



# Study on the Awareness among Mothers about Safe Motherhood

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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 under 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. To assess the knowledge status of safe motherhood among mothers in Bangladesh. To find out practices of safe motherhood performed during pregnancy among mothers in Bangladesh. To provide policy recommendations for safe motherhood in Bangladesh. A questionnaire survey was conducted among 400 pregnant women. Sociodemographic data and details of knowledge and behaviour about safe motherhood practices were collected using a predesigned pretested questionnaire. Data was analysed using SPSS software. Participants' mean age was 23.9 years. 84% of pregnant women had average knowledge while 68.4% had poor behaviour regarding Safe Motherhood Practices. Statistically significant associations were observed between knowledge and education level, employment status and socio-economic class, between behaviour and age at the time of marriage of the women and also between knowledge and behaviour ( $p$ -value  $<0.05$ ). 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:** *Behaviour, knowledge, pregnant, safe motherhood, awareness, nursing*

## INTRODUCTION

Maternal mortality (death of a woman while pregnant, during delivery or within 42 days of the end of pregnancy from a cause related to or made worse by pregnancy) and morbidity (illness and health complications) affect women of all ages and nationalities. But women in developing countries are disproportionately affected. While there are 27 maternal deaths for every 100,000 live births in developed countries, in developing countries the figure is 480 maternal deaths for every 100,000 live births. In addition to maternal deaths, each year more than 50 million women experience pregnancy-related complications, many of which lead to long-term illness or disability.

Safe motherhood is also a matter of infant survival. Each year, there are almost 8 million perinatal deaths (stillbirths and deaths within the first week) that are largely the result of the same factors that cause the death and disability of their mothers as well as lack of newborn care. The means to prevent most maternal deaths, millions of cases of disease and disability, and the deaths of at least 1.5 million infants each year are known basic health services and information. Such care can cost about US\$3 per person per year in low-income countries. Basic antenatal, delivery, and postpartum care alone can cost as little as US\$2 per person. Safe motherhood is a matter of social justice and women's human rights throughout the world women face poverty, discrimination, and gender inequalities. These factors contribute to poor reproductive health and unsafe motherhood even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun. High levels of maternal mortality are a symptom of a neglect of women's most fundamental human rights. Such neglect affects most acutely the poor, the disadvantaged, and the powerless.

Protecting and promoting women's rights, empowering women to make informed choices, and reducing social and economic inequalities are key to safe motherhood. Safe motherhood is an important social and economic investment. Complications of pregnancy and childbirth are the leading cause of death and disability for women in developing countries aged 15 to 49. Clearly safe motherhood benefits individuals the woman, the child, and family members. Safe motherhood also has important social and economic benefits. When a mother dies or is disabled, her children's health, well-being, and survival are threatened. Her family loses her contribution to household management and the care she provides for children and other family members. The economy loses her productive contributions to the work force.

Investments in safe motherhood reduce household poverty, save families and governments the costs of treatment and other services, and strengthen the health system. An investment in safe motherhood is an investment in the emotional, physical, social, and economic well-being of women, their children, their families, and their communities. Safe motherhood is an investment in the future of millions of women and their families. This has important consequences for all nations of the world.

Safe motherhood is a call to action. Safe motherhood begins long before a woman becomes pregnant and requires collaborative actions on the part of the woman, her family, her community, NGOs, the health care system, the government, and other partners.

Safe motherhood will become a reality for all the world's women only when women are respected members of their societies and when the maintenance of their lives and productivity are of value to decision makers, at the national level and within families. Women's health and status will improve where there are opportunities for full participation in social and economic development, support for their education and skill development, and community based actions to ensure access to health care, among the many actions needed.

The tragedy of maternal death for individual women, their families, their communities, and their countries and the knowledge that most of these deaths could be prevented has led to numerous international agreements that incorporate calls for action to ensure safe motherhood.

These include the SMI and:

- Convention on the Rights of the Child (1990)
- Convention on the Elimination of All Forms of Discrimination Against Women (1992)
- World Conference on Human Rights Programme of Action (1993)
- The International Conference on Population and Development Programme of Action (1994)
- Fourth World Conference on Women Platform for Action (1995)
- World Summit on Social Development Programme of Action (1995)
- The Joint WHO/UNFPA/UNICEF/World Bank Statement on Reduction of Maternal Mortality (1999)

## OPERATIONAL DEFINITION

**Safe motherhood:** Safe motherhood means preventing maternal and infant death and disability through access to basic health care

**Scientific motherhood:** Scientific motherhood is the belief that women need scientific and expert advice in order to properly raise a child. It discredits a mother's intuition and generations of knowledge accumulated by mothers. Pregnant women and mothers are given expectations for what it takes to ensure their child's safety and success. The bases of these expectations were developed in the 19th century and have progressed with the technological advances to the present day.

**Mother:** A mother is the female parent of a child. A woman may be considered a mother by virtue of having given birth, by raising a child who may or may not be her biological offspring, or by supplying her ovum for fertilization in the case of gestational surrogacy. A biological mother is the female genetic contributor to the creation of the infant, through sexual intercourse or egg donation. A biological mother may have legal obligations to a child not raised by her, such as an obligation of monetary support. An adoptive mother is a female who has become the child's parent through the legal process of adoption. A putative mother is a female whose biological relationship to a child is alleged but has not been established. A stepmother is a woman who is married to a child's father and they may form a family unit, but who generally does not have the legal rights and responsibilities of a parent in relation to the child.

**Maternal health:** Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. In most cases, maternal health encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience. In other cases, maternal health can reduce maternal morbidity and mortality. Maternal health revolves around the health and wellness of pregnant women, particularly when they are pregnant, at the time they give birth, and during child-raising. WHO has indicated that even though motherhood has been considered as a fulfilling natural experience that is emotional to the mother, a high percentage of women develop health problems and sometimes even die. Because of this, there is a need to invest in the health of women. The investment can be achieved in different ways, among the main ones being subsidizing the healthcare cost, education on maternal health, encouraging effective family planning, and ensuring progressive check up on the health of women with children. Maternal morbidity and mortality particularly affects women of color and women living in low and lower-middle income countries.

### **OBJECTIVES OF THE STUDY**

The objectives of the study are as follows:

1. To assess the knowledge status of safe mother hood among mothers in Bangladesh.
2. To find out practices of safe mother hood performed during pregnancy among mothers in Bangladesh.
3. To provide policy recommendations for safe mother hood in Bangladesh.

### **METHODOLOGY OF THE STUDY**

**Study area:** The study area was at Mymensingh District in Bangladesh.

**Study Design:** It was a Cross-Sectional descriptive type study.

**Study place:** The study was conducted at Mymensingh Medical College Hospital.

**Sampling method:** Purposive sampling method was used for the study.

**Sample size:** Total 400 mothers were selected from the Hospitals of the study area.

**Sources of Data:** Data were collected from primary and secondary sources.

**Sources of Primary:** Primary data were collected from the respondents of the study area.

**Sources of secondary data:** Secondary data were collected from books, research reports, journals, annual reports, Website of Ministry of Health and family planning internet etc.

**Method of data collection:** Data were collected by face to face interview with the respondents.

**Duration of the Study:** Duration of the study was 24 months.

**Tool of Data Collection:** The tool was prepared by keeping the objectives of the study as the framework that reflect the study variables. A pre-designed semi-structured questionnaire was developed use as data collection instrument.

**Procedure of Data Collection:** Prior to the interview, the purposes of data collection were explained to the respondents and verbal consent was obtained. Data were collected by face-to-face interview by the investigator.

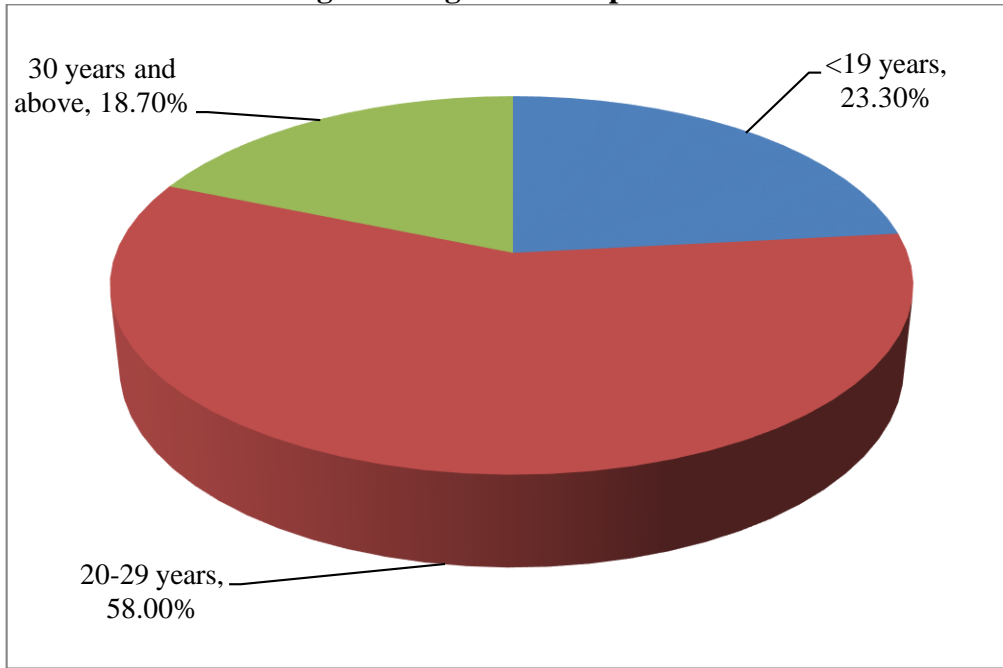
**Data Processing and Analysis:** All the data were checked, cleaned and edited after collection. Then those cleaned data were analyzed by computer program Statistical Package for the Social Sciences (SPSS).

**RESULTS AND DISCUSSION**

**Table 1: Age of the respondents**

Age	Percentage
<19 years	23.30%
20-29 years	58.00%
30 years and above	18.70%
Total	100.00%

**Figure 1: Age of the respondents**

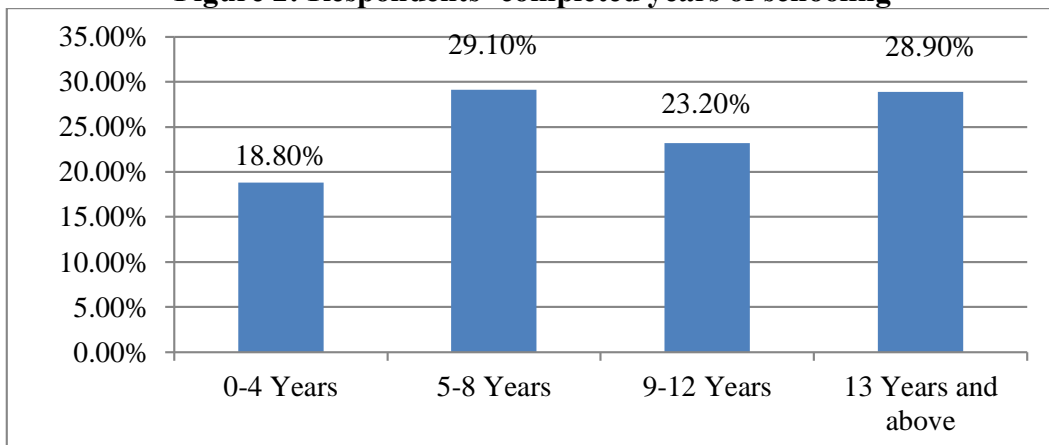


Age of the respondents has shown in the above table and graph. From the result it was found that 23.30% respondents were age group less than 19 years, 58% respondents were age group 20-29 years and 18.70% respondents were age group 30 years and above.

**Table 2: Respondents' completed years of schooling**

Years of schooling	Percentage
0-4 Years	18.80%
5-8 Years	29.10%
9-12 Years	23.20%
13 Years and above	28.90%
Total	100.00%

**Figure 2: Respondents' completed years of schooling**



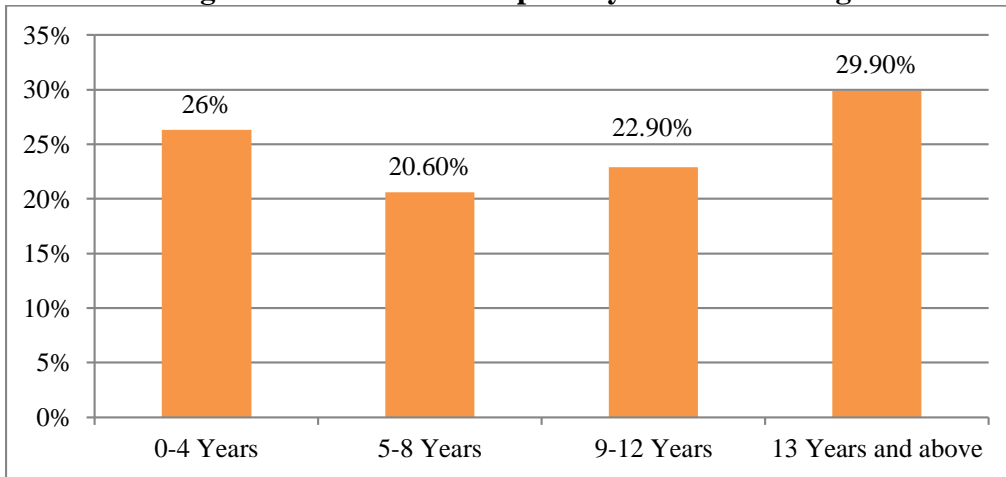
Respondents' completed years of schooling has shown in the above table and graph. From the result it was found that 18.80% respondents completed 0-4 years of schooling, 29.10% respondents completed 5-8 years

of schooling, 23.20% respondents completed 9-12 years of schooling and 28.90% respondents completed 13 and above years of schooling.

**Table 3: Husband’s completed years of schooling**

Years of schooling	Percentage
0-4 Years	26%
5-8 Years	20.60%
9-12 Years	22.90%
13 Years and above	29.90%
Total	100%

**Figure 3: Husband’s completed years of schooling**

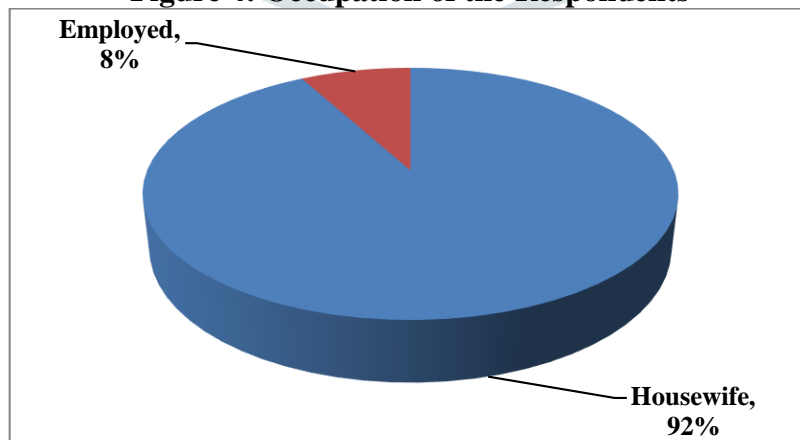


Husband’s completed years of schooling has shown in the above table and graph. From the result it was found that 26% respondents’ husband completed 0-4 years of schooling, 20.60% respondents’ husband completed 5-8 years of schooling, 22.90% respondents’ husband completed 9-12 years of schooling and 29.90% respondents’ husband completed 13 and above years of schooling.

**Table 4: Occupation of the Respondents**

Occupation	Percentage
Housewife	92%
Employed	8%
Total	100%

**Figure 4: Occupation of the Respondents**

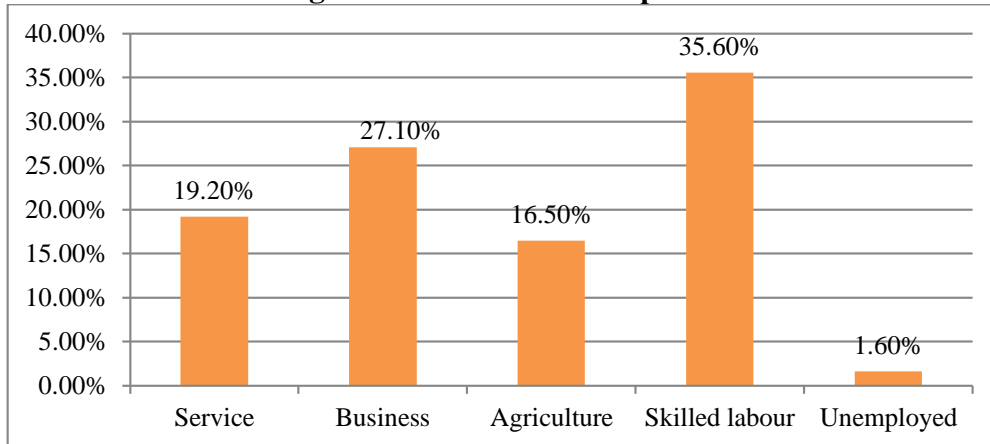


Occupation of the Respondents has shown in the above table and graph. From the result it was found that 8% respondents were employed and 92% respondents were housewife.

**Table 5: Husband’s Occupation**

Occupations	Percentage
Service	19.20%
Business	27.10%
Agriculture	16.50%
Skilled labour	35.60%
Unemployed	1.60%
Total	100%

**Figure 5: Husband’s Occupation**

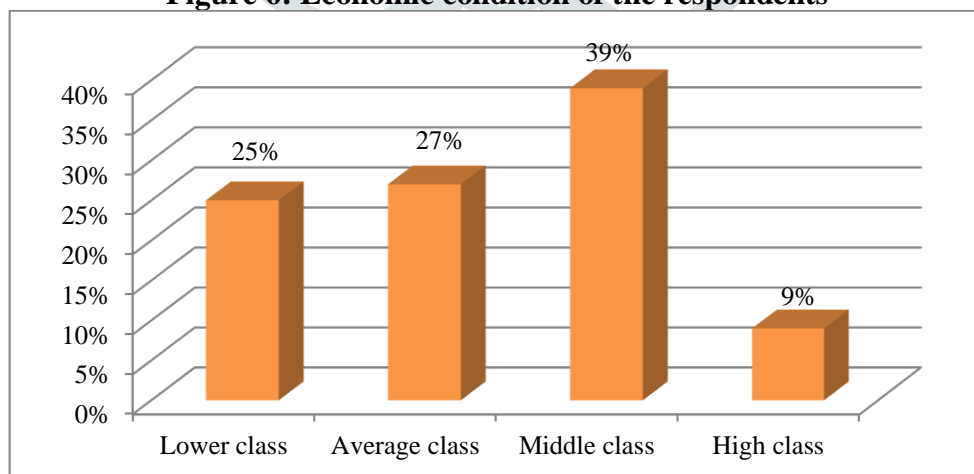


Husband’s Occupation has shown in the above table and graph. From the result it was found that 19.20% respondents’ husband were service holder, 27.10% respondents’ husband were businessmen, 16.50% respondents’ husband were related to agriculture, 3.60% respondents’ husband were skilled labor and only 1.60% respondents’ husband were unemployed.

**Table 6: Economic condition of the respondents**

Class	Percentage
Lower class	25%
Average class	27%
Middle class	39%
High class	9%
Total	100%

**Figure 6: Economic condition of the respondents**

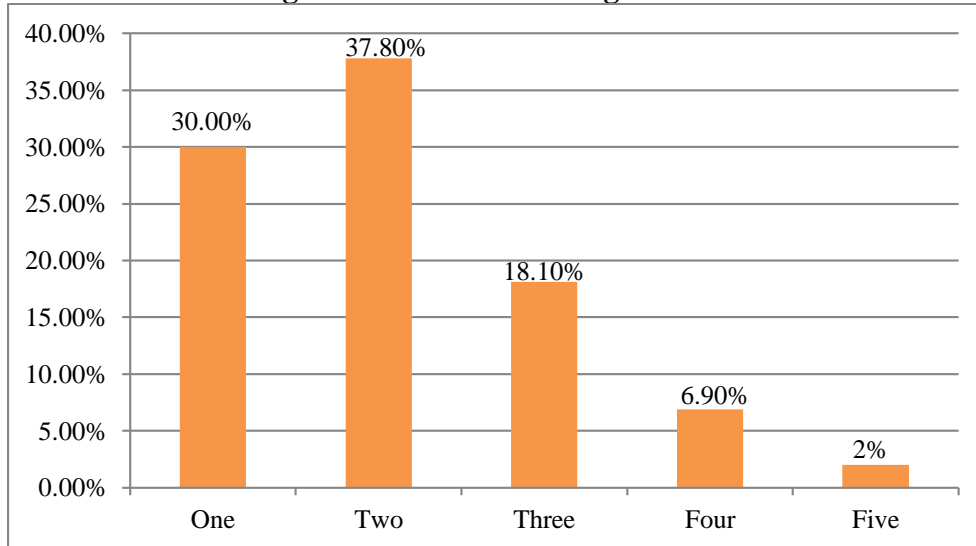


Economic condition has shown in the above table and graph. From the result it was found that 25% respondents were from lower class, 27% respondents were from average class, 39% respondents were from middle class and 9% respondents were from high class.

**Table 7: Number of living children**

Number of living children	Percentage
One	30.00%
Two	37.80%
Three	18.10%
Four	6.90%
Five	2%

**Figure 7: Number of living children**

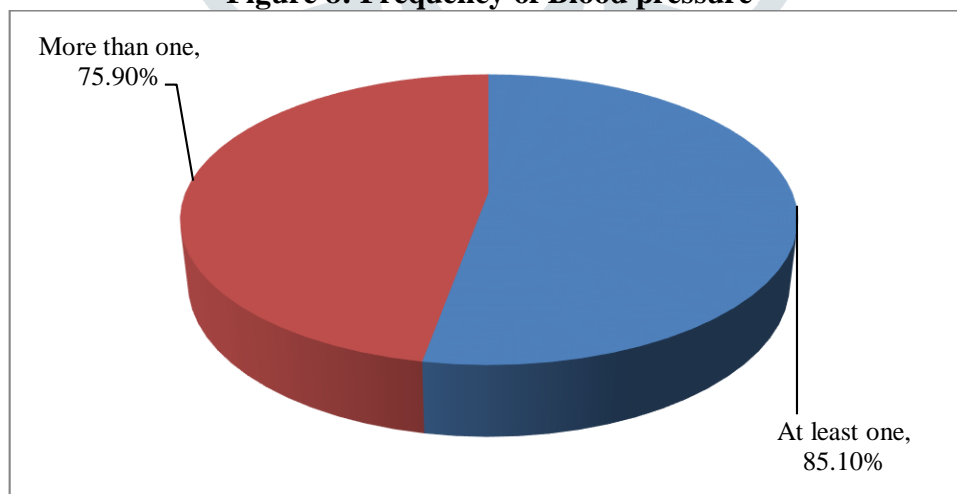


Number of living children has shown in the above table and graph. From the result it was found that 30.00% respondents had one living child, 37.80% respondents had two living children, 18.10% respondents had three living children, 6.90% respondents had four living children and 2% respondents had five living children.

**Table 8: Frequency of Blood pressure**

Time	Percentage
At least one	85.10%
More than one	75.90%

**Figure 8: Frequency of Blood pressure**

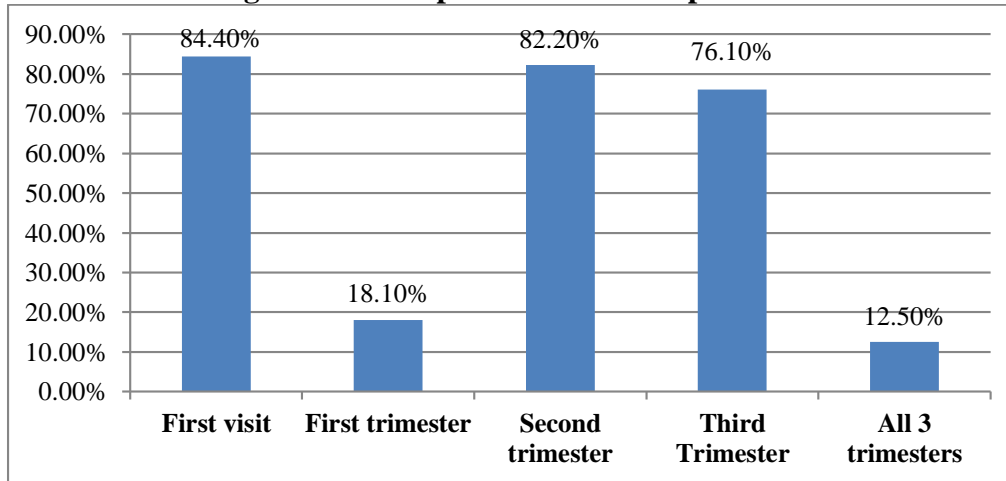


Frequency of Blood pressure has shown in the above table and graph. From the result it was found that 75.90% respondents replied that the frequency of blood pressure were more one time and 85.10% respondents replied that the frequency of blood pressure were at least one.

**Table 9: Blood pressure of the respondents**

Timing	Percentage
First visit	84.40%
First trimester	18.10%
Second trimester	82.20%
Third Trimester	76.10%
All 3 trimesters	12.50%

**Figure 9: Blood pressure of the respondents**

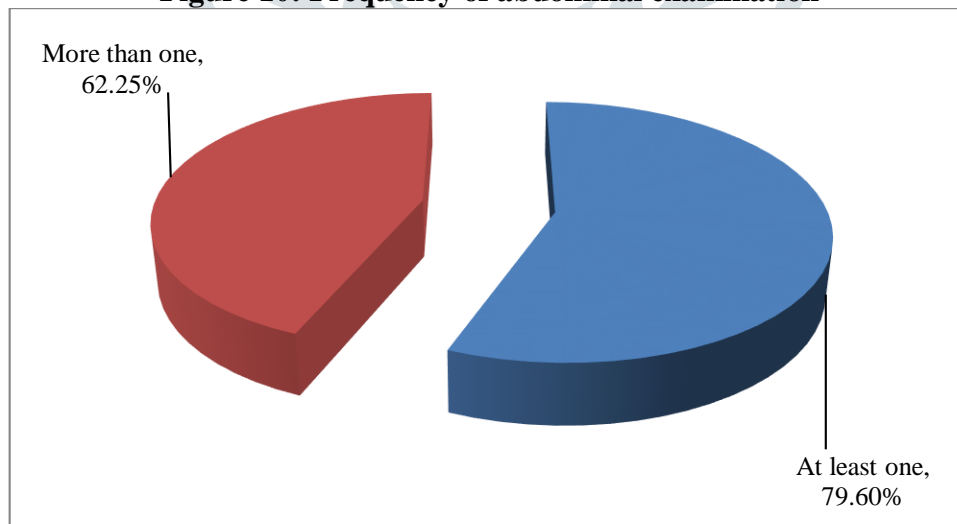


Blood pressure of the respondents has shown in the above table and graph. From the result it was found that 84.40% respondents replied that blood pressure occurred at first visit, 18.10% replied at first trimester, 82.20% respondents replied at second trimester, 76.10% respondents replied at third trimester and 12.50% respondents replied at all 3 trimesters.

**Table 10: Frequency of abdominal examination**

Time	Percentage
At least one	79.60%
More than one	62.25%

**Figure 10: Frequency of abdominal examination**



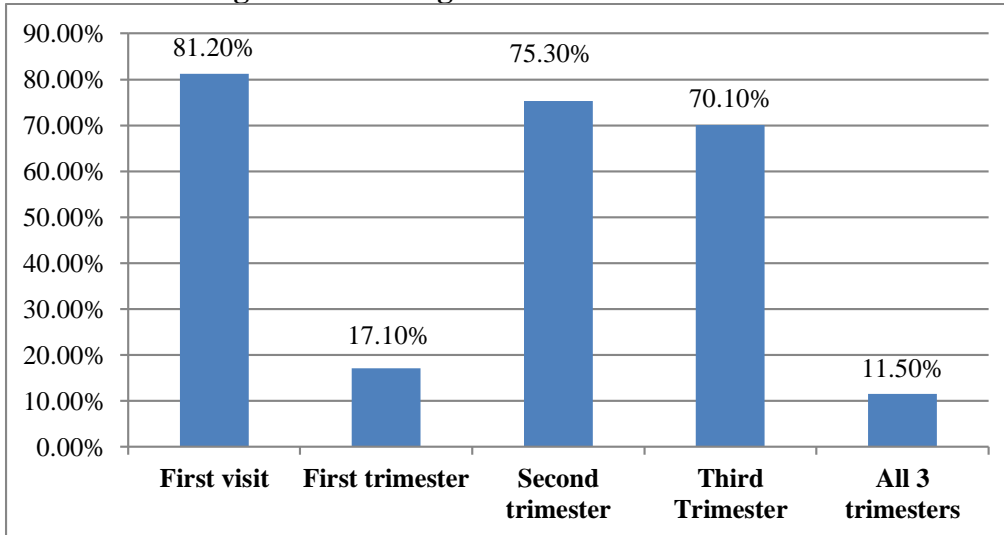
Frequency of abdominal examination has shown in the above table and graph. From the result it was found that 62.25% respondents replied that the abdominal examination done more than one time and 79.60% respondents replied that the abdominal examination don at least one.



**Table 11: Timing of abdominal examination**

Timing	Percentage
First visit	81.20%
First trimester	17.10%
Second trimester	75.30%
Third Trimester	70.10%
All 3 trimesters	11.50%

**Figure 11: Timing of abdominal examination**

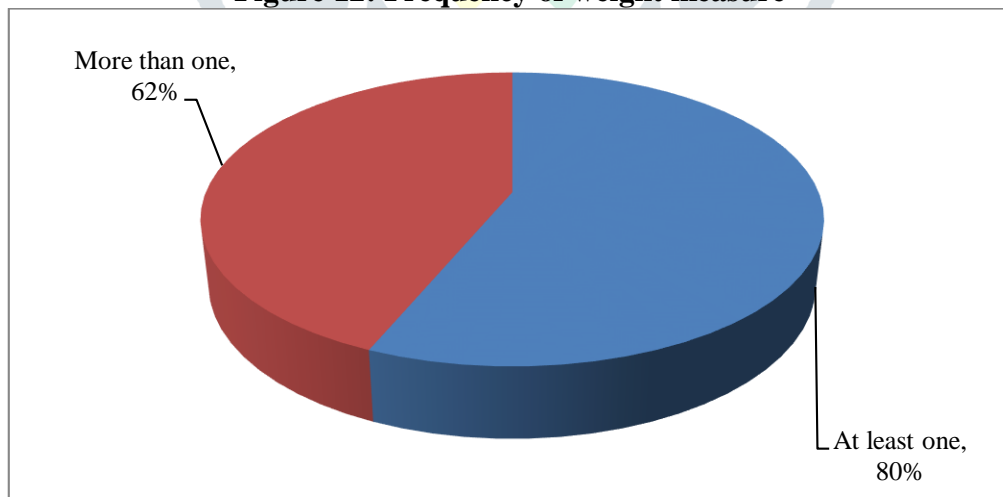


Timing of abdominal examination has shown in the above table and graph. From the result it was found that abdominal examination was done at first visit, 81.20% replied at first trimester, 17.10% respondents replied at second trimester, 75.30% respondents replied at third trimester and 11.50% respondents replied at all 3 trimesters.

**Table 12: Frequency of weight measure**

Time	Percentage
At least one	80%
More than one	62%

**Figure 12: Frequency of weight measure**

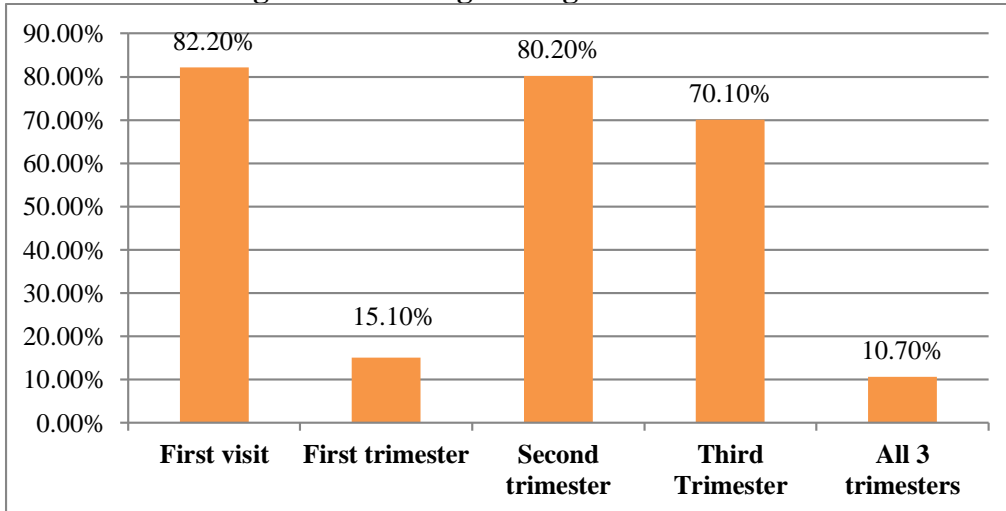


Frequency of weight measure has shown in the above table and graph. From the result it was found that 62% respondents measured weight more than one time and 80% respondents measured weight at least one time.

**Table 13: Timing of weight measurement**

Timing	Percentage
First visit	82.20%
First trimester	15.10%
Second trimester	80.20%
Third Trimester	70.10%
All 3 trimesters	10.70%

**Figure 13: Timing of weight measurement**

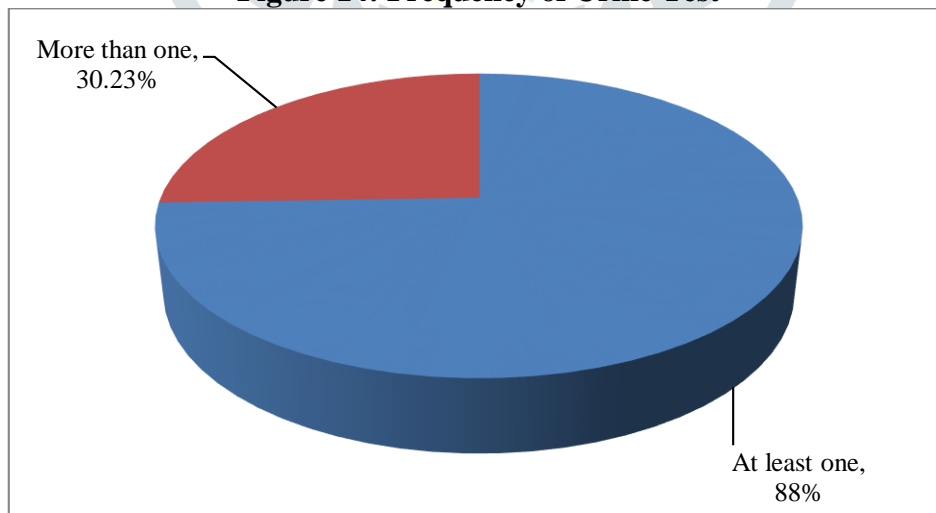


Timing of weight measurement has shown in the above table and graph. From the result it was found that 82.20% respondents replied that weight measurement were done at first visit, 15.10% replied at first trimester, 80.20% respondents replied at second trimester, 70.10% respondents replied at third trimester and 10.70% respondents replied at all 3 trimesters.

**Table 14: Frequency of Urine Test**

Time	Percentage
At last one	88.27%
More than one	30.23%

**Figure 14: Frequency of Urine Test**

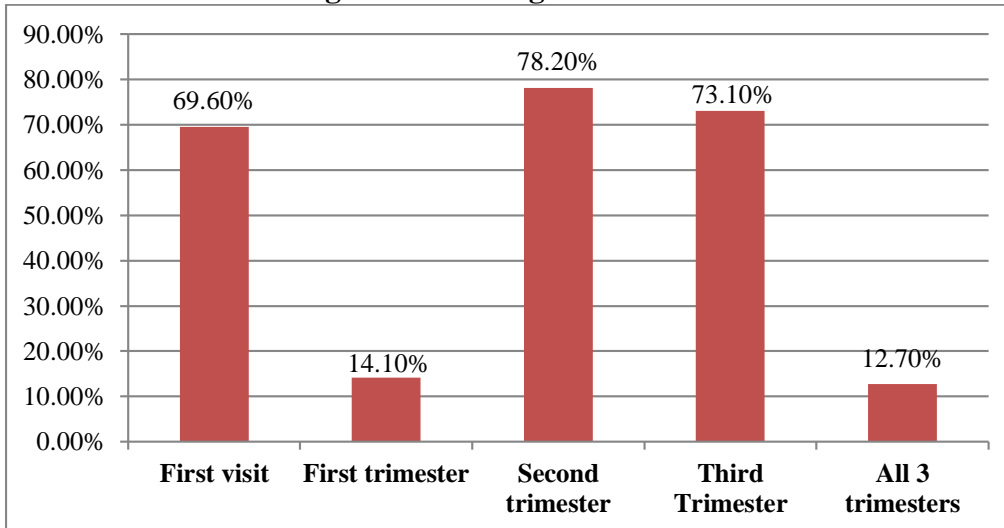


Frequency of Urine Test has shown in the above table and graph. From the result it was found that 30.23% respondents done urine test more than one time and 88% respondents done urine test at least one time.

**Table 15: Timing of urine Test**

Timing	Percentage
First visit	69.60%
First trimester	14.10%
Second trimester	78.20%
Third Trimester	73.10%
All 3 trimesters	12.70%

**Figure 15: Timing of urine Test**

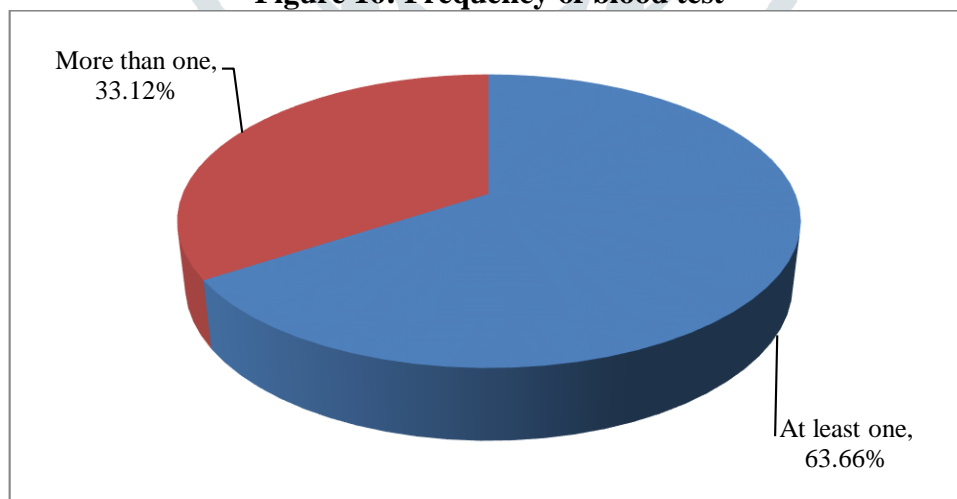


Timing of urine Test has shown in the above table and graph. From the result it was found that 69.60% respondents replied that urine test were done at first visit, 14.10% replied at first trimester, 78.20% respondents replied at second trimester, 73.10% respondents replied at third trimester and 12.70% respondents replied at all 3 trimesters.

**Table 16: Frequency of blood test**

Time	Percentage
At least one	63.66%
More than one	33.12%

**Figure 16: Frequency of blood test**

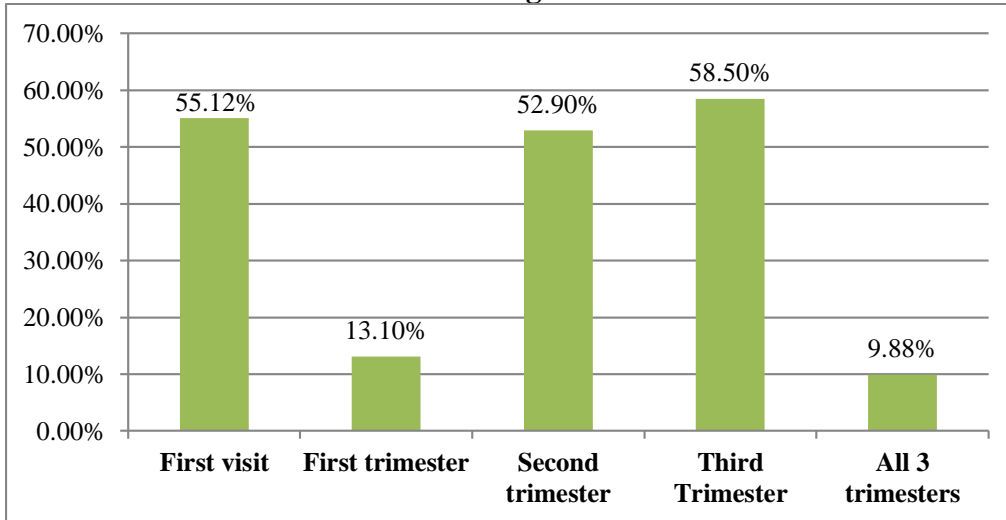


Frequency of blood test has shown in the above table and graph. From the result it was found that 33.12% respondents replied blood test were done more than one time and 63.66% respondents replied blood test were done at least one time.

**Table 17: Timing of blood test**

Timing	Percentage
First visit	55.12%
First trimester	13.10%
Second trimester	52.90%
Third Trimester	58.50%
All 3 trimesters	9.88%

**Table 17: Timing of blood test**

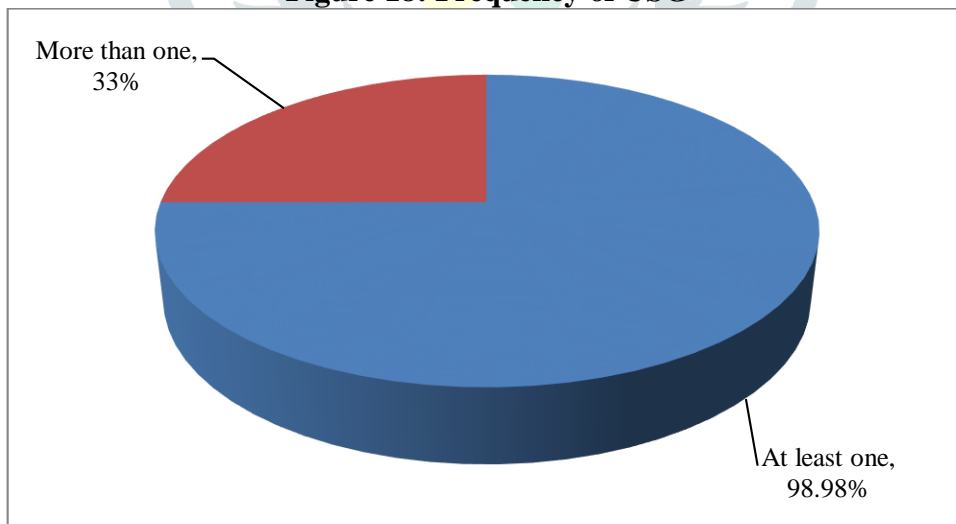


Timing of blood test has shown in the above table and graph. From the result it was found that 55.12% respondents replied that weight measurement were done at first visit, 13.10% replied at first trimester, 52.90% respondents replied at second trimester, 58.50% respondents replied at third trimester and 9.88% respondents replied at all 3 trimesters.

**Table 18: Frequency of USG**

Time	Percentage
At least one	98.98%
More than one	33%

**Figure 18: Frequency of USG**

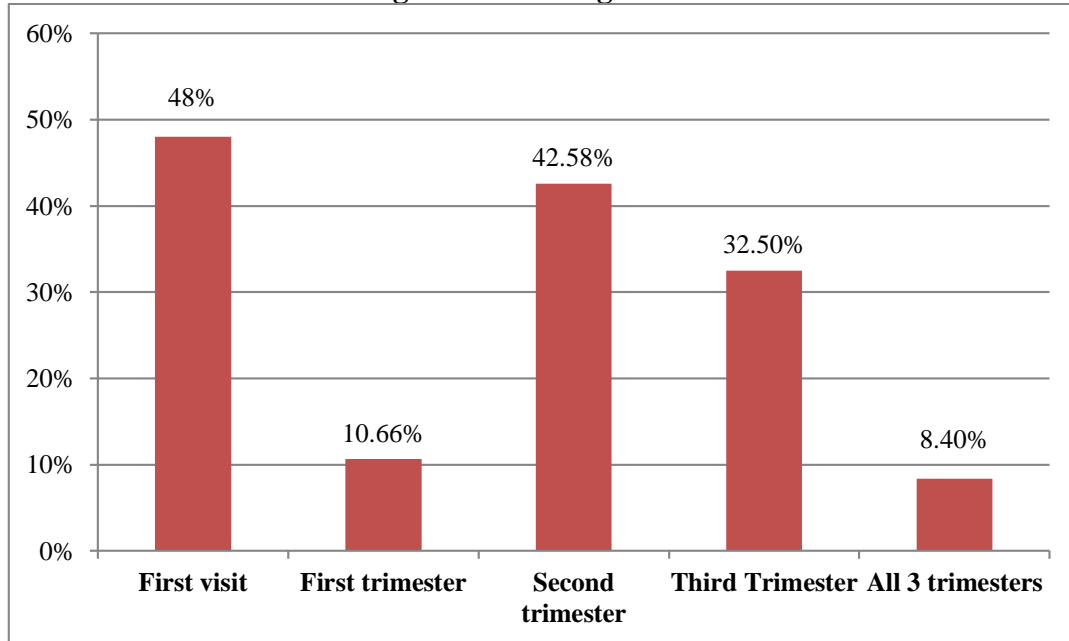


Frequency of USG has shown in the above table and graph. From the result it was found that 33% respondents replied that USG were done more than one time and 98.98% respondents replied that USG were done at least one time.

**Table 19: Timing of USG**

Timing	Percentage
First visit	48%
First trimester	10.66%
Second trimester	42.58%
Third Trimester	45.32.50%
All 3 trimesters	8.40%

**Figure 19: Timing of USG**

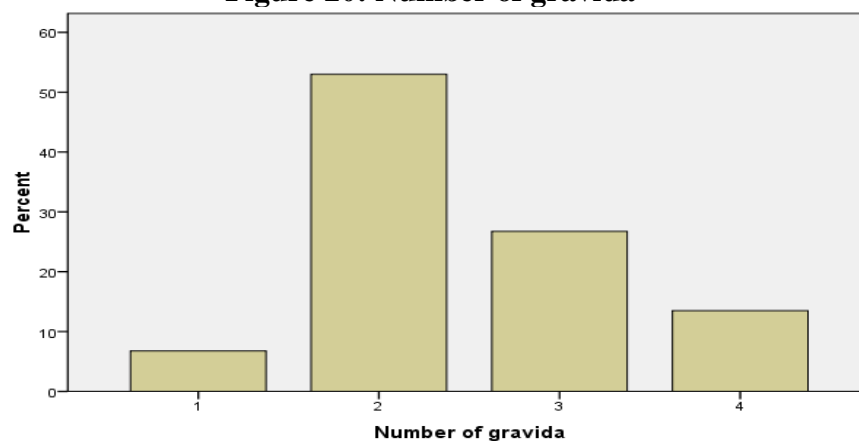


Timing of USG has shown in the above table and graph. From the result it was found that 48% respondents replied that USG were done at first visit, 10.66% replied at first trimester, 42.58% respondents replied at second trimester, 32.50% respondents replied at third trimester and 8.40% respondents replied at all 3 trimesters.

**Table 20: Number of gravida**

Number of gravida	Frequency	Percent	Cumulative Percent
1	27	6.8	6.8
2	212	53.0	59.8
3	107	26.8	86.5
4	54	13.5	100.0
Total	400	100.0	

**Figure 20: Number of gravida**

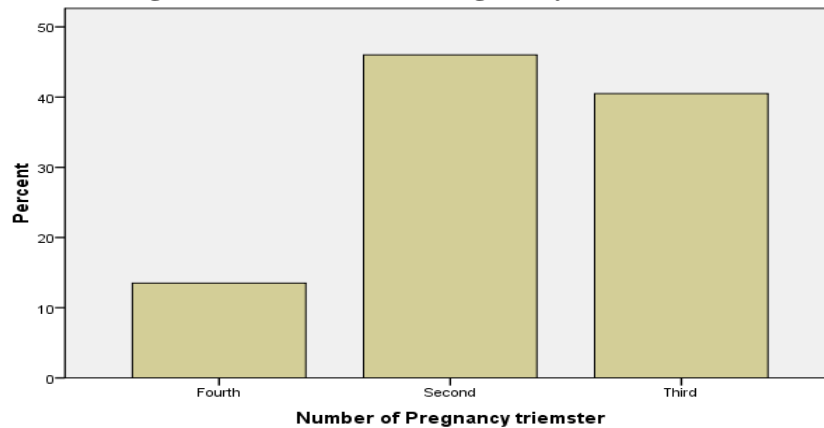


Number of gravida has shown in the above table and graph. From the result it was found that 6.8% respondents had 1 gravid, 53% respondents had 2 gravid, 26.8% respondents had 3 gravid and 13.50% respondents had 4 gravid

**Table 21: Number of Pregnancy trimester**

Number of Pregnancy trimester	Frequency	Percent	Cumulative Percent
Fourth	54	13.5	13.5
Second	184	46.0	59.5
Third	162	40.5	100.0
Total	400	100.0	

**Figure 21: Number of Pregnancy trimester**

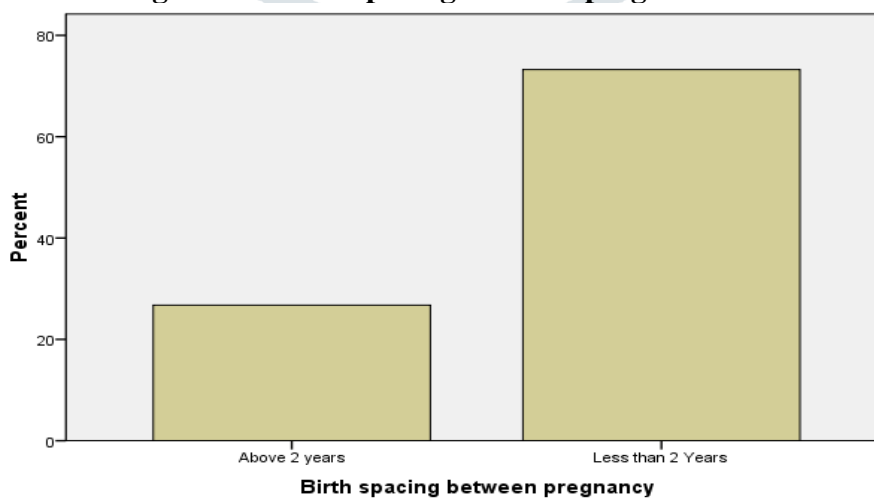


Number of Pregnancy trimester has shown in the above table and graph. From the result it was found that 13.5% respondents had fourth pregnancy trimester, 46% respondents had second pregnancy trimester and 40.50% respondents had third pregnancy trimester,

**Table 22: Birth spacing between pregnancies**

Birth spacing	Frequency	Percent	Cumulative Percent
Above 2 years	107	26.8	26.8
Less than 2 Years	293	73.2	100.0
Total	400	100.0	

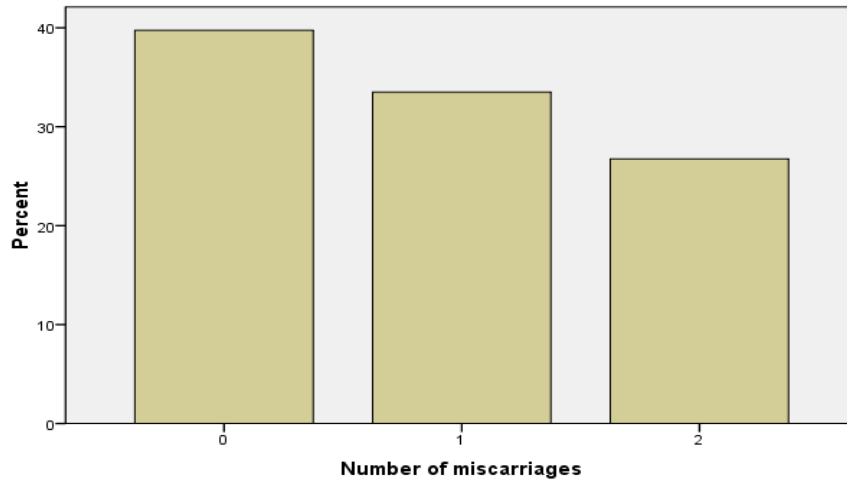
**Figure 22: Birth spacing between pregnancies**



Birth spacing between pregnancies has shown in the above table and graph. From the result it was found that 26.8% respondents had above 2 years spacing between pregnancies and 73.20% respondents had less than 2 years spacing between pregnancies.

**Table 23: Number of miscarriages**

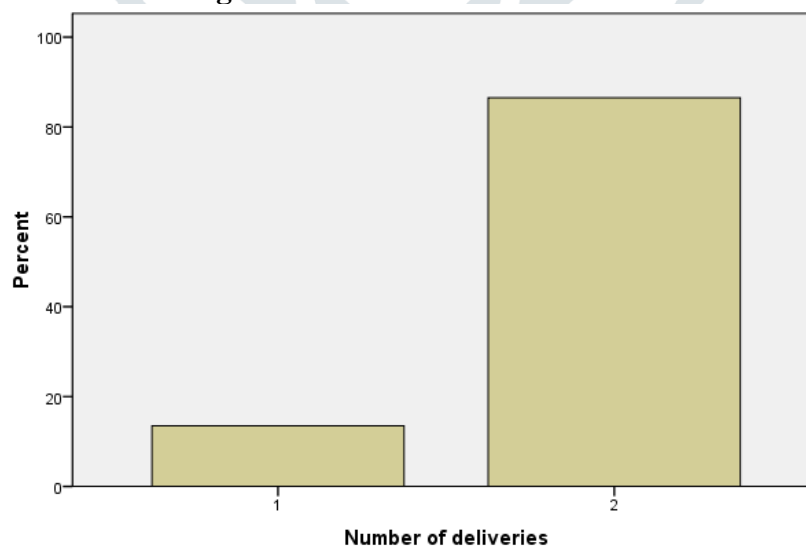
Number of miscarriages	Frequency	Percent	Cumulative Percent
0	159	39.8	39.8
1	134	33.5	73.2
2	107	26.8	100.0
Total	400	100.0	

**Figure 23: Number of miscarriages**

Number of miscarriages has shown in the above table and graph. From the result it was found that 39.80% respondents had 0 miscarriages, 33.50% respondents had 1 miscarriage and 26.80% respondents had 2 miscarriages.

**Table 24: Number of deliveries**

Number of deliveries	Frequency	Percent	Cumulative Percent
1	54	13.5	13.5
2	346	86.5	100.0
Total	400	100.0	

**Figure 24: Number of deliveries**

Number of deliveries has shown in the above table and graph. From the result it was found that 13.50% had 1 delivery number and 86.50% had 2 delivery numbers.

## 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.

In conclusion, this study found that there is generally poor knowledge about safe motherhood practices including the knowledge of maternal danger signs among women of reproductive age in Bangladesh. However every woman has the right to make informed decisions about her pregnancy and childbirth. This is more likely where there is equitable access to information about safe motherhood practices.

There is a clear need to strengthen and fully utilize the existing sources of information about safe motherhood practices in addition to increasing access to affordable emergency obstetric care services in order to reduce maternal mortality. It is anticipated that the implementation of the safe motherhood programs intervention in Bangladesh will help to address this poor knowledge about safe motherhood which was observed within communities in Bangladesh. But more importantly, it is hoped that an increased knowledge of safe motherhood practices will translate into safer pregnancy and delivery practices among households in these communities.

## **RECOMMENDATION**

### **Government, elected, and appointed officials**

The primary role that elected and appointed officials members of Parliament, government ministers, and other key policy-makers can play is to ensure that the political, health, and legal systems address the multiple causes of poor maternal health. They therefore need accurate information about maternal health, which they can use to formulate laws, establish policies, and provide financial support for essential safe motherhood services.

Important actions for policy-makers include:

- Invest in cost-effective safe motherhood programs.
- Promote legal reform and community mobilization to address gender inequalities and discrimination.
- Establish policies and plans to train a sufficient number of health workers with midwifery skills, provide them with essential supplies and equipment, and ensure that they are accessible to poor and rural communities.
- Guarantee that every pregnant woman has access to high quality, integrated safe motherhood services.
- Ensure that the coverage and use of maternal health services is monitored and the findings are used to strengthen future activities.
- Ratify international treaties supporting safe motherhood.
- Encourage other countries to invest in cost-effective safe motherhood programs.

District and community-level government bodies such as town councils are taking on increasing responsibility for health care and other services as countries implement decentralization policies.

These regional and municipal governments also need to learn more about safe motherhood and provide resources to support appropriate education and services in their communities. For example, municipal governments can sponsor town meetings on safe motherhood and other forums for citizens to discuss safe motherhood with officials.

### **Health care system**

The health care system, including both public- and private-sector services, is a focal point for stimulating and coordinating partnerships to help reduce maternal morbidity and mortality. The more efficient and successful the health care system is, the greater the benefit to women, their families, their communities, and their countries. Health care systems have the primary responsibility to:

- Offer a comprehensive package of services for safe motherhood, including antenatal care and counseling during pregnancy, skilled care during labor and delivery, postpartum care, family planning before and after pregnancy, and post abortion care.



- Ensure that health facilities are located close to where women live.
- Update health provider training curricula to reflect new research findings on midwifery skills and the working conditions in the country.
- Work with and train traditional birth attendants (TBAs) to provide education to women before childbirth.
- Deploy an adequate number of trained staff.
- Provide a continuous supply of drugs and equipment.
- Link community services to hospitals by an emergency communication, transport, and referral system.
- Enforce standards and protocols for service delivery, management, and supervision.
- Respect the needs and concerns of women seeking care.
- Monitor and evaluate the quality of services.
- Conduct surveillance and routine data collection for diseases and conditions contributing to maternal death and illness.
- Investigate causes of maternal death and address those problems related to the health system.
- Provide free or affordable maternal and infant health services.

In partnership with others such as NGOs and community groups, health care systems also:

- Educate women, their families, husbands, community leaders, and policy-makers about the importance of maternal health and appropriate services.
- Provide reproductive health education and services for adolescents.
- Identify and implement strategies for improving maternal health care.
- Involve service clients in defining problems, identifying solutions, and implementing actions.

### Media

The mass media can be critical to creating public awareness about the need to make pregnancy and childbirth safe for all women. It can target policy-makers and others with information about safe motherhood.

**Print media, including newspapers and magazines:** As literacy levels increase, the print media gain greater importance in informing people. Articles written by authorities, letters to the editor, and editorials can influence many readers.

**Broadcast media:** Radio and television have a large reach and can play a direct role in raising awareness among the general public as well as policy-makers. For example, televising the involvement of the head of state or other dignitaries in a White Ribbon Alliance event can emphasize the national importance of safe motherhood. A radio or TV station can co-sponsor an Alliance event.

The content of mass media information should center on:

- Reminders that there are individual, community, social, legal, and health care system approaches to prevent maternal and newborn morbidity and mortality.
- Public debate and the decisions of public officials on resource allocation for maternal health.
- Reports on successful community collaborations and White Ribbon Alliance events.
- Education to dispel myths and promote safe practices.
- Awareness of safe motherhood issues.
- Importance of recognizing danger signs and avoiding delay in seeking help, as well as healthy behaviors.

### Women, their families, and their communities

Many of the actions needed to ensure safe motherhood take place at the community level & in the household. These can expand women's decision-making power and access to information, education, and other resources and encourage them to receive proper care during pregnancy and childbirth. These actions include:

- Allow women greater freedom to make their own health and life choices.
- Support education and opportunities for girls and women.
- Encourage delayed marriage and childbearing.
- Help men and other influential's such as elderly female family members understand their role in expanding choices for women and in ensuring responsible sexual and family life.

- Learn how to recognize, prevent, or treat pregnancy complications, and when and where to seek medical help.
- Understand that pain, suffering, and humiliation are not an inevitable part of childbirth and demand appropriate and respectful medical care.
- Help girls and women prepare for successful pregnancy and childbirth by supporting adequate nutrition.
- Inform children and adolescents about sexuality, contraception, reproductive health, and other healthy behaviors.
- Urge the establishment of and participate in local safe motherhood committees.
- Establish action groups and community loan funds for emergency transport, cost of care, and facilitating referral.
- Collaborate with the health care system to report and investigate the causes of maternal deaths.
- Contact local elected officials and media to demonstrate support for safe motherhood.
- Be part of community White Ribbon Alliance activities and wear the white ribbon.

### Health care providers

Doctors, midwives, nurses, nurse-aides, and community health workers such as TBAs, community-based distribution agents, village health promoters, and others, regardless of the level of care in which they operate, are a fundamental part of the White Ribbon Alliance and efforts to achieve safe motherhood. They can:

- Educate women about how to stay healthy during pregnancy.
- Help women and families prepare for childbirth.
- Raise awareness about possible pregnancy complications and how to recognize and treat them.
- Provide advice and support for breastfeeding.
- Counsel women and men on family planning and contraceptive choices.
- Learn more about women's beliefs and concerns regarding pregnancy, childbirth, and motherhood and incorporate these into education and services.
- Provide good quality care to all women in a culturally appropriate and sensitive manner.
- Support and contribute to family life education in schools.
- Establish links with other community organizations working to promote safe motherhood and support collaborative activities.
- Work with community groups to establish emergency transport and referral systems.

### Health professional associations

Organizations of health professionals such as midwifery and medical associations can:

- Support and join the White Ribbon Alliance.
- Conduct continuing education sessions on safe motherhood and emergency obstetric care.
- Develop quality assurance guidelines on safe motherhood issues.
- Advocate for including safe motherhood in pre-service and in-service training of health professionals.
- Organize a roster of spokespersons for safe motherhood issues and seek out opportunities for spokespersons to promote these issues at appropriate public events.
- Provide prompt, credible responses to media inquiries about safe motherhood.
- Hold training sessions for spokespersons on how to work with the media.
- Offer clinical expertise to government and others on complications that are the main causes of maternal suffering and death.

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