*Original Article*

# Child Delivery Practice among the Rural Mothers in Bangladesh

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## Abstract

***Background:*** *Childbirth is a significant event in a woman's life, and the place of delivery plays a crucial role in determining maternal and neonatal health outcomes. In Bangladesh, where a substantial portion of the population resides in rural areas, understanding the dynamics of child delivery locations is paramount for improving maternal and child health.* ***Objectives:*** *The study conducted among the rural mothers with a view to find out the place of child delivery among the rural mothers and their associated factors.* ***Materials & Methods:*** *Total 420 rural mothers were interviewed through face to face interview session with a structured questionnaire. The questionnaire was prepared keeping in view with the objectives, hypothesis and variables considered in the study.* ***Results:*** *Among 420 married women having at least one child; 323(76.7%) preferred home delivery, citing factors such as good health service (16.72%), poor health service (3.72%), low socio-economic condition (4.34%), family choice (9.28%), and the absence of complications (65.94%). Conversely, 97(23.3%) opted for hospital delivery, with reasons including pre-mature rupture of membranes (25.8%), postdated pregnancies (16.5%), abnormal positions of the baby (10.3%), self-consciousness (37.1%), and high-risk mothers (10.3%).* ***Conclusion:*** *The study highlights the complex interplay of cultural, economic, and infrastructural factors influencing maternal healthcare choices. Efforts to improve maternal and child health outcomes must be tailored to address these challenges. By combining targeted interventions, community engagement, and policy initiatives, there is a significant opportunity to enhance the well-being of mothers and newborns in rural Bangladesh, ensuring safer childbirth experiences and healthier futures.*

**Keywords:** Child delivery practice, Rural mothers, Bangladesh.

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## Introduction

Globally, 1500 women die every day because of complications in pregnancy and childbirth, the burden is highest in Africa, followed by the South Asian region. The disparity between maternal mortality in low and high income countries is striking, almost all (90%) maternal deaths occur in low income countries.[1] In Bangladesh, maternal mortality is progressively reducing from 320 to 194 per 100000 live births during the last decade. The country has been putting tremendous effort to achieve millennium developmental goals (MDGs) in time.[2] Globally many strategies have been implemented preventing the overwhelming majority of maternal mortality from direct maternal causes.[3] Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth and 99% of all maternal deaths occur in developing countries. Maternal mortality is higher in women living in rural areas and among poorer communities.[4] Some factors that might affect women's health care seeking behaviors for safe motherhood in rural areas of Bangladesh are age at marriage, age at childbirth, education level, work status, economic status, location of the residence, and husband's awareness and so on. Another serious problem in this regard is that there are many non-qualified health care providers in Bangladesh.[5] Traditionally, children in Bangladesh are delivered at home with the assistance of birth attendants or elderly women of the community (BDHS, 2009).[6] Most deliveries at home in slum areas are conducted by women with some practical experience but with little formal training.[7] Lack of knowledge about antenatal care (ANC) and place of delivery is responsible for such a situation.[8] Women are most in need of skilled

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care during delivery and immediate post-partum period, when roughly seventy five percent of all maternal death occurs.[9] Appropriate delivery care is crucial for both maternal and perinatal health, and increasing skilled attendance at birth is a central goal of the safe motherhood and child survival movements. In addition, it is important that mothers should deliver in an appropriate setting where lifesaving equipment and hygienic conditions are available and can help reduce the risk of complications that may cause death or illness to the mother and the child.[10] Social and cultural beliefs and practices regarding pregnancy and childbirth have a significant influence on maternal health. For example, in the context of Bangladesh, pregnancy is considered as a normal event unless complications arise and care during pregnancy and childbirth is offered by female members of the household.[11] and several studies have identified a variety of cultural norms and superstitions that still exist in Bangladesh and are harmful for achieving healthy and safe motherhood.[12]

## Materials and Methods

This study was a cross-sectional descriptive study and was conducted in the department of Community Medicine of Ad-din Sakina Women's Medical College in the month of January 2017 at Ghoragacha, Rupdia, Jashore using random sampling method from 420 married women having at least one child, aged between 15-55 years. Data were collected by 3rd year female medical students through face-to-face interviews using semi-structure questionnaire. The interviewers were trained by the investigators on interview skills, research ethics and about the objectives of the study. All interviews were conducted with adequate privacy. Data were analyzed using IBM SPSS statistics 25. All participants provided written informed consent before participating in the interview.

## Results

The mean age of the respondents were 34 years ranging from 15 to 55 years.

**Table I : Age distribution of the respondents (n=420)**

| Age of Respondents | No of Respondents | Percentage (%) |
|---|---|---|
| 15-20 | 10 | 4.3 |
| 20-25 | 75 | 16.3 |
| 25-30 | 85 | 21.5 |
| 30-35 | 77 | 17.4 |
| 35-40 | 65 | 17.4 |
| 40-45 | 59 | 12 |
| 45-50 | 37 | 8.8 |
| 50-55 | 12 | 2.3 |

One fifth (21.5%), that is 85 were in the range of 25 to 30 years. 65 that is 17.4% were in the range of 35 to 40 years. 37 that is 8.8% were in the range of 45 to 50 years & the lowest number of 10 (4.3%) in the range of 15 to 20 years (Table I). Among the respondents, 407 (96.9%) were housewife, 7 (1.7%) were involved in some kind of service & only 6 (1.4%) were laborer. Their average monthly income was 24986 taka. The mean age of respondents at 1st child birth was 18 and having average 2 children and maximum family members was 3-6 (87.3%) and belonging from 362 (88.3%) to Muslim community & 58 (11.7%) belong to Sanatan community.

**Table II: Family head of Respondents**

| Family head | No of Respondents | Percentage (%) |
|---|---|---|
| Husband | 376 | 89.8 |
| Father | 13 | 3.3 |
| Mother | 3 | 0.2 |
| Son | 28 | 6.7 |

The family head (Table II) distribution among respondents indicates that the majority 376 (89.8%) are headed by husbands, followed by sons 28(6.7%), fathers 13 (3.3%), and a small percentage headed by mothers 3 (0.2%).

**Table III: Educational status of Respondents**

| Educational status | No of Respondents | Percentage (%) |
|---|---|---|
| Illiterate | 109 | 25.5 |
| Class V | 156 | 37.4 |
| Class X | 76 | 19.5 |
| SSC | 44 | 9.0 |
| HSC | 21 | 5.2 |
| Graduate | 14 | 3.3 |

The educational status of respondents shows a diverse distribution (Table III), with 156 (37.4%) have completed Class V, 76 (19.5%) reaching Class X, and smaller percentages for higher education levels, including 44 (9.0%) with SSC, 21 (5.2%) with HSC, and 14 (3.3%) as graduates, while 109 (25.5%) are illiterate.

**Table IV: 1st Child delivery Place of the respondents (n=420)**

| Place of Delivery | No of Respondents | Percentage (%) |
|---|---|---|
| Home | 323 | 76.7 |
| Hospital | 97 | 23.3 |

The majority of respondents 323 (76.7%) delivered their first child at home (Table IV); while a smaller percentage 97 (23.3%) opted for a hospital delivery.

The reasons or factors associated with home delivery 323 (76.7%); among the respondent (Table V) 54 (16.72%) respondents mentioned good health service as a factor, 12 (3.72%) cited poor health service, 14 (4.34%) mentioned low socio-economic condition, 30 (9.28%) mentioned family choice, and the majority, 213 (65.94%) respondents, mentioned no complications as a reason for choosing home delivery.

**Table V: Associated factors for Home Delivery. (n=323)**

| Reasons of Delivery | No of Respondents | Percentage (%) |
|---|---|---|
| Good health service | 54 | 16.72 |
| Poor health service | 12 | 3.72 |
| Low socio-economic condition | 14 | 4.34 |
| Family choice | 30 | 9.28 |
| No complication | 213 | 65.94 |

**Table VI: Reasons of Hospital Delivery (n=97)**

| Reasons of Delivery | No of Respondents | Percentage (%) |
|---|---|---|
| Pre mature rupture of membrane | 20 | 25.8 |
| Postdated pregnancy | 16 | 16.5 |
| Abnormal position of baby | 10 | 10.3 |
| Self-consciousness | 36 | 37.1 |
| High risk mother | 10 | 10.3 |

Hospital deliveries (n=97) were primarily influenced by reasons (Table VI) such as premature rupture of membrane (25 respondents, 25.8%), postdated pregnancy (16 respondents, 16.5%), abnormal position of the baby (10 respondents, 10.3%), self-consciousness (36 respondents, 37.1%), and high-risk mother (10 respondents, 10.3%).

## Discussion

The study conducted in Ghoragacha, Rupdia, Jashore aimed to investigate the place of child delivery among rural mothers. The findings revealed that the mean age of respondents was 34 years, ranging from 15 to 55 years. Notably, 76.7% of respondents delivered their child at home, primarily driven by family choice, good health service, poor transport facilities, and low socioeconomic conditions. Similar study Fronczak et.al (2007)[7] (82%) and Begum et al (2013)[9] (82.5%) found most of the deliveries took place at home. In terms of education, a significant portion of respondents had limited education, with 37.4% studied up to class five, 25.5% being illiterate, and only 3.3% being graduates and similar to the study conducted by Kamal(2013).[10] The majority of respondents belonged to the Muslim community (88.3%), and belonging from low and middle income family. The reasons for home delivery included family choice (7%), no complications (52.6%), good health service (12.9%), poor health service (2.9%), and low socioeconomic conditions (3.3%). Conversely, hospital deliveries (23.3%) were attributed to factors such as postdated pregnancy, self-consciousness, premature rupture of membranes, abnormal baby position, and high-risk mothers. In a similar study conducted by Begum M et al (2013),[9] among the rural women of Bangladesh shows majority of the respondents (71.2%) felt that home delivery was comfortable and 10.1% were compelled to deliver at home due to family decision, financial constraint (4.7%), and other causes. The discussion highlighted the challenges faced by rural mothers in accessing hospital facilities for childbirth, emphasizing the impact of family and social barriers on proper birth planning and maternal healthcare seeking behavior. The study underscored the prevalence of home deliveries and associated risks, including unhygienic practices and the absence of medical knowledge and facilities. The discussion also addressed the global context, citing statistics on maternal mortality and emphasizing the importance of safe motherhood for a country's overall development.

## Conclusion

The places of child delivery among the rural mothers of Bangladesh are in home rather than hospital. There are various determinants for the place of the child birth among rural mothers of Bangladesh and these identified factors can inform policy makers and program implementers to adopt socially and culturally appropriate interventions that can improve delivery seeking behavior and thus contribute to the reduction of maternal and neonatal mortality and morbidity in rural Bangladesh.

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