Original Article

KNOWLEDGE, ATTITUDE AND PRACTICE REGARDING HOSPITAL DELIVERY AMONG RURAL MARRIED WOMEN IN NORTHERN BANGLADESH

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Abstract

Various programs for safe motherhood aiming to reduce maternal and neonatal mortality are undertaken by public sectors as well as the NGOs. This descriptive cross-sectional study was conducted on the married women in their reproductive age (15-40y) belonging to 211 households of Shitlai village of Kahalu Thana of Bogra district in Bangladesh from January to April 2007. Using a semi-structured questionnaire, data were collected by door-to-door visits and through face-to-face interviews with the respondents. Considering the knowledge on safe motherhood and safe delivery, majority of the respondents (98.6%) mentioned that every pregnant mother should receive antenatal care, and 97.6% said that pregnancy is a period of risk. Regarding safety, 96.2% mentioned hospital delivery as safe, while 80.6% mentioned home delivery as a risk. Among the respondents, 70.1% said that ANC is important, 29.9% was found to be informed of child birth complications, 16.1% knew the duration of pregnancy, 8.1% knew the danger signs of pregnancy, 4.7% about emergency obstetric care (EOC), 4.3% about expected date of delivery (EDD), 2.4% about safe motherhood and 28.4% about the access of health facilities in the village. Among the respondents, 85.3% showed a positive attitude towards hospital delivery while 14.7% had a negative attitude. Study also showed that majority of the respondents (66.8%) had delivered at home, and only one-fourth of the respondents delivered their index child in a hospital. Thus the study recommends to improve the knowledge, economic status, to change the decision making process through the launching of different activities with appropriate health programmes.

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Key Words: Knowledge, attitude and practice (KAP), hospital delivery, married women

Introduction

Pregnancy and childbirth related complications are among the leading causes of maternal mortality in Bangladesh. Lack of knowledge about ANC and place of delivery is responsible for such a situation. According to Bangladesh Demographic and Health Survey Report (2004), only 13% of births in Bangladesh are assisted by doctors, trained nurses and midwives.[1] The utilization of safe motherhood services including maternity care in Bangladesh is very poor. If the respondents suffer from diseases/symptoms, then it is more likely that the delivery would take place at the mother's home.[2]

Study conducted on prevalence of home deliveries and antenatal care coverage in some selected villages found that 83% of the respondents received antenatal check-up throughout their last pregnancy.[3] There was association between the place of delivery and level of education and family income of the respondents. Also there were associations of utilization of antenatal care with level of education and family income of the respondents.[3]

Core components of maternal and child health, like safe delivery and safe motherhood, have been focused

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in the MDGs and HNPSP. The peripheral and hard to reach areas show crux of the menace regarding such issues and are areas of priority for research. Owing to socio-demographic, socioeconomic, socio-cultural as well as knowledge, attitude, belief and practice related factors, hospital delivery among rural married women are still poor. There is lack of such studies in this field and in the study area of Bogra, no such study could be found. Therefore, it was attempted to explore the knowledge, attitude and practice regarding hospital delivery among rural women in Bangladesh.

Methodology

The present descriptive cross-sectional study was done on the married women of reproductive age (15-40y) of 211 households of Shitlai village of Kahalu Thana of Bogra district in Bangladesh from January to April, 2007. Using a semi-structured questionnaire, data were collected by door-to-door visits and through a face-to-face interview with the respondents.

Results

A factorial analysis of principal component analysis (PCA) to assess the composite knowledge of duration of pregnancy, expected date of delivery, emergency obstetric care, availability and receiving of ANC in the village, pregnancy as a period of risk, vaccination during pregnancy, danger sings during pregnancy, home delivery as risk were done. It was found that, about one-third (34%) of the respondents had a poor knowledge, 40% had average and 25.6% had good knowledge (Table-1).

Table-1. *Distribution of the respondents by level of attitude on safe motherhood (n=211)*

Variables	No.	%
Importance of ANC for every mother	211	100.0
Attitude for hospital delivery	211	100.0
Attitude to seek care during danger signs	210	99.5
Attitude towards vaccination during pregnancy	209	99.1
Motivate others for hospital delivery	208	98.6
Married women having knowledge on danger signs	207	98.1
Male attendance during labour	84	39.8
Autonomy in treatment seeking	12	5.7
Hospital delivery considered as shameful	11	5.2
Hospital delivery considered as sin	2	0.9
Obstacle from family	1	0.5

Table-2. *Distribution of the respondents by level of practice on safe motherhood*

Variables	Frequency(n)	Percentage(%)
Registered for health problem		
Yes	203	96.2
No	8	3.8
Taking suggestions from hospital		
Yes	11	5.2
No	200	94.8
Faced complications at home during delivery		
Yes	30	14.2
No	164	77.7
Not applicable	17	8.1
Trained Birth Attendant at delivery		
Yes	11	5.2
No	18	8.5
Not applicable	182	86.3
Ever practiced ANC		
Yes	152	72.0
No	43	20.4
Not applicable	16	7.6
Vaccination during last pregnancy		
Yes	150	71.1
No	45	21.3
Not applicable	16	7.6
Index birth at hospital		
Yes	53	25.1
No	140	66.4
Not applicable	18	8.5
History of hospital delivery		
Yes	52	24.6
No	141	66.8
Not applicable	18	8.5
Any family member had practice of hospital delivery		
Yes	113	53.6
No	98	46.4

Based on principal component analysis (PCS) among the interviewed respondents, 85% had a positive attitude towards hospital delivery and the rest showed a negative attitude towards hospital delivery.

Regarding the level of attitude on safe motherhood on different aspects, it was found that, all the respondents had a positive attitude towards importance of ANC and hospital delivery, seeking care after notification of danger sign and vaccination. However, 40% of the respondents did not agree to the presence of male attendants during labor. Most striking finding was that, only 6% had autonomy in health care seeking behavior. Very few opined that hospital delivery is a sin or shameful practice.

Regarding the practice of safe motherhood, it was found that 96% of the respondents registered for their health problems. However, few of them took suggestions from a hospital. Among the interviewed respondents, 14% faced complications at home during last pregnancy. It was found that 72% received ANC and an equal percentage received TT vaccine during last pregnancy. One-fourth of the respondents delivered their index child in the hospital.

Majority of the respondents (79.6%) had knowledge on the place of safe delivery, 49.3% respondents gave their opinion on hospital delivery as safe. Regarding the necessity of Caesarean section during labour, 98.6% respondents were not in favour. Almost half (48.8%) of the respondents preferred TBA as a birth attendant. Regarding access to health care facilities, 16.1% and 35.5% of the respondents did not know the availability of TBA and MCH clinic in the village respectively. A fourth (24%) of the respondents gave history of birth complications with prolonged labour being the major (44.2%) cause. It was found that 34.1% of the respondents had a poor knowledge on safe motherhood and only 25.6% had a good knowledge. Majority had poor knowledge on pregnancy and childbirth related complications. Regarding attitude on safe motherhood, it was found that only 6% had autonomy in health care seeking behavior. Over all, 85.3% were positive towards hospital deliveries. It was found that only 25.1% of the respondents had their index birth in a hospital, 66.8% never went for hospital delivery and 53.6% reportedly mentioned that some of their family members had a hospital delivery.

Discussion

In a study on complications of pregnancy in rural Bangladesh, it was stated that more than half of the women in Abhoynagar and 40% women in Mirsarai were aware of the availability of trained TBAs in their community. The study further showed that 83% of the respondents received antenatal check-ups throughout their last pregnancy. Out of 505 respondents 91.3% of the respondents were found to have delivered at home while only 8.7% had institutional deliveries.[4]

In a similar study on obstetric complications, health care seeking behavior and cost involved in it in rural Bangladesh, it was found that, among the respondents 74% had history of home delivery out of which only 26% was reported to deliver in the hospital.[5] In another study in a village of Manikgonj District of Bangladesh,[6] 8 out of 10 women had maternal health problems, while almost all deliveries (97%) took place at home. In a study on mother and child health care in Kabul, Afghanistan[7] with focus on the mother, it was found that sixty-one out of 100 women in the community, delivered at home exclusively, 35 having experienced both home and institutional deliveries, four women had hospital childbirths only. In a small Nigerian community,[8] it was found that, although a functioning government maternity center in the community offered a full range of antenatal and delivery services, most of the women did not register for ANC until their sixth month of pregnancy or later, and 65% delivered at home. All these reviews suggest that the findings on rural deliveries in the developing countries are almost similar in nature and the present findings of this study are no different.

Conclusion

Addressing the special needs of the pregnant mother, MCH program should be designed and different IEC and BCC programs should be launched to increase the knowledge about childbirth complications, EOC, ANC/PNC, and practice of hospital delivery. Home delivery should be discouraged and institutional/hospital delivery should be encouraged. Steps should be taken for utilizing the existing EOC and MCH facilities properly.

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