

# A Study on Awareness of Birth Preparedness and Safe Delivery in Selected Rural Area in Bangladesh

Maksuda Khatun

Nursing Instructor, Rajshahi Nursing College, Rajshahi, Bangladesh

## Abstract

Pregnancy is an exciting time and a great opportunity to learn about the child development. Maternal health is important to families, communities and the nation due to its profound effects on the immediate survival of the newborn, health of women, and long-term well-being of children. In developing countries, one out of six women in the age group of 15-45 years dies due to maternal disorders. This study an aim was to explore Awareness of birth preparedness and safe delivery in selected rural area in Rajshahi district. It was cross-sectional descriptive types of study. The study was conducted in Rajshahi Medical College & Hospital. 300 pregnant mothers who come for treatment from Rajshahi District in Bangladesh during the study period constituted the study population. In the study revealed that respondent's information about types of outcome may arise due to unsafe delivery. Majority of the respondents were said maternal death 36.0%. Infant death 25.0%, infection 8.3%, uterine rupture 14.0%, postpartum hemorrhage 7.3%, Prolonged/obstructed labour 3.3%, respiratory distress syndrome 6.0%, neonatal infection/sepsis 5.3%, prolonged hospital stay 4.0%. Breast feeding not established 2.01%. Retain placenta 0.7%. It was found that majority (43.3%) of the respondents experienced excessive vaginal bleeding during pregnancy, Delayed labor 18.3%, 15.7% experienced retained placenta and 2.0% experienced did not know. Also study showed the relationship between occupation and ideal place for safe delivery. About 93.5% of the respondents who were house wives prefer hospital for safe delivery, 90.9% who were in service prefer hospital and 100.0% who were in business prefer hospital for safe delivery. The relationship between occupation and place for safe delivery was found statistically non-significant ( $p>0.01$ ).

**Keywords:** *Birth preparedness, Safe Delivery, Complication readiness, Awareness, Knowledge, Bangladesh.*

## I. Introduction

Childbirth is a very important event in women's life. Pregnancy involves a complex interaction of maternal and foetal physiology. Complications during pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in developing countries. Each year, approximately 536,000 women die from complications related to pregnancy and childbirth, with 99% (533,000) of these deaths occurring in Asia. The maternal mortality rate (MMR), which measures the number of deaths to women per 100,000 live births due to pregnancy-related complications is highest among the developing regions. Women's low status in society, lack of access to and control over resources, limited educational opportunities, poor nutrition, and lack of decision-making power contribute significantly to adverse pregnancy outcomes.

The Present Maternal Mortality rate is 170 per 100000 live births as per UN and WHO estimate (2014) in Bangladesh Perspective. (Source: The Daily Star)

Pregnancy is an exciting time and a great opportunity to learn about the child development. Each week of pregnancy includes a description of baby's development as well as a explanation of the changes taking place in the body.

Birth preparedness and complication readiness is a strategy to promote the timely use of skilled maternal and neonatal care, especially during childbirth, based on the theory that preparing for childbirth and being ready for complications reduces delays in obtaining this care.

High risk pregnancy is a critical problem for modern medical and nursing care. The leading cause of maternal attributable to pregnancy differs over the world the factors that are strongly related to maternal death include age, lack of prenatal care, low educational attainment.

Maternal deaths are thought to occur due to three delays: delay in deciding to seek appropriate care; delay in reaching an appropriate health facility; and delay in receiving adequate emergency care once at a facility these delays may be reduced if pregnant women are prepared for birth and complications.

In developing countries, one out of six women in the age group of 15-45 years, dies due to maternal disorders.

Globally, of an estimated 515,000 maternal deaths in 1995 only 206(0.4%) reported from developed region. Though the maternal mortality rate in the world estimated to be about 400 per 1,00,000 live births, it varies widely from 830

per 1,00,000 in Africa, compared to 24 in Europe. Thus we find that it is as low as 20 per 1,00,000 in developed regions, and 440 in developing regions. Over 75% of global maternal deaths are reported from the developing countries of just two continents- Asia and Africa. China, with a population larger than that of India accounts for only 6% of global maternal deaths compared to 25% in India, because of its higher literacy rate. In Karnataka maternal death rate estimated to be 171 per 1,00,000 live births during 2007-2009.

In most developing countries, 80% of the deaths are due to direct causes and 20% to associate causes. The leading direct causes are hemorrhage (25%), infections (15%), unsafe abortions (13%), eclampsia and pre eclampsia (12%), obstructed labour (8%), and others (7%). Amongst the associated causes of maternal deaths, anaemia, malaria, and viral hepatitis complicating pregnancy are common. Globally, over 50% of pregnant women are anaemic. Many of them suffer from nutritional anaemia worsened by helminthiasis and malaria, and this is responsible for 10-15% maternal deaths in developing countries.

The better the care during pregnancy and labour, the safer the delivery and mothers health. In the developing world, only 66% get prenatal care, 45% deliver in institutions and 50% access skilled care during delivery. The high maternal death rates in south Asian countries may be explained by poor maternity care as only one in two get prenatal care, one in four have institutional delivery and less than three get skilled attention during delivery. Of the maternal deaths 25% occur in pregnancy 15% intrapartum, 50-70% postpartum.

The poorer the prenatal care, the more unsafe is motherhood. The coverage of maternity care is over 90% in East Asia but hardly 25% in the southern subcontinent, the high death rates are due to poor prenatal care with practically no risk screening, and the intranatal supervision is mostly by illiterate and untrained traditional birth assistants. Lack of proper transport facilities also contribute to the delay in emergencies like hemorrhage, obstructed labour and eclampsia.

Maternal mortality is a substantial burden in developing countries. Improving maternal mortality has received recognition at the global level as evidenced by the inclusion of reducing maternal mortality in the Millennium Development Goals. Since it is not possible to predict which women will experience life -threatening obstetric complications that lead to maternal mortality, receiving care from a skilled provider (doctor, nurse or midwife) during childbirth has been identified as the single most important intervention in safe motherhood..

#### **Definition of Birth Preparedness**

Birth preparedness—i.e. advance planning and preparation for delivery—can do much to improve maternal health outcomes. Birth preparedness helps ensure that women can reach professional delivery care when labour begins. In addition, birth preparedness can help reduce the delays that occur when women experience obstetric complications, such as recognizing the complication and deciding to seek care, reaching a facility where skilled care is available and receiving care from qualified providers at the facility.

#### **Key elements of Birth Preparedness include:**

- Attending antenatal care at least four times during pregnancy;
- Identifying a skilled provider and making a plan for reaching the facility during labour;
- Delivering with a skilled provider and any required supplies;
- Recognizing signs of complications;
- Knowing what community resources emergency transport, funds, communications, etc. are available in case of emergencies;
- Having a plan for emergencies.

#### **Importance of Birth Preparedness and Safe delivery**

Birth Preparedness and Safe delivery is the process of planning for normal birth and anticipating the actions needed in case of an emergency. Birth preparedness is a strategy to promote the timely use of skilled maternal care, especially during childbirth, based on the theory that preparing for childbirth reduces delays in obtaining this care. A birth plan/emergency preparedness plan includes identification of the following elements: identifying a skilled birth attendant; identifying the location of the closest appropriate care facility; transport to a health facility for the birth and obstetric emergency; and identification of compatible blood donors in case of emergency. The role of BPSD improving the use and effectiveness of key maternal and neonatal services is through reducing delays in deciding to seek care in two ways. First, it motivates people to plan to have a skilled provider at every birth. Second, complication readiness raises awareness of danger signs thereby improving problem recognition and reducing the delay in deciding to seek care. Making arrangements for blood donors is also important because women giving birth may need blood transfusions in the event of hemorrhage or cesarean section.

## **II. Justification of the study**

Pregnancy is a normal physiological process but sometimes it may be complicated and life threatening due to lack of awareness during pregnancy. Under nutrition, infections and lack of medical care during pregnancy are powerful contributors to the poor outcome of pregnancy and low birth weight. Some of the risks can be modified by appropriate medical, social and nutritional intervention. Comprehensive prenatal care with appropriate nutrition has been shown to be more important in improving the pregnancy outcome. Some risks can only be altered by the will; to take on a very difficult task during and after pregnancy. Only a well motivated pregnant mother can ensure the health of her unborn baby. So awareness of the pregnant mothers regarding their pregnancy status is very much important to restore their optimum health during pregnancy and a healthy baby at the end of the pregnancy.

This study generated information that can be used by decision makers to improve birth preparedness and consequently increase skilled birth attendance. The implementation of the findings of this study will lead to change in decisions at individual, family, county and national level. It can be used at policy and operational levels.

### III. Objectives of the Study

The objectives of the study are as follows:

1. To explore Awareness of birth preparedness and safe delivery in selected rural area in Bangladesh.
2. To find out the relationship between socio-demographic characteristics and birth preparedness & safe delivery.

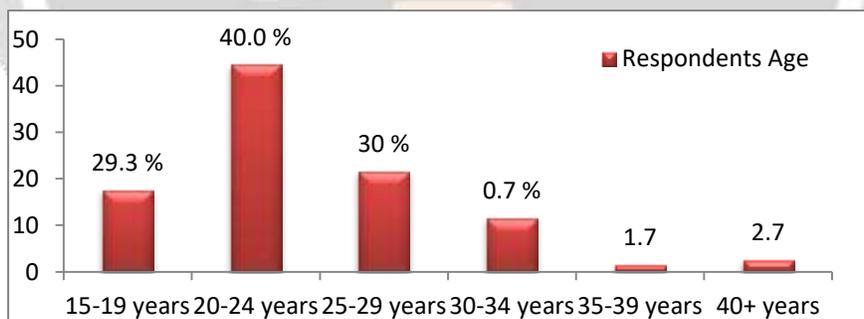
### IV. Methods and Materials

This Study was a cross-sectional type of descriptive study. This research work was done with duration of 2 years.

All those pregnant mothers and health care providers (Nurse). All those pregnant mothers who come in treatment for Rajshahi District. A purposive sampling technique was followed for the study. 300 respondents were selected through purposive sampling from selected sampling area. Data was collected from primary Sources. A structured questionnaire in English was duly pre-test and used for data collection from the respondent. Data will be collected through interview method, i.e. Interviewers were collect data from study participants through administered questionnaire by face to face interview. After entire proper verification, data was coded and entered into the computer by using suitable data entry software, such a SPSS, MS. Excel etc. Data was analyzed according to the objectives of the study by using SPSS software program and M.S. Excel. Table and graphs and statistical analysis will be done by adequate tables and graphs. Finally, it was presented as a research report.

### V. Results and Discussion

**Fig. 1:** Percentage distribution of respondents by their age.



**Regarding Age of the respondent:** The socio demographic information of the respondent's age. The age of respondents is an important aspect during the interpretation of results. Regarding age the respondents were divided in six age groups; 15 - 19 years 53(17.7%), 20 - 24 years 134(44.7%), 25 - 29years 65(21.0%), 30 - 34 years 35(11.7%), 35 - 39 years 5(1.7%) and 40 year and Above 8(2.7%) respondents of the total 300 respondents.

**Table 1.** Distribution of the respondents by their Age

Name of variable	Parameters	Frequency	Percentage (%)
Age	15-19 years	53	17.7
	20-24 years	134	44.7
	25-29 years	65	21.7
	30-34 years	35	11.7

	35-39 years	5	1.7
	40+ years	8	2.7
<b>Total</b>		<b>300</b>	<b>100</b>

**Table 2.** Distribution of respondent’s type

Name of variable	Parameters	Frequency	Percentage (%)
<b>Type of respondents</b>	Pregnant mothers	275	91.7
	Health providers	25	8.3
<b>Total</b>		<b>300</b>	<b>100</b>

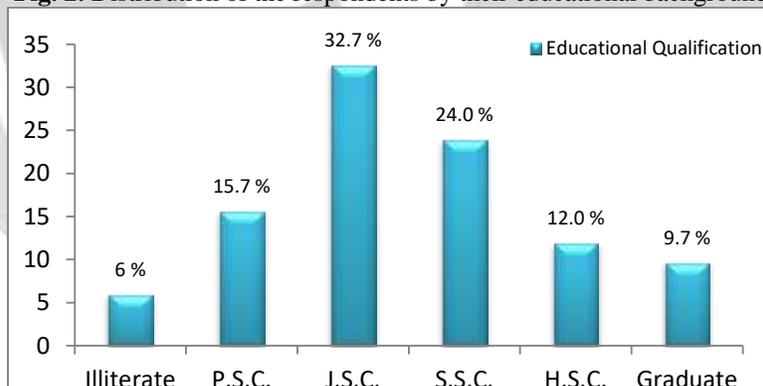
In this Figure shows that respondent’s 8.3% were health providers and 91.7% were pregnant mother.

**Table 3.** Distribution of the respondents by their educational background

Name of variable	Parameters	Frequency	Percentage (%)
<b>Educational Background</b>	Illiterate	18	6.0
	P.S.C.	47	15.7
	J.S.C.	98	32.7
	S.S.C.	72	24.0
	H.S.C.	36	12.0
	Graduate	29	9.7
<b>Total</b>		<b>300</b>	<b>100</b>

Regarding educational background, the result showed that maximum number of respondents was complete J.S.C. and percentage was 98 (32.7%), P.S.C. was 47(15.7%), S.S.C. was 72(24.0%), H.S.C. was 36(12.0%), Graduate was 29(9.7%) and Illiterate was 18(6.0%).

**Fig. 2.** Distribution of the respondents by their educational background



Regarding age distribution of the respondents it was found that out of 300 respondents majority (36.3%) were in the age group of <20 years, 31.3 % were in the age group of 20-24 years, 20.7% were in the age group of 25-29 years, 8.7% were in the age group of 30-34 years and only 3.0% were in the age group of 35+ years. The mean age of the respondents was 22.04 ± 5.126 years.

**Table4.** Distribution of the Respondent by their religion

Name of variable Religion	Respondents Frequency	Percentage (%)
Muslim	282	94.0
Hindu	15	5.0
Christian	3	1.0
<b>Total</b>	<b>300</b>	<b>100</b>

Regarding religion, the result showed that maximum number of respondents 282(94.0%) were Muslim, while Hindu were 15(5.0%) and Christian were 3(1.0%).

**Table5:** Distribution of the respondents by their occupational status.

Name of variable	Parameters	Frequency	Percentage (%)
<b>Occupation</b>	Housewife	273	91.0
	Service	20	6.7
	Business	4	1.3
	Others	3	1.0
<b>Total</b>		<b>300</b>	<b>100</b>

According to the table, the current employment status of the respondents. The majority of the respondents, that was 273 (91.0%) were housewife, 20 (6.7%) were service-holder, 4 (1.3%) had occupation of business and the rest of them 3 (1.0%) constituted other types of occupation.

**Table 6.** Distribution of the respondents by their monthly family income

Name of variable	Parameters	Frequency	Percentage (%)
<b>Monthly family average income</b>	< 10000/= Taka	96	32.0
	10000-20000/= Taka	128	42.7
	20000-30000/= Taka	51	17.0
	> 30000/= Taka	25	8.3
<b>Total</b>		<b>300</b>	<b>100</b>

This table showed the distribution of the respondents according to their monthly family income. Majority of the respondents (42.7%) had monthly family income of Taka 10000-20000/=, (17.0%) had family income of Taka 20000-30000/=, (8.3%) had family income greater than 30000/= and (32.0%) had monthly income of Taka 10000/= or less.

**Table 7:** Distribution of the respondents by their husband occupational status

Name of variable	Parameters	Frequency	Percentage (%)
<b>Occupation of husband</b>	Service	65	21.7
	Business	101	33.7
	Day labor	94	31.3
	Others	40	13.3
<b>Total</b>		<b>300</b>	<b>100</b>

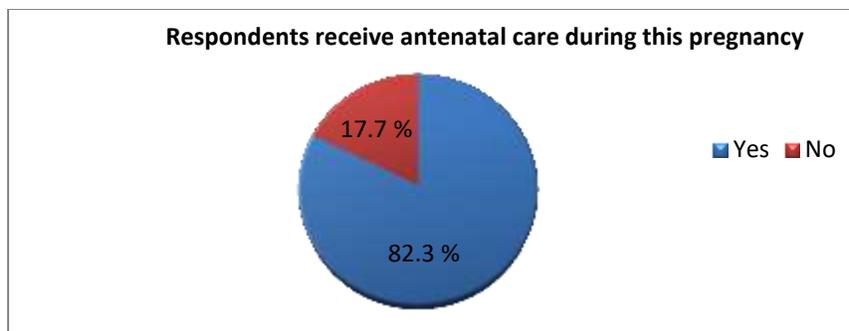
This table showed that majority of the respondents by their husband occupational status 101(33.7%) had business 94(31.3%) were day labor, 65(21.7%) were service holder and the rest of them 40(13.3%) constituted other type of occupation.

**Table8.** Distribution of the respondents by their educational background of husband

Name of variable	Parameters	Frequency	Percentage (%)
<b>Educational Background of husband</b>	Illiterate	43	14.3
	P.S.C.	51	17.0
	J.S.C.	53	17.7
	S.S.C.	54	18.0
	H.S.C.	48	16.0
	Graduate +	51	17.0
<b>Total</b>		<b>300</b>	<b>100</b>

This table showed that the respondents by their educational background of husband P.S.C. was 51(17.7%), J.S.C. was 53(17.7%), S.S.C. was 54(18.0%), H.S.C. was 48(16.0%), Graduate+ was 51 (17.0%) and illiterate person was 43(14.3%).

**Fig. 3.** Distribution of the respondents receive antenatal care during this pregnancy



The result shows of the respondents' that 82.3% were antenatal care received during this pregnancy and 17.7% were not received antenatal care during pregnancy.

**Table 9.** Distribution of who's the person respondents receive antenatal care during this pregnancy

Name of variable	Parameters	Frequency	Percentage (%)
<b>Person respondents receive antenatal care during this pregnancy</b>	Doctors	111	37.0
	Nurse	72	24.0
	Family welfare visitor	75	25.0
	Community health care providers	23	7.7
	Others	19	6.3
<b>Total</b>		<b>300</b>	<b>100</b>

In this table, the person respondents receive antenatal care during this pregnancy 111(37.0%) was Doctor, 72(24.0%) was Nurse, 75(25.0%) was Family welfare visitor, 23(7.7%) was Community health care provider, 19(6.3%) was other-specify.

**Table 10.** Distribution of the respondent's information provide to during antenatal visit

Name of variable	Parameters	Frequency	Percentage (%)
<b>Respondent's information provides to during antenatal visit</b>	Nutrition	154	51.3
	Place of delivery	76	25.3
	Vaccination	51	17.0
	Transport	7	2.3
	Blood donor	4	1.3
	Others	8	2.7
<b>Total</b>		<b>300</b>	<b>100</b>

The result shows the respondents information provide to during antenatal visit. Where nutrition was 154(51.3%), place of delivery was 76(25.3%), vaccination was 51(17.0%), Transport was 7(2.3%), Blood donor was 4(1.3%) and others was 8(2.7%).

**Table 11.** Distribution of the respondent’s knowledge about the Risk Factors for Pregnancy outcome

Name of variable	Parameters	Percentage (%)
Respondent’s knowledge about the Risk Factors for Pregnancy outcome	Multiple pregnancy & Anemia	8.3
	Multiple pregnancy, Malnutrition & Anemia	34.0
	Multiple pregnancy & infections	2.3
	Multiple pregnancy, high blood pressure (hypertension), cardiovascular disease & infections	22.0
	Multiple pregnancy, Malnutrition & diabetes	10.3
	Hypertension, diabetes & cancer	1.7
	Hypertension, Malnutrition & Anemia	3.3

Results revealed that Respondents has knowledge about the Risk Factors for Pregnancy outcome. In this table Multiple pregnancy & Anemia was 8.3%, Multiple pregnancy, Malnutrition & Anemia was 34.0%. Multiple pregnancy & infections was 2.3%, Multiple pregnancy, high blood pressure (hypertension), cardiovascular disease & infections was 22.0%, Multiple pregnancy, Malnutrition & diabetes was 10.3%, Hypertension, diabetes & cancer was 1.7% and Hypertension, Malnutrition & Anemia was 3.3%.

**Table 12.** Distribution of who’s the person respondents receive antenatal care during this pregnancy

Name of variable	Parameters	Percentage (%)
Respondent’s knowledge about the necessary for safe delivery	Good prenatal care, Proper decision & Proper place for delivery	8.3
	Proper decision, Proper caregiver & Proper transport	10.0
	Good prenatal care, Proper place for delivery & Proper nutrient	34.0
	Proper decision, Proper caregiver & Healthy and nutritious food	2.3
	Proper decision, Proper place for delivery & Proper attendant	22.0
	Proper place for delivery, Proper transport & Proper attendant	10.3
	Proper timing, Proper place for delivery & Proper caregiver	1.7

Results revealed that Respondents knowledge about the necessary for safe delivery. Table showed that Good prenatal care, Proper decision & Proper place for delivery was 8.3%, Proper decision, Proper caregiver & Proper transport was 10.0%, Good prenatal care, Proper place for delivery & Proper nutrient was 34.0%, Proper decision, Proper caregiver & Healthy and nutritious food was 2.3%, Proper decision, Proper place for delivery & Proper attendant was 22.0%, Proper place for delivery, Proper transport & Proper attendant was 10.3%, Proper timing, Proper place for delivery & Proper caregiver was 1.7%.

**Fig. 4.** Distribution of the respondents by ever receive any information on safe delivery



The result shows of the respondents that any information received on delivery was 87.3% and 12.7% was not received any information.

**Table13.** Distribution of the respondent's where received information on safe delivery

Name of variable	Parameters	Percentage (%)
Respondent's where received information on safe delivery	Mother	27.0
	Healthcare provider	50.7
	Friends	5.3
	Peers	3.0
	Newspaper	5.7
	Elderly women	8.3
<b>Total</b>		<b>100</b>

In this table, the respondents received information on safe delivery. From this table mother was 27.0%, most of health care provider was 50.7%, friends were 5.3%, peers were 3.0%, Newspaper was 5.7%, and Elderly women were 8.3%.

**Table 14.** Distribution of the respondent's received any information regarding birth preparedness

Name of variable	Parameters	Percentage (%)
Respondent's received any information regarding birth preparedness	Yes	84.7
	No	15.3
<b>Total</b>		<b>100</b>

The result shows the respondents any information received regarding birth preparedness received was 84.7% and not received was 15.3%.

**Table15.** Distribution of the respondent's where received information on regarding birth preparedness

Name of variable	Parameters	Percentage (%)
Respondent's where received information on regarding birth preparedness	Husband	28.7
	Health service providers	46.7
	Friends	7.0
	Peers	5.0
	Relatives	8.0
	Mass media	4.0
	Others specify	1.7
<b>Total</b>		<b>100</b>

In this table, the respondent's where received information on regarding birth preparedness different percentage were Husband 28.7%, Health service providers 46.7%, Friends 7.0%, Peers 5.0%, Relatives 8.0%, Mass media 4.0% and Others 1.7%.

**Table 16.** Distribution of the respondent’s knowledge about necessary for Birth preparedness

Name of variable	Parameters	Percentage (%)
<b>Respondent’s knowledge about necessary for Birth preparedness</b>	Identification of health facility.	34.0
	Identification of skilled provider.	30.3
	Identification of mode of transport.	3.3
	Saving of money for delivery.	14.0
	Saving of money for transportation	2.0
	Identification of blood donor	3.3
	Identification of skilled care person	13.0
<b>Total</b>		<b>100</b>

Results revealed that respondent’s knowledge about necessary for Birth preparedness. From the result Identification of health facility was 34%, Identification of skilled provider was 30.3%, Identification of mode of transport was 3.3%, Saving of money for delivery was 14%, Saving of money for transportation was 2%, Identification of blood donor was 3.3%, Identification of skilled care person was 13%.

**Fig. 5.** Percentage distribution of the respondent’s knowledge about the ideal place of safe delivery



In this figure shows that distribution of the respondent’s knowledge about the ideal place of safe delivery Home 5.0%, Hospital 92.7%, Clinic 1.7%, others 0.7%.

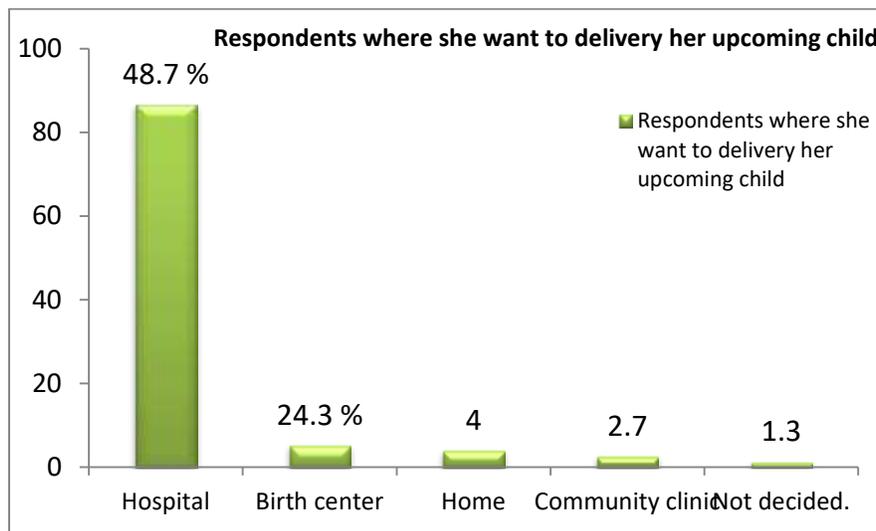
**Table 17.**Percentage distribution of the respondent’s knowledge about reason of hospital is the ideal place of safe delivery

Name of variable	Parameters	Percentage (%)
<b>Respondent’s knowledge about reason of hospital is the ideal place of safe delivery</b>	Presence of skilled and trained personnel.	58.7
	Availability of necessary medicine	9.7
	Availability of equipment.	7.3
	Availability of transport facility.	1.0
	Availability of comprehensive healthcare services.	14.7
	Availability of complication management facility.	8.7
<b>Total</b>		<b>100</b>

Results revealed that respondent’s knowledge about reason of hospital is the ideal place of safe delivery Presence of skilled and trained personnel 58.7%, Availability of necessary medicine 9.7%, Availability of equipment 7.3%,

Availability of transport facility 1%, Availability of comprehensive healthcare services 14.7%, Availability of complication management facility 8.7%.

**Fig. 6.** Distribution of the respondents where she want to delivery her upcoming child



According to the figure shows that respondents where she wants to delivery her upcoming child Hospital 48.7%, Birth Center 24.3%, Home 4%, Community clinic 2.7%, Not decided 1.3%.

**Table 18.** Distribution of the respondent’s opinion that the Danger signs of pregnancy

Name of variable	Parameters	Percentage (%)
<b>Respondent’s opinion that the Danger signs of pregnancy</b>	severe vaginal bleeding	14.0
	severe vaginal bleeding, swollen hands and face, fever & Blurred vision	24.7
	severe vaginal bleeding, swollen hands and face & prolonged labor.	14.0
	severe vaginal bleeding, Blurred vision & convulsion	30.0
	swollen hands and face, Blurred vision & prolonged labor	7.3
	Blurred vision, convulsions & retained	9.3
	swollen hands and face, Blurred vision, convulsions & fever	8.5
	severe vaginal bleeding, prolonged labor & retained	5.7
<b>Total</b>		<b>100</b>

This table shows the respondent’s opinion that the Danger signs of pregnancy. Where severe vaginal bleeding percentage was 14.0%, severe vaginal bleeding, swollen hands and face, fever & Blurred vision percentage was 24.7%, severe vaginal bleeding, swollen hands and face & prolonged labor 14%. severe vaginal bleeding, Blurred vision & convulsion 30.0%. swollen hands and face, Blurred vision & prolonged labor 7.3%. Blurred vision, convulsions & retained 9.3%. swollen hands and face, Blurred vision, convulsions & fever 8.5%. severe vaginal bleeding, prolonged labor & retained 5.7%.

**Table 19.** Distribution of the respondent’s opinion that Reasons for home delivery

Name of variable	Parameters	Percentage (%)
Respondent’s opinion that Reasons for home delivery	Poverty	36.0
	Traditional views	25.0
	poor road conditions	8.3
	Religious fallacy	14.0
	Limited access of women to decision making in the family.	7.3
	Lack of transportation to reach the nearest health facility.	3.3
	Lack of knowledge and awareness.	5.3
	Lack of female doctors in the health care facilities	0.7
<b>Total</b>		<b>100</b>

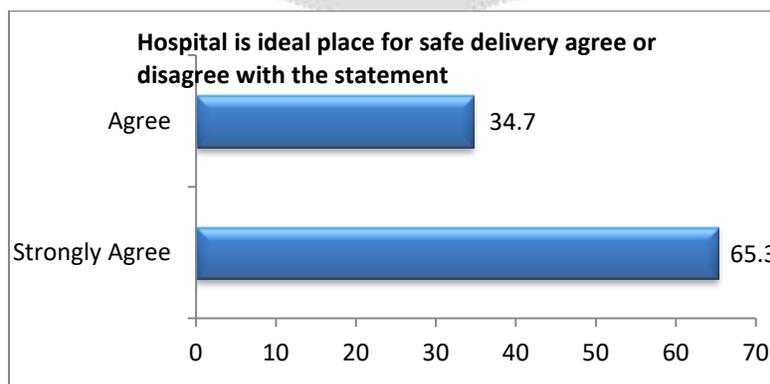
This table shows the respondent’s opinion that reasons for home delivery were Poverty 36%, Traditional views 25%, poor road conditions 8.3%, Religious fallacy 14%, Limited access of women to decision making in the family 7.3%, Lack of transportation to reach the nearest health facility 3.3%, Lack of knowledge and awareness 5.3%, Lack of female doctors in the health care facilities 0.7%.

**Table 20.** Distributions of the respondent’s opinion about the complication that may arise during delivery

Name of variable	Parameters	Percentage (%)
Respondent’s opinion about the complication that may arise during delivery	Breech presentation	12.0
	Retained placenta	15.7
	Delayed labor	18.3
	Excessive vaginal bleeding	43.3
	Others	8.7
	Do not know	2.0
<b>Total</b>		<b>100</b>

Results revealed that respondent’s most of excessive bleeding 43.3%, Breech presentation 12.0%, Retained placenta 15.7%, Delayed labor 18.3% ,8.7% other complications may arise and 2.0% does not know.

**Fig.7.** Distribution of the respondent’s opinion about Hospital is ideal place for safe deliveries agree or disagree with the statement



In this Figure shows that respondent's opinion about Hospital is ideal place for safe delivery were 34.7% agree and 65.3% strongly agree.

## VI. Recommendations

Based on these findings, it is recommended that.....

- (i) Birth preparedness and complication readiness should be made an integral part of maternal and child health services in the Bangladesh, to enable women to recognize danger signs and access a skilled caregiver in pregnancy;
- (ii) An emergency response system at the community level to provide emergency funds, transport, and blood donors must be put in place and made known to the public.

It is believed that with the removal of delays in decision to seek care and timely access to skilled attendance, the prevailing high maternal/infant morbidity and mortality in Bangladesh can be reduced to acceptable limits.

## VII. Conclusion

Although awareness of the concept of birth preparedness was high, recognition of key danger signs in pregnancy was poor. Proportion of births attended to by skilled attendant was low. Educational level, marital status, and parity were not good predictors of intention to attend at least four ANC visits with a skilled provider. The knowledge of available community support systems was very poor.

## Acknowledgement

First of all, I am grateful to Almighty Allah, the most merciful, for enabling me to complete this research work. I would like to express my indebtedness heartfelt gratitude, sincere appreciation and profound regards to my honorable teacher Dr. Md. Manjur Hossain for his sincere co-operation. I convey my special thanks for his hard job. I wish to express my sincere thanks Prof. Dr. Mohammed Salim Bhuyan, Dr. Sadrul Amin, Dr. Kamrul Alom Khan, Dr. A K M Obaydullah, Dr. Md. Jawadul Hoque. I must be grateful to my colleagues and friends who helped me directly or indirectly at different stages of my research work and report preparation. I would like to express deep regards and thanks to my parents for their prayerful concern, support and patience during the completion of this research work. Finally, I am highly grateful to my beloved husband sayed Abdul Mannan and son Tuzo, Tibro, Tonmoy for their encouragement and sacrifice to complete the research work successfully.

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