

**Ethical Issues in Maternal Health Care:
A Study of Community Based Health Organization in
Rural Bangladesh**

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Abstract: *Women living in Bangladesh are at high risk due to maternal mortality and morbidity in the prenatal and postpartum period. Issues like inadequate health service providing; poor antenatal and postpartum care are concerned as the major causes of high mortality rate and morbidities during pregnancy period in rural Bangladesh. Community based health services (CBH) providers are facing ethical issues possibly because of their interactions with patients in the reproductive age groups. The objective of this study is to evaluate whether and how the community-based health service providers, ethically supply maternal health service to the disadvantaged women. Both primary and secondary data are used in this paper. Primary data is collected through semi-structured questionnaires from the selected number of mothers and health care service providers under the coverage of 'LAMB Community Health and Development program' of Badarganj upazila in Rangpur district. A total of 150 respondents, 100 reproductive age of mothers and 50 LAMB health care providers are randomly selected from this study area. A multiple linear regression model is used to estimate the influencing elements for antenatal care including ethics in treatment-seeking behaviors. The regression result of antenatal care (ANC) shows that providing ANC by health care givers to mother, place of ANC care, cost of ANC, and level of trust have significant influence on the frequency of ANC care during pregnancy as a indicator of maternal death prevention and age, education of mother, education of respondents' husband, income level of household, distance to service center are insignificant on ANC care.*

Keywords: *Ethical issues, Health care provider, Community health organization, ANC care, Trust, Rural sector.*

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Introduction

Across the world ethical issues remain a challenge for maternal health services providers. The level of trust on maternal health care givers positively influences the health outcome and a problem for decision making which need to be aware.

In this paper, primary data is collected from 100 reproductive age of mother and 50 health care givers using simple random sampling method from the coverage of LAMB community health and development programs in Rangpur. Multivariate analysis using a multiple linear regression model is employed to estimate the influencing factors for the antenatal including ethics in the tobacco yield. Tabular method is used to describe the socio-economic profile and explore ethical consideration of tobacco farmers regarding its cultivation

The regression result of ANC care show that provided ANC by givers to respondent mother, place of ANC care, cost of ANC and level of trust on health provider have significant influence on the frequency of ANC care during pregnancy as indicator of maternal death prevention and age, education level of mother, education level of respondents husbands, income of household, distance to service center are insignificant on ANC care.

To find out the determinants of the maternal health relating to community based maternal health organization a multiple linear regression model is used.

Women living in Bangladesh are at high risk for maternal mortality and morbidity in the prenatal and postpartum period. Issues like inadequate health service providers, poor antenatal and postpartum care, and nutritional deficiencies are concerned as the major causes of high mortality rate and morbidities during pregnancy or childbirth period in rural Bangladesh. Community based health services (CBH) providers particularly, MBBS doctors, nurses, skilled birth attendant, Family welfare visitors (FWV) face ethical issues possibly because of their interactions with patients and clients in the reproductive age groups. Socio-economic barriers during the pregnancy period is other important ethical issues for improving maternal health care that need to be addressed. The objective of this study is to evaluate whether and how the community based health service givers ethically provide maternal health service to the disadvantaged women? This paper also tried to find out the essential elements of maternal health care under CBHO activities.

This study is based on primary data collected through semi-structural questionnaires from the selected number of mothers and health care service provider under the coverage of 'LAMB Community Health and Development

program' in Rangpur. A total of 120 respondents, 100 reproductive age of mother and 20 LAMB health care providers are randomly selected from this study area.

In Bangladesh, both formal and informal sectors provide maternal health services. Non-public services are well-used and must be widely available, including private care providers (for-profit and not-for-profit) in the formal sector and in the non-formal sector, e.g. traditional birth attendants (TBAs) (52% of all institutional deliveries took place in community based organizations and private health facilities in 2007 while 82% of all deliveries were with a TBA or other untrained care providers)

Bangladesh is a poor country in South Asia, with a projected population of 135.43 million in 2007, 74 percent of whom live in rural areas. The crude birth rate was 20.8 per 1,000 people, and the crude death rate was 5.8 per 1,000 people while the average literacy rate was only 46 percent (male 50%, female 42%).

Bangladeshi women report low but increasing use of antenatal care, as well as low rates of delivery in a health facility or with the assistance of a skilled provider. Although almost half of women reported having one or more complications during pregnancy that they perceived as life threatening, only one in three sought treatment from a qualified provider. More than three-fourths of women with the time-sensitive complications of convulsions or excessive bleeding either failed to seek any treatment or sought treatment from an unqualified provider. The principal reason cited for failing to seek care for life-threatening complications was concern over medical costs, and pronounced socioeconomic disparities were found for maternal care-seeking behavior in both urban and rural Bangladesh.

To determine the specific needs of this community, it is important to understand the medical needs, local practices, and perceptions of pregnancy, birth, and the postpartum period and how they are affected by culture, religious beliefs and by the economic condition. In Bangladesh, social, health, nutrition, and economic opportunities are severely diminished for many women (Iyenger, 2012). Therefore, research is needed to determine the specific pregnancy-related health care needs of women living in Bangladesh provided by CBHO because community based organizations achieved considerable progress in the health indicators over the last decade through expanding the coverage of essential services to the disadvantaged women. The paper shows the delivery of primary health care through a region wide network called "LAMB Community health and development program" started in 1979.

The objectives of the study are:

- To investigate the role of community based health provider to improve maternal health care in view of LAMB Community Health and Development Program.
- To find out the indicators for the antenatal care, postnatal care, neonatal care etc. for the promotion of maternal health.
- To evaluate the treatment-seeking behavior of the community health givers for decision making.

Literature review

Different aspects and issues of the role of community based organization to improve maternal health care have been done by extended studies. Most of the studies tried to show the socio-economic condition to improve maternal health care. Usually the researchers used different technique of tabular analysis of comparison previous and present condition of health care service. This study also found that community based organization like (lamb) has increased health care service for antenatal, postnatal, neonatal care. Two thirds (63%) of mothers do not receive antenatal care that is influencing maternal mortality ratio. Urban area health care service is very. 59% urban mothers receive antenatal care while in rural area is only 28 percent (NIPORT 2001) post natal care is one of the most risky periods for occurrence of life threatening complication. The ratio of mother seeking postnatal care is professionally very low.

Bangladesh Maternal Mortality Survey 2010 (NIPORT 2011) showed that maternal mortality declined from 322 in 2001 to 194 in 2010 which was showing a 40 percent decline that gives an average rate of decline of about 3.3 percent per year. The overall proportion of births attended by skilled health personnel increased by more than eight-folds in the last two decades, from 5.0 percent in 1991 to 43.5 percent in 2012-2013. The first MDG Progress Report published in 2005, the MMR in 1990 was 574 per 100,000 live births in Bangladesh. However, according to Bangladesh Maternal Mortality Survey (BMMS) 2010 (NIPORT 2011), maternal mortality declined from 322 in 2001 to 194 in 2010, a decline of about 40 percent. The average rate of decline was about 3.3 percent per year, compared with the average annual rate of reduction of 3.0 percent required for achieving the MDG in 2015.

According to BDHS 2011, 67.7 percent of women with a birth in the three years preceding the survey received antenatal care at least once from any provider. Most of the women (54.6 percent) received care from a medically trained provider, e.g.,

doctor, nurse, midwife, family welfare visitor (FWV), community skilled birth attendant (CSBA), medical assistant (MA), or sub-assistant community medical officer (SACMO). The urban-rural differential in antenatal care coverage continues to be large: 74.3 percent of urban women receive antenatal care from a trained provider, compared to only 48.7 percent of rural women. In the public sector, 63 percent of the total workforce is involved in providing health services. Human resources for maternal healthcare include specialist doctors, general physicians, nurses, medical assistants, pharmacists, medical technologists, family welfare visitors, community-based skilled birth attendants, family welfare assistants, and health assistants. Bangladesh, 53 female community health volunteers and 53 female traditional birth attendants have been trained on maternal and newborn care and are doing home visits to pregnant women to educate them on eating nutritious foods, going for antenatal care visits, making birth preparedness plans and watching for danger signs that indicate a need to go to the health facility. These volunteers are currently doing home visits to 3,325 households. 106 informal service providers have been trained to reduce harmful practices and to increase appropriate referrals for mothers and newborns. 35 percent of deliveries were attended by SBAs: 22.8 percent at health facilities and 12.4 percent at home. Of the 22.8 percent facility-deliveries, 12.9 percent took place at private facilities, 9.1 percent in government facilities, while only 0.8% was in community based organization facilities. About two-thirds of all deliveries took place at home with unskilled birth attendants. Caesarean sections were performed on 10.8 percent of the study population, while 93 percent and 28 percent had at least one antenatal and postnatal care visit respectively. Of all caesarean deliveries, 73 percent took place at private facilities, 13 percent in government facilities, and the remaining 14 percent were in community-based facilities.

Most of the rural expected women who received antenatal care, 32 percent had their last visit at government facilities, 16 percent at community clinics, 24.5 percent at private facilities, and the remaining 27.5 percent were at home. By type of service providers, 32.5 percent received their last antenatal-care visit from qualified physicians, 36 percent from community based paramedics (including home-based SBAs), 25.4 percent from government paramedics, and 6.1 percent from informal providers (including TBAs and village doctors). Of those who received postnatal care, their mean number of visits was 1.8. Only 5.5 percent of mothers received postnatal care within 48 households and 14 percent within 1 week after giving birth. Even though Community Clinic maternity-care services make up a small proportion of those used by Bangladeshi women, use of maternal

health-care services in the home-based Community-Based Organizations areas in Bangladesh is higher than national averages 18 (35% versus 13% skilled attendance), and increases with use of antenatal care. Inequities in the NGO areas were not equal for all indicators: they varied by the type and place of services. Higher-level costlier services were more inequitably distributed than front-line, less-expensive, preventive services.

About 82 percent of women deliver at home, and the programme has tried to increase access through trained community skilled birth attendants (CSBAs) which is a community-based programme. As yet, available data does not enable an analysis of how effective this intervention has been. Only about 43 percent of the estimated requirement of 15,000 CSBA has been trained, but the pool of eligible candidates from the public sector is almost exhausted.

Research Methodology

In this study both the qualitative and quantitative approaches will be used to collect and analyze data. To collect information and data from both the primary and secondary sources, multiple methodologies will be used in this study. These are as follows:

Sampling Method: Selection of sampling design

Primary data will be collected through personal interview with the respondents. To attain accuracy and reliability of data, care and caution will be taken in data collection. Before interviewing, the aims and objectives of the study will be explained to each and every mother. The secondary sources include govt. publications; seminar papers, journals, published a thesis and topic relected various books, BBS, web sites etc. Rangpur division is selected purposively as a study area as one of the notable areas in Bangladesh for development of women's maternal health through community based organizations Programs in Bangladesh.

Population of the research: The women having child under the year 5 in Rangpur will be considered as the population of the research.

To collect data and information sampling is very important. It is a tool which helps to know the characters of the population by examining only a small part of it. As time and budget is limited, purposive Sampling will be used here. About 100 women (70 baby caring mother and 30 baby carrying mother) under community based organization LAMB health programs will be selected here as sample.

Survey Method

The Role of community based organizations health service programs in women maternal health is enormous. Survey method is used to collect data from the selected number of mothers and their children under the coverage of 'LAMB Community Health and Development program' in Rangpur. Structured, open-ended, closed-ended, contingency questionnaires are used here to collect data.

Analytical framework

In this study, tabular technique was used to illustrate the overall socio-economic characteristics of the samples. Tabulated data were analyzed by using frequencies, percentages etc. An econometric model such as linear regression model was used to find out the level of maternal health indicators.

Regression models for maternal care

To find out the determinants of the maternal health relating to community based maternal health organization, the following linear regression model was applied

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X_7 + \beta_8 X_8 + \varepsilon$$

Where, Y = Number of ANC checking providing to the responding mother.

X₁ = Age of respondent mother (In Years)

X₂ = Education level of respondent mother

X₃ = Income level of respondent's household

X₄ = Education level of respondent's husband

X₅ = Distance from home to community center.(Respondent's home far from LAMB community health center) .

X₆ = Provided ANC by home to the respondent mother

X₇ = ANC cost of respondent mother

X₈ = ANC checking place related to respondent mother

ε = Disturbance term

$\beta_0, \beta_1, \dots, \beta_8$ are known as the parameters of the model or intercept and slope coefficients respectively. There are seven explanatory variables. Here the independent variable is respondent home LAMB Community health and development programme.

We also utilize the SPSS method to measure the maternal care by various aspects.

Data and Result Analysis

Maternal health services in Bangladesh are delivered through both community-based and facility-based approaches. The emphasis on community-based approaches was initiated in 1978 to reach the goal—'Health for All by the Year

2000'. The facility-based approach gained momentum in 1987 only after the commencement of the safe motherhood initiative.

For field-data collection, self-weighted cluster sampling was used. Selection of clusters was with equal probability and a take-all strategy was followed at the second stage. A list of primary sampling units was generated after reviewing the population distribution in each study area. To reduce the workload, populations of study survey area were divided into segments according to the union perished with each segment consisting of about 1000 people or even more. Each segment was considered a primary sampling unit. In each study area, an exhaustive list of primary sampling units was generated with the help of local LAMB personnel. Six primary sampling units were then selected randomly.

Seven qualified interviewers collected data by use of a structured questionnaire. The questionnaire gathered information on background, use of antenatal care, use of SBA, use of postnatal care, perceived quality of care and cost of services. In total, 100 women were interviewed. The non-response rate was 0 percent.

Antenatal care was measured in number of visits to any provider whether formal or informal. Outcome measures focused on whether an SBA (doctor, nurse or midwife, including trained or untrained traditional birth attendant) was present at delivery, whether caesarean section was used, or whether any postnatal care was received. Home-based attendants with 6 months or 18 months midwifery training in this study, respectively, were considered SBAs in this study which is main concern of this study.

Most respondents were Muslims (87%) and housewives (95%). Average household size was 6.3 people, and daily household expenditure approximately US\$ 1.50. More than 80 percent of households had sanitary latrines, 86 percent had mobile phones, and 51 percent had electricity. At least 1 year of schooling had been completed by 86 percent of respondents, while the rate was 72 percent among their husbands. Of the respondents, 15% were less than 20 years old while 85% were in 20 to 35 years old. About 17 percent were in their first pregnancy and 10% of women had had five or more pregnancies.

In the case other parts of the world, women in Bangladesh are relatively disadvantaged in terms of their economic, social, educational and health conditions. The survival probability of females beyond the age of 30 years is significantly lower than males. The strong patriarchal structure of society has resulted in poor status of women in family and society. This is reflected in restrictions on women's movements, low self-esteem, a culture of acceptance, early marriage, lack of effective community support structure, and inappropriate

allocation and utilization of resources. The employment opportunities for women also remain quite restricted in the country.

Age of Respondent Mother

From this table it shows that age of respondent mothers are 100. The age of respondent mother less than 20 years is 26 percent, 20-25 years is 60 percent

Table 1 : Age of Respondent Mother

Age of Respondent	Frequency	Percent
less than 20 years	26	26.0
20 to 25 years	60	60.0
26 to 30 years	11	11.0
31 to 35 years	3	3.0
Total	100	100.0

respectively 31-35 years is 3 percent. Finally we can say that the age of respondents mother 20-25 years is 60 percent which is very high.

Education Level of Respondent Mother

From the above table 2, it shows that education level of respondents mother none level is 3 percent, primary non-completed level is 10 percent, primary completed education level is 22 percent respectively Honor's and above education level is 2

Table 2: Education Level of Respondent Mother

Education Level	Frequency	Percent
None	3	3.0
Primary non-completed	10	10.0
Primary completed	22	22.0
Secondary non-completed	24	24.0
Secondary completed	33	33.0
Higher secondary completed	6	6.0
Hon's and above	2	2.0
Total	100	100.0

percent. Carefully we saw that secondary completed; education level is 33 percent which is very high for collecting respondent mother education level randomly.

Education Level of Respondent's Husband

From the above table 3 we carefully saw that the total the education level of respondents husband is 100. None level of respondents husbands is 12 percent primary non completed is 13 percent, primary completed is 21 percent, secondary

Table 3 : Education Level of Respondent's Husband

Education Level	Frequency	Percent
None	12	12.0
Primary non-completed	13	13.0
Primary completed	21	21.0
Secondary non-completed	11	11.0
Secondary completed	21	21.0
Higher secondary completed	10	10.0
Hon's and above	12	12.0
Total	100	100.0

non-completed 11 percent, secondary completed 21 percent, higher secondary completed is 10 percent. Finally, we can say that primary completed and secondary completed the education level of respondents husbands percentage rate is same.

Occupation of Respondent's Husband

From the above table it shows that the occupation of the most of the respondents' husband is farmer, which is 25 percent. In the second position, the occupation of respondent's husbands is business. 16 percent respondents' husbands are day laborer and 17 percent is NGO employee. A few respondents husbands occupation is govt. service. Others belong to other occupation like clerical.

Table 4 : Occupation of Respondent's Husband

Occupation	Frequency	Percent
Farmer	25	25.0
Businessman	21	21.0
Day laborer	16	16.0
Govt. employee	5	5.0
NGO employee	17	17.0
Other occupation	16	16.0
Total	100	100.0

Respondent's household Income Category (in Taka)

From the above table its shown that most of the respondents household income is in the range of 5000 -10000 TK in month. The 26 percent respondents' family

Table 5: Respondent's household Income Category In Thousand(tk.)

Respondent's household income	Frequency	Percent
1000 to 5000 tk. in month	2	2.0
5000 to 10,000 tk. in month	55	55.0
10,000 to 15,000 tk. in month	26	26.0
15,000tk. to 20,000tk. in month	14	14.0
20,000tk. to more	3	3.0
Total	100	100.0

income is in the range of 10000-15000TK in month. 2 percent family has monthly income to 1000-5000 TK. And other 14 percent family has 15000-20000 TK in month. Only few families earn 20000 to more in a month which is 3 percent.

The above graph demonstrates the same characteristics of respondent's household income category in thousand in a bar graph snapshot.

Antenatal care provided to the rural mothers

The LAMB community based maternal health care system aiming to reduce morbidity and mortality related to pregnancy must focus on maternal and newborn health. The health care that a woman receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and the child. The health care that a woman receives during the pregnancy until the delivery is known as antenatal care.

Antenatal care (ANC) from a medically-trained provider is important to monitor the status of a pregnancy, identify the complications associated with the pregnancy, and prevent adverse pregnancy outcomes. To be most effective, there should be regular ANC throughout pregnancy. Information on ANC was assessed for women who gave birth in the five years preceding the survey as well as baby carrying mother. Among women with two or more live births during the three-year period, data refer to the most recent live birth only.

The below table shows that about 98.57 percent baby caring mother have been provided antenatal care and 100% baby carrying mother get antenatal care either by themselves or by the health workers. So it is clear that the rural mother is aware of their health condition.

No. of Respondents' children

The respondents selected randomly for measuring the contribution of the community based maternal health organization like LAMB community and development programme have 2 children mostly and the percentage is 42. 38

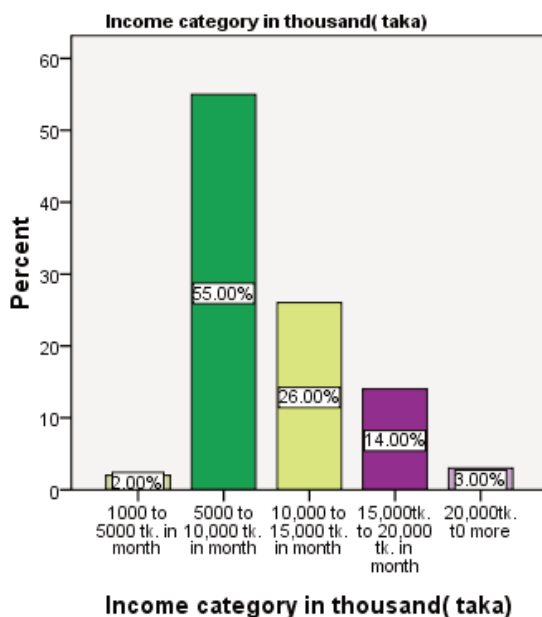


Table 6: No. of Children of Respondent Mother

No. of Children	Frequency	Percent
1 Child	38	38.0
2 Children	42	42.0
3 Children	15	1.0
4 Children	5	5.0
Total	100	100.0

percent respondents have 1 child. 3 children belong to 15 percent respondents only. 4 children belong to 5 percent respondents only.

No of ANC checking

In table 7, most of the respondents have checked their physical condition during pregnancy time which is called ANC checking 4 times which is in percentage 36.

Table 7: No. of ANC Provided to the Respondent Mother

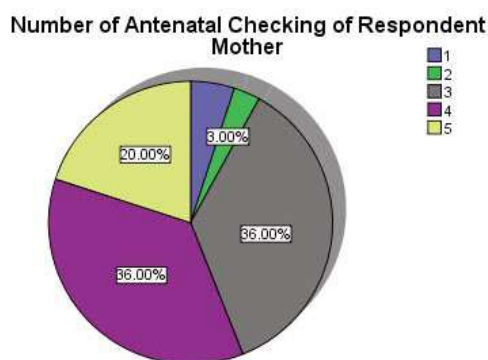
No. Of ANC	Frequency	Percent
1 Time ANC checking	5	5.0
2 Times ANC Checking	3	3.0
3 Times ANC Checking		
4 Times ANC Checking	36	36.0
5 Times ANC Checking	20	20.0
Total	100	100.0

20 respondents have 5 time ANC checking. 2 times ANC checking belong to 3 percent respondent. 1 time ANC checking has been visited only 5 respondents.

The above pie chart also shows the same result of respondents' ANC checking.

ANC checking provider

From the above table it shows that most of the respondents mother have checked their health condition by skilled birth attendant which percentage rate is 48



percent. We also see that the respondent mother have checked their physical condition by family welfare visitors that is 43 percent. The remaining amount of respondent mothers have checked their health condition by MBBS doctor which percentage rate is 9 percent

ANC checking place

From the above table 9 it shows that total number of respondent mothers is 100 percent. Most of the respondent mothers have checked their physical condition by community clinic which percentage rate is 48 percent. In the first position of private clinic has 4 percent checking their ANC place of respondent mothers.

ANC checking Cost

The above table shows that 43 respondent doesn't have ANC cost though they have checked their physical condition during pregnancy. And they have received ANC checking from family welfare centre. 48 respondents checked their physical condition during pregnancy bearing the cost 60 -100 TK and they received ANC checking from LAMB community health and development programme. Other 9 percent has received ANC checking from govt. as well as public hospital and bore the cost 500 to 2000.

Table 8: Provided ANC Checking by Whom to the Respondent Mother

ANC by whom	Frequency	Percent
MBBS doctor	9	9.0
Family welfare visitor(FWV)	43	43.0
Skilled birth attendant	48	48.0
Total	100	100.0

ANC checking: ANC cost and by whom

The above graph shows that 43 percent respondents received ANC checking from family welfare visitor spend no money. 48 percent respondents received ANC checking spend 60-100 TK and other 9 percent respondents received ANC checking from MBBS doctor and their ANC checking cost depends on their ANC category.

Table 9: ANC Checking Place of The Respondent Mother

ANC checking place	Frequency	Percent
Private clinic	4	4.0
Govt. Hospital	5	5.0
Community clinic	48	48.0
Family welfare centre	43	43.0
Total	100	100.0

Mother's thought about ANC checking time

51 percent respondents' mothers think that a pregnant woman should check up her physical condition at least 3 times. 39 percent and 5 percent respondents think that a pregnant should check up at least 4 and 5 times respectively. Only few 5% women think that a woman should checked up 2 times ANC checking during her pregnancy.

Table 10: ANC Checking Cost of Respondent Mother

ANC checking cost	Frequency	Percent
0 Taka	43	43.0
60 Taka	21	21.0
80 Taka	17	17.0
100 Taka	10	10.0
500 Taka	2	2.0
1000 Taka	5	5.0
1500 Taka	1	1.0
2000 Taka	1	1.0
Total	100	100.0

Respondent’s delivery place

From the above table12, it shows that most of the respondent mother 41 percent have given birth their child at home with the help of traditional birth attendant as well as charlatan. 37 respondent mother have given birth their child at community clinic. 13 percent women have gone to private clinic to give a birth. And other 7 percent and 2 percent respondent mother have gone to family welfare center and government hospital to give a birth respectively.

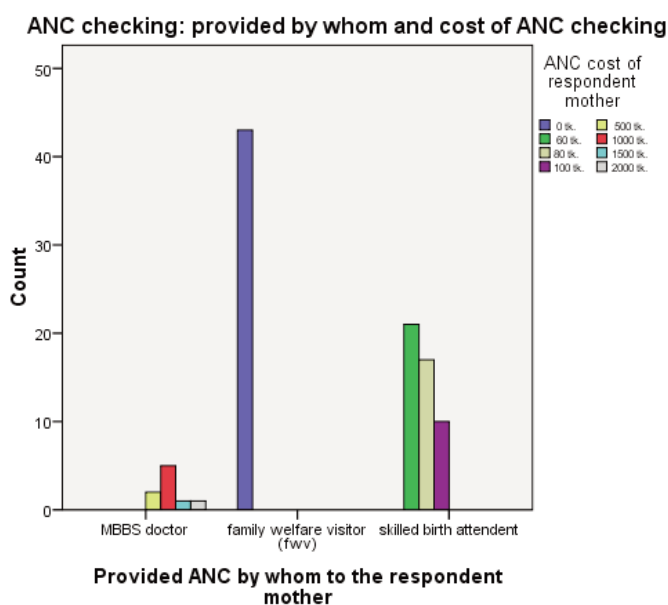


Table 11: Mother's Thought About ANC Checking Time

ANC checking time	Frequency	Percent
2 Times ANC checking	5	5.0
3 Times ANC checking	51	51.0
4 Times ANC checking	39	39.0
5 Times ANC checking	5	5.0
Total	100	100.0

Respondent's delivery type

In the above table 13, 81 percent respondent mother has normal delivery and other 14 percent and 5 percent went through by operation and apparatus to give a birth.

Assistance during delivery

From the above table 14, it is shown that 39 percent women have given birth with the assistance of community skilled birth attendant who belongs to community clinic of LAMB community health and development program. 37 percent respondent mother has given birth with the help of traditional birth attendant at home. 14 percent women have been given their birth by M.B.B.S. doctor. The remaining number 6 percent and 4 percent went through by family welfare visitor and charlatan.

Table 12: Delivery Place of Respondent Mother

Delivery Place	Frequency	Percent
At home	41	41.0
private clinic	13	13.0
Govt. hospital	2	2.0
Community clinic	37	37.0
Family welfare centre	7	7.0
Total	100	100.0

The above graph shows the same result of the assistance of during delivery service respondent mother in a snapshot.

Appropriate delivery birth attendant

In the above table 15, 61 percent respondent mother thinks that skilled birth attendants are appropriate for delivery service. 26 percent respondent mother thinks about M.B.B.S. doctor to give a birth. 7 percent women think that a woman

Table 13: Delivery Type of Respondent Mother

Delivery Type	Frequency	Percent
Normal delivery	81	81.0
By operation	14	14.0
By apparatus	5	5.0
Total	100	100.0

needs traditional birth attendant to give a birth. The remaining number 4 and 2 women think that a pregnant woman needs to have family welfare visitor and others (nurse, BRAC HA and relatives) to give a birth successfully.

Table 14: Assistance during Delivery of Respondent Mother

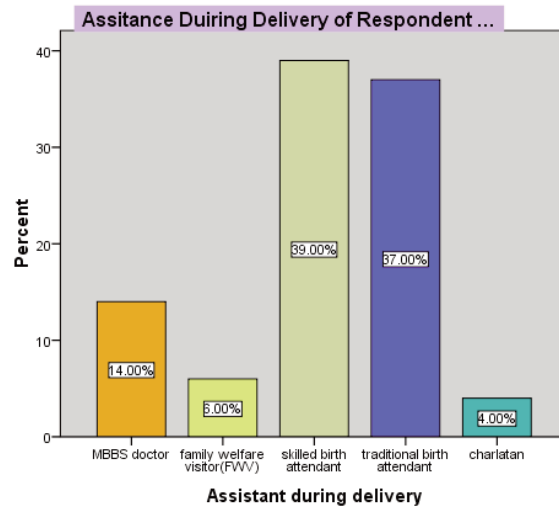
Assistant during delivery	Frequency	Percent
MBBS doctor	14	14.0
Family welfare visitor(FWV)	6	6.0
Skilled birth attendant	39	39.0
Traditional birth attendant	37	37.0
Charlatan	4	4.0
Total	100	100.0

PNC checking

Postnatal care is a crucial component of safe motherhood. Postnatal checkups provide an opportunity to assess and treat delivery complications and to counsel mothers on how to care for themselves and their babies. A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days following delivery are critical for monitoring complications arising from the delivery.

Table 15: Respondent's Thought About Appropriate Delivery Birth Attendant

Appropriate Delivery Birth Attendant	Frequency	Percent
MBBS doctor	26	26.0
Family welfare visitor(FWV)	4	4.0
Skilled birth attendant	61	61.0
Traditional birth attendant	7	7.0
Others(nurse, BRAC HA and relatives)	2	2.0
Total	100	100.0



To assess the extent of postnatal care utilization, this survey asked the respondent whether she and her child had received a health checkup after the delivery, the timing of the first check, and the type of health provider for the last birth in the five years preceding the survey.

In the above table 16, 92 percent respondent mother has received their PNC checking and other 8 percent haven't received their PNC checking after delivery.

No of PNC checking

From the above table 17, 67 percent respondent mother have received PNC checking 4 times, 20 percent received 5 times and other 13 percent received 3 times PNC checking after delivery.

PNC checking provider to respondent mother

In the above table 18, 32 percent respondent mother received PNC checking skilled birth attendant, 20 percent from traditional birth attendant, 16 percent from family welfare visitor, and 15 percent from M.B.B.S. doctor. And others 8 percent and 9 percent received PNC checking from Charlatan and others (nurse, BRAC HA and relatives).

PNC checking: By whom and in where

From the above graph, it is cleared that, 32 percent respondent mother received their PNC checking from community skilled birth attendant at community clinic. 36 percent respondent mother received their PNC checking at home by traditional

Table 16: PNC Checking of Respondent Mother

PNC Checking	Frequency	Percent
Yes	92	92.0
No	8	8.0
Total	100	100.0

birth attendant, charlatan and others. 15 percent respondent mother received PNC checking from M.B.B.S. doctor either at private clinic or government hospital. 16 percent respondent mother received PNC checking from family welfare center.

PNC checking cost

In the above table, 19.76 percent respondent mothers have received PNC checking by spending below 100 taka. 16 percent respondent mothers have received PNC checking spent 300 to 2000 taka in different cases. Remaining 10 percent spent for PNC checking above 2500 taka according to their demands.

Table 17: No. of PNC Checking Provided to the Respondent Mother

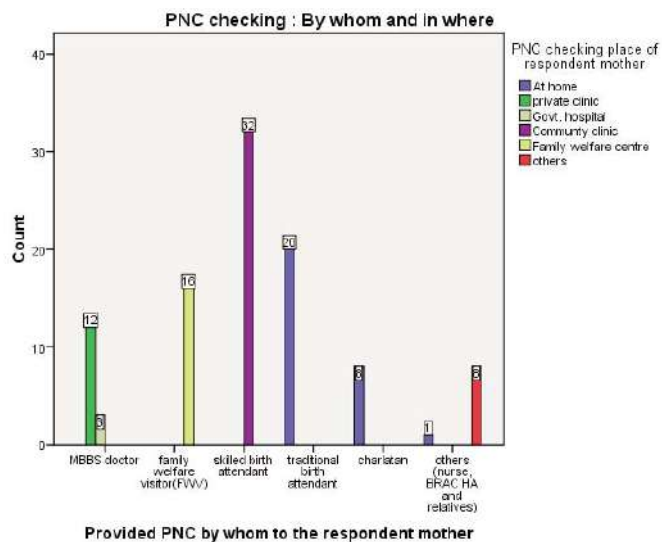
PNC Checking	Frequency	Percent
3 Times PNC checking	13	13.0
4 Times PNC checking	67	67.0
5 Times PNC checking	20	20.0
Total	100	100.0

Distance between respondent's home and community clinic

The pie chart shows that, respondent's home far from LAMB Community Clinic within 2 k.m. is 40 percent and others respondent's home far from 3-5 k.m. Only 18 percent respondent's home belong to within 6 to more k.m.

Table 18: Provided PNC Checking by Whom to the Respondent Mother

PNC Checking Provider	Frequency	Percent
MBBS doctor	15	15.0
Family welfare visitor(fwv)	16	16.0
Skilled birth attendant	32	32.0
Traditional birth attendant	20	20.0
Charlatan	8	8.0
Others(nurse, BRAC HA and relatives)	9	9.0
Total	100	100.0



Breast-feeding time

From the above table 20, 94 percent respondent mother have practiced breast feeding to their children till to 6 months after given birth. And 6 percent respondent mothers have practiced breast feeding to their children till to 5 months after given birth.

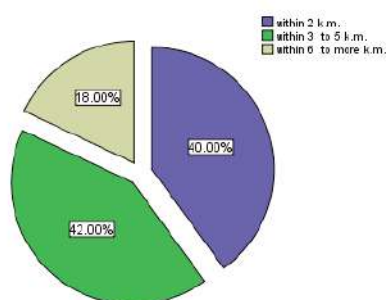
Table 19: PNC Checking Cost of Respondent Mother

PNC Checking Cost (in Tk.)	Frequency	Percent
0 Taka for PNC checking	24	24.0
10 Taka for PNC checking	1	1.0
60 Taka for PNC checking	2	2.0
80 Taka for PNC checking	26	26.0
100 Taka for PNC checking	23	23.0
300 Taka for PNC checking	8	8.0
500 Taka for PNC checking	1	1.0
1000 Taka for PNC checking	1	1.0
2000 Taka for PNC checking	4	4.0
2500 Taka for PNC checking	2	2.0
3000 Taka for PNC checking	2	2.0
4000 Taka for PNC checking	1	1.0
5000 Taka for PNC checking	5	5.0
Total	100	100.0

Naval cutting tool

In the above table 21,62 percent respondent mother told that a pair of Scissors was used to cut their new born baby’s naval. And 38 percent have used new blade to cut their new born baby’s naval.

Respondant's Home Far from LAMB Community Clinic



Taking the first bath of new-born baby

In the above table 22, 57 percent respondent mother have made a bath their children within 7 days or more and 31 percent respondent mother made their

Table 20: Duration Of Breast-feeding Of Respondent Mother To Her Child

Duration Of Breast-feeding in Month	Frequency	Percent
5 Months breast feeding	6	6.0
6 Months breast feeding	94	94.0
Total	100	100.0

children taken a bath within 2 to 3 days. And other 12 percent practiced to make a bath after giving birth or within 6 hours.

Knowledge of first aid of child-common diseases

From the above graph, it has been shown that 93% women know the first aid when their children fall in heavy fever, vomiting several times and shortness of breath and other 7 percent knows nothing.

Table 21: Tools For Cutting Naval of New-born Baby

Cutting tool	Frequency	Percent
New blade	38	38.0
Scissors	62	62.0
Total	100	100.0

This table shows that age of respondent mother significance level is 6.8 percent. This significant level is not accepted to the age of respondent mother. Education level of respondent mother significance level is 7.2 percent which is not accepted to the education level of respondent mother. Education level of respondent husband significance level is 49.9 percent which is not accepted. Income level of household significance level is 34.3 percent which is not accepted. Provided ANC by who to the respondent mother significance level is 0 percent which is accepted to the respondent mother. ANC place of the respondent mother significance level is 0 percent which is accepted to the respondent mother. ANC cost of respondent mother significance level is 0.1 percent. Which is accepted? Respondent's home

Table 22: Time of Taking A First Bath For A New-Born Baby

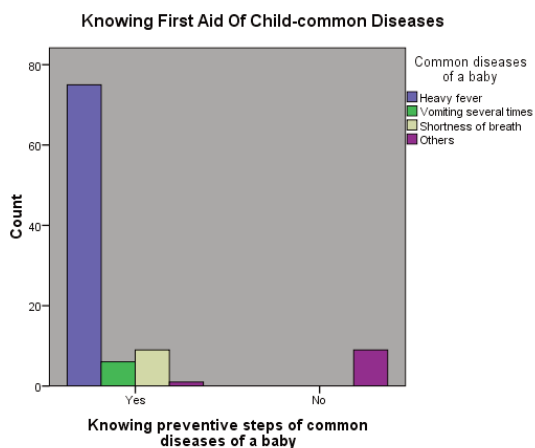
Taking a first bath	Frequency	Percent
After giving birth	11	11.0
After 6 hours	1	1.0
Within 2 to 3 days	31	31.0
Others	57	57.0
Total	100	100.0

far from LAMB community clinic significance level is 38.8 percent which is not accepted.

Conclusion

This analysis on the role and impact of community based maternal health organization in capacity development has been explored with one main question in mind: Has community based health organization's action evolved with the improvement of maternal health program implementation more beneficial? Our findings can be summarized systematically by recalling the objectives presented at the outset of the paper:

Community based maternal health organizations are moving towards increased involvement in capacity development for maternal health. The capacity development approach is gaining attention among field working by providing ANC and PNC in improvement maternal health assuming capacity development activities. Community based maternal health organizations, the focus of this study, is quite clearly influenced by the international development discourse and is adapting their activities accordingly. Even though capacity development has always existed, it is gaining ground on the national level as an overarching concept promoted by the multilateral aid agenda. As a result, community based



Coefficients

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
Model (Constant)					
Age of respondent mother	-4.766	1.480	-	-3.219	.002
Education level of respondent mother	-.216	.117	-.151	-1.848	.068
Education level of respondent's husband	.044	.065	.083	.678	.499
Income level of household	3.250E-5	.000	.124	.954	.343
Provided ANC by whom to the respondent mother	1.075	.191	.697	5.624	.000
ANC place of the respondent mother	1.441	.230	1.072	6.252	.000
ANC cost of respondent mother	.002	.001	.705	3.579	.001
Respondant's home far from LAMB community clinic	-.091	.105	-.067	-.868	.388

a. Dependent Variable : No. of ANC provided to the respondent mother

maternal health organizations constitute important resources for capacity development, and vice versa.

This involvement changes the ways in which community based maternal health organizations operate. Whereas an increasing number of communities based maternal health organizations are involved in capacity development, many still remain committed to education provision and replacing the state on the ground.

Capacity development activities compliment this traditional area of community based maternal health organization intervention and constitute a way of scaling up in a qualitative sense by enhancing the sustainability of community based maternal health organization efforts. As a result, community based maternal health organizations action is increasingly diversified.

Through their involvement, they have an impact on the interpretation of capacity development. Community based maternal health organizations do have an influence on the concept and content of capacity development. Community based maternal health organizations are to a large extent influenced by the rural women's health development discourse and as a result, adapt their activities and strategies to accommodate external demands concerning capacity development. However, through their actions, and by making new activities complementary to and coherent with traditional ones, they engage in a process of shaping the meaning of capacity development.

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