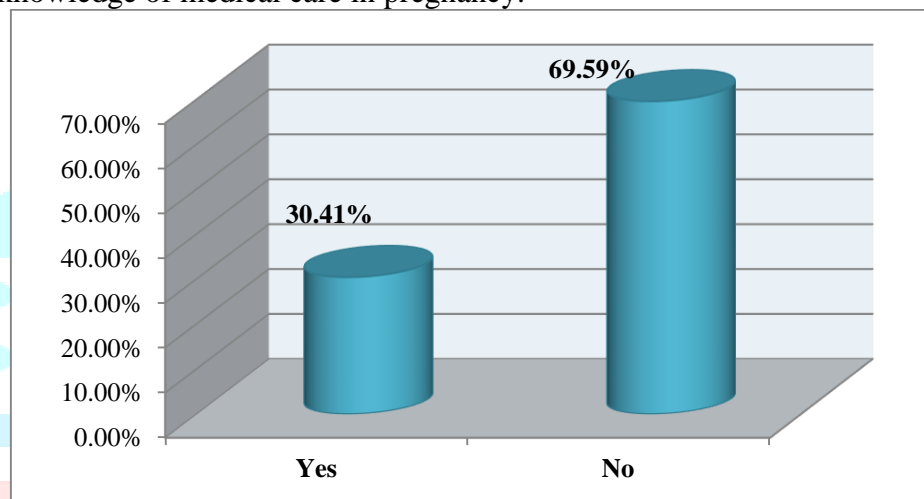


Fig. 2: Distribution of respondents by knowledge about TBA required or not during delivery

Fig. 2 shows the distribution of respondents by knowledge about TBA required or not during delivery maximum number 69.59 percent of respondents did not know about the requirement of TBA during delivery of child only 30.41 percent had knowledge about TBA required during delivery of child.

DISCUSSION

The present description type of cross-functional study was conducted among the mother in selected area at Mymensingh Medical College & Hospital to assess the level of knowledge of mother on safe motherhood practices among the mothers of reproductive age who are pregnant & having more than one child attending in Obstetrics & Gynecology Out Patients Department in Mymensingh Medical College Hospital & the relation of their knowledge with academic qualifications, occupations, monthly family income & with other parameters of safe motherhood. In this study a total of 170 respondents were interviewed with the help of pre-tested structured questionnaire.

The present study showed that maximum 78.82 percent mothers suffered from economic hardship with monthly family income below 5000 taka. A study was conducted on safe motherhood regarding socioeconomic & socio-demographic aspects of maternal mortality in South Asia countries stated that most of the girls started their life as a married women around 12-18 years of age in Bangladesh. The present study also showed that regarding trained birth attendants 70.59 percent respondents had no knowledge for the requirement of trained birth attendants during delivery of child. But 29.41 percent respondents had knowledge regarding the requirement of TBA during delivery of child.

CONCLUSION

The participants had overall average to poor knowledge as well as poor behaviour regarding safe motherhood practices and because of their lack of knowledge and awareness they are not able to avail the safe motherhood services. The knowledge of pregnant women regarding safe motherhood had a strong association with their education level, employment status and socio-economic status, while the behaviour was strongly associated with age at marriage. The knowledge was also strongly associated with the

behaviour. If women are given higher education which will enable them to seek employment and have a better socio-economic status the knowledge regarding safe motherhood may also increase. Also increasing the age at which girls are getting married may improve their behaviour regarding safe motherhood. Thus, if the knowledge increases it will lead to a better behaviour thus making pregnancy and delivery safer. Worldwide emphasis is given on safe motherhood to reduce high prevalence of maternal mortality and morbidity. Under the umbrella of safe motherhood steps were taken globally to overcome this constraints regarding up liftmen maternal health. In Bangladesh most of the peoples live in rural area and they are not economically solvent and educated. Many approaches are taken by the government of Bangladesh to ensure family planning, ante-natal care, clean and safe delivery and essential obstetric care under the guidance of primary health care. But significant results are not achieved due to lack of proper knowledge on the safe motherhood practice among the rural peoples. This cross sectional study was conducted among the mother of reproductive age group who are pregnant and having more than one child for focusing some socio-economic characteristics related to knowledge on safe motherhood.

RECOMMENDATIONS

From the date analysis reviewing the findings of the result of present study, it is important of formulate the following recommendations:

1. Nationwide survey should be made to get information regarding the present knowledge of safe motherhood. Proper & effective counseling service & health education regarding the safe motherhood practices must be reaching to each and every woman through health worker at grass root level of the community.
2. Informal education community education for women, their families, and decision makers includes safe motherhood is required.
3. Public awareness should be raise on the importance of health care of maternal and neonatal particularly recognizing life threatening complication and emergency readiness.
4. Community participation, inter-sectoral co-operation, strong political commitment can improve the legal, social, and economic status of women.
5. Promote research on knowledge on safe motherhood practices to contribute to improved planning, higher quality and more cost effective intervention.
6. Ensure that a functioning system of communication links with health worker who are working in communities, health center and hospitals so that women with pregnancy complication can receive prompt and appropriate medical care and advice.

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