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Awareness of Safe Motherhood Patterns

A Cross-Cultural Comparison between Muslim and Horizon Communities in Rajshahi Metropolitan City of Bangladesh

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Abstract. *Safe motherhood is one of the very important elements of human, economic and social investment. The awareness of safe motherhood enhances human being to get proper mother and child healthcare facilities all over the world. In Bangladesh health is one of the main fundamental rights of every citizen, which is ensured by the constitution. The present study, the author tried to find out awareness of safe motherhood patterns between the two communities (Muslim and Horizon). The purpose of the study was to examine and compare how awareness of safe motherhood influences on mother and child healthcare outcomes between Muslim and Horizon communities. In this study, total number of 275 (150 for Muslim and 125 for Horizon) participants were interviewed by the author during April to July, 2013 in the Rajshahi Metropolitan City of Bangladesh. The simple random sampling technique was applied when sample size selected. Various statistical techniques were used during analyzed data with SPSS software in version 15. The present study showed that awareness of safe motherhood knowledge was greatly influence over the mother and child healthcare outcomes. The author found that Muslim community dominated the minor community (Horizon) in the various sphere of life. Most of the participants studied up to primary level which was 45.09%. 83.46% participants seemed that awareness of safe motherhood knowledge positively enhanced to get healthy mother and child life style. 49.10% participants seemed that communal destitution is existed to get educational attainment and take healthcare facilities. 87.28% participants argued that they were concern either permanent or temporary family planning methods. 79.35% participants showed their opinion that awareness of safe motherhood knowledge made conscious about pregnancy periodical diseases, how and where to take diagnosis and treatment of their suffering diseases. 83.23% participants expressed their fillings that awareness of safe motherhood and educational knowledge enhances to get better mother and child healthcare facilities and lead their better healthier life.*

Introduction

Safe motherhood is a vital economic and social investment attainment and the universal phenomenon all around the world. UN Millennium Development Goal (MDGs), goal no. four and five that is Reduce Child Mortality and Improve Maternal Health enlisted. This is the achieving mental and physiological aspect of human behavior across the socio-economical systems. Maternal health care services in our country are not adequate enough to provide treatment facilities of the total population. Moreover, poverty, illiteracy and lack of safe motherhood awareness knowledge cause miserable sufferings and premature death to our mother and children. The quacks and village doctors are aggravating the situation (BPHMS: 2011). An individual with his or her personal education and health status attainment not only occupies certain status in the family, group, community or wider society but also acquires certain prestige through which s/he meets his or her day-to-day human needs and solves personal physical, mental and social problems faced in a particular environment(Uddin:2009). In Bangladesh, according to constitution section-2, article-15, the government ensures free medical care (Bangladesh constitution: 2011). Likewise education and health status attainment refers to the achievement of

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persons' relative position of education, occupation and income within that particular social system (Hossain: 2012). This paper focuses on cross-cultural comparison of awareness of safe motherhood patterns and health status attainments and its interrelationships between Muslim and Horizon communities in Rajshahi metropolitan city of Bangladesh. In Rajshahi Zila (district) the literacy rate is 53.0% and school attendance rate (5 to 24 years) is 58.9% (census report: 2011). Where the national literacy rate (7 years and above) is 51.8% and ethnic population is 1.10 %(census report: 2011). Maternal morality rate (MMR) per 1000 live births is 2.9 (MDG Progress Report: 2007). Infant mortality rate (IMR) (0-1 Year) per 1000 live births 52 and child mortality rate (<5 Years) per 1000 live births 62 and Delivery by medically trained personnel 18% and contraceptive prevalence rate (CPR) 55.8% (BDHS: 2011).

Maternal Health. Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. Maternal mortality is higher in women living in rural areas and poorer communities. Young adolescents face a higher risk of complications than older women (WHO).

Safe Motherhood Initiatives. In 1987 the World Bank, in collaboration with WHO and UNFPA, sponsored the safe motherhood Conference in Nairobi. The launch of the Safe Motherhood Initiative (SMI) was seen as a major milestone in the race to reduce the burden of maternal mortality throughout the world, particularly in developing countries. The Safe Motherhood Initiative is a worldwide effort that aims to increase attention to reduce the devastating numbers of women that suffer death or serious illness every year. In order to reduce life – threatening risks and reduce mortality, good-quality maternal health services by trained health workers must be available and used. Safe motherhood encompasses social and cultural factors, as well as addresses health systems and health policy. Indicators used to measure maternal health include skilled attendance at birth, contraceptive prevalence rates and maternal mortality and morbidity. Improving maternal health is one of the eight *Millennium Development Goals*, and great efforts have been put forth to achieve that goal. However, much work has yet to be done to assure maternal health for women worldwide. Safe motherhood programs emphasize addressing all of these issues as well as other reproductive health issues, such as sexually transmitted infections, unplanned pregnancy, obstetric fistula, and female genital cutting (FGC). The eight essential component on awareness of safe motherhood patterns are: (i) Education and information about prevailing health problems and methods of preventing and controlling them; (ii) Promotion of food supply and proper nutrition; (iii) Adequate supply of safe water and basic sanitation; (iv) Maternal and child health care including family planning; (v) Immunization against infectious diseases; (vi) Prevention and control of endemic diseases; (vii) Treatment for minor ailments and injuries, and (viii) Provision of essential drugs (Rashid, Khabiruddin and Hyder: 2004). The knowledge on awareness of safe motherhood patterns status persons singly or collectively attain is socio-culturally constructed and modified in every society. Social scientists separately suggest three approaches to study awareness of safe motherhood patterns status attainment: Prestige approach by National Opinion Research Center, Functionalist approach by Duncan and others, and Class approach by Marx and Weber, including its categorical and numerical variables. These approaches generally assume that awareness of safe motherhood patterns status attainment may vary across the class, caste, sex, religion, race, region etc. due to inequality in property, power and opportunity distribution in the hierarchical social structure in every society. Based on the assumption relevant cross-cultural comparative studies conducted across the cultures reveal that awareness of safe motherhood patterns status attainment widely varies people in the dominant market economy compared to the non-dominant ones achieve high status. These studies argue that without high status achievement people in the highly modernized market economy cannot fulfill their human problems like health awareness faced in that environment. Other comparative studies reveal that this awareness of safe motherhood patterns status achievement also varies among the different classes, castes, religions, races, regions within a given culture, because dominant class or cultural group always dominates, deprives and exploit non-dominant classes or cultural groups within a society. Regarding this several researches investigated in multicultural societies indicate that every parental awareness of safe motherhood patterns status attainment of the cultural groups is transformed into the next generation. As awareness of safe motherhood patterns status attainment of minority parents or non-dominant groups (Black, Hispanic, Asian and African born) compared to the majority or dominant ones (White) is low, so their children's health awareness patterns status attainment is also low. In addition, it is widely reported that males' awareness of safe motherhood patterns status attainment compared to the females within the family and other formal organizations also varies in different cultures. Awareness of safe motherhood patterns status attainment of males

is higher than the females. These awareness of safe motherhood patterns status attainments education, occupation and income are cyclical process in which low educational attainment by someone influences his or her low prestige job involvement that in turn influences low income rate in the particular social system in Bangladesh report that awareness of safe motherhood patterns status attainment of the dominant group (Muslim) is higher than the minority groups of Horizon in Bangladesh (Hossain: 2012). In Bangladesh patient doctor ratio is 2773:1 and the available pure drinking water user 85% and the available of sanitary latrine is 87 %(Bangladesh Economic Survey: 2012). Where pure drinking water user is 82.55% and the user of sanitary latrine is 77.45% in study area.

Background and Methodology

Background. Community is a group of people who not only share the same believe system but also acquire more or less the status in a particular environment. This community status may vary from other community. A community is a group or a collection of groups that inhabits a locality. The residential tie to an area is one attribute that distinguished a community from other groups. Another distinguished feature of a community is the total organization of social life in the area (Ogburn and Nimkoff: 1960). Bangladesh is an agrarian economic based rural country where various religious and ethnic communities, especially Muslim and Horizon, live in the same geographical location, and involve in the historical and social processes for livelihood (Uddin: 2009). The Muslim in this country is the dominant group, while the Horizon (Ancient believer) is non-dominant group. Religiously, the former believe in Monotheism, but the later have a syncretistic belief (Bongas). The former speak in Bengali language with the mixture of Arabic-Urdu preference. On the other hand the later speak in Austric-Mundary, and sometimes speak in Bengali version with the other Bengali-speaking people. Based on their respective fundamental believe system both the communities interact with agriculture economy for their livelihood. Although about 75% of the rural people live in subsistent economy in which most of them are poor, minority groups such as the Horizon are the poorest of the poor. One report indicates that 53% of the rural peoples are poor and there are 55 million food insecure households and 62% adults are illiterate. In Bangladesh current total fertility rate (TFR) is 2.3%, child mortality rate is 53 per 1,000 and current use of contraceptive instruments is 56.9% (BDHS: 2011). It is more interesting that although main occupation of the rural villagers is agriculture, man-land ratio is very low and many of them are landless or near the landless due to law of inheritance, land fragmentation and over-population. Some reports indicate that about 62% of the rural households are functionally landless. In the education and health status attained by the Muslim, Horizon is embedded in Rajshahi city of Bangladesh (Hossain: 2012).

Objectives of the Study

The study is based on the awareness of safe motherhood patterns between Muslim and Horizon communities in Rajshahi metropolitan city of Bangladesh. The main objectives of the study are as follows:

1. To closely know the awareness of safe motherhood patterns between Muslim and Horizon communities.
2. To find out and compare the situation of the awareness of safe motherhood patterns and healthcare facilities attainments between Muslim and Horizon Communities in Rajshahi metropolitan city of Bangladesh.
3. To know what types of barriers, diseases and health hazards of safe motherhood activities faces by the respective community people.

Hypothesis of the study

Hypothesis 1: Awareness of safe motherhood attainment of the Muslim community is higher than that of Horizon community in the Rajshahi metropolitan city of Bangladesh.

Hypothesis 2: There are positive significant relationships between awareness of safe motherhood knowledge on healthcare attainment and well healthcare of mother and child on Muslim and Horizon communities in the study area.

Hypothesis 3: Better quality of safe motherhood knowledge enhances the better quality of healthcare outcomes of mother and their child.

Hypothesis 4: Well Knowledge of safe motherhood people is very much conscious about various diseases, cured system and prevention than illiterate people of the study area.

Methodology

This study was conducted during April to July, 2013 in the Rajshahi Metropolitan City of Bangladesh where Muslim and Horizon community people live side by side. Three villages like Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana (Police Station), were purposefully selected for this study. Muslim community people live in Hetem Khan Pan Bahar, and Karigar Para village and Horizon community people live in Methor Para village.

Features of Sample. There were total numbers of participants 275 (Muslim no.150 and Horizon no.125) who were enlisted in this study. 275 participants were selected by using simple random sampling procedure whose age ranged 10 to 40 and above years and male (200) and female (75). Most of them were day laborers (23.63%) and rests of them were Sweeper (22.92%), Rickshaw puller (24%) and small Shopkeeper (11.27%). Most of the participant's monthly income was Tk.5000 to 7500 (34.55%), (1 U.S Dollar = 79.75 Taka in Bangladeshi currency).

Variable and Measure. Community was nominally measured and coded as 1= Muslim, 2= Horizon. Sex was nominally measured and coded as 1= Male, 2= Female. Age was numerically measured in years. Family structure was nominally measured and coded as 1= Nuclear, 2= Joint. Family authority was nominally measured and coded as 1= Parental, 2= Maternal. Occupation was nominally measured and coded as 1= Job holder, 2= Sweeper, 3= Rickshaw puller, 4= Small shopkeeper, 5= Day laborers. Education was nominally measured and coded as 1= Primary level, 2= Secondary level and 3= Tertiary level. Knowledge of health care facilities in pregnancy period were nominally measured and coded as 1= Yes, 2= No, Awareness Safe Motherhood Patterns measured and coded as 1=Good, 2=Moderate, 3=Poor, Knowledge about Safe Drinking Water measured and coded as 1=Good, 2=Moderate, 3=Poor,, Knowledge about Hygiene measured and coded as 1=Yes 2=No, Types of Latrine measured and coded as 1=Sanitary, 2=Unsanitary, Knowledge about Safe Delivery and Maternity measured and coded as 1=Govt. Hospital, 2=Mother and Child Welfare Center, 3=Private Hospital, 4=Own Home, Using Family Planning Methods measured and coded as 1=Permanent , 2=Temporary, 3=None, Communal Destitution to Get Healthcare Facilities were nominally measured and coded as 1= Yes, 2= No.

Relationship on awareness of safe motherhood patterns, here awareness pattern was independent variable and mother and child healthcare outcome was dependent variable

Instrument and Procedure. The data of this study were quantitative in nature of awareness of safe motherhood patterns between Muslim and Horizon communities. In order to collect data semi-structured questionnaire with close and open ended questions was made in Bengali language version, because of these communities participants did not understand English. After collecting necessary data, it was converted into English version. In order to ensure reliability and validity of the data rapport was build up and followed with the participants from initial stage to last stage.

Data Analysis. Based on author's objective, the collected data were analyzed by descriptive statistics, presenting frequency distribution, percentage and grand total was applied to measure the relationship about awareness of safe motherhood patterns. The author used the SPSS software version 15 to analyze the necessary data. Especially different statistical techniques were applied to find out similarities or differences and associations in the awareness of safe motherhood patterns attainment on mother and child healthcare outcome between Muslim and Horizon communities in the three villages like Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana (Police Station). These statistical techniques to find out cross-cultural differences and interrelationships for the safe motherhood status attainment variables included were more relevant, because most of the variables used were numerical (quantitative) in nature (Uddin : 2009).

Results

In order to find out and compare awareness of safe motherhood patterns by Muslim and Horizon communities people in Rajshahi metropolitan city of Bangladesh, knowledge of safe motherhood education, various healthcare awareness ingredients , occupation and the income in the study area were measured and compared. In addition, this study also analyzed and compared how awareness of safe motherhood patterns influences each other between the Muslim and Horizon communities. The findings of the comparative analysis are given in below the tables no. I-XV

Table I

Sex of the Community between Muslim and Horizon

Sex of the community	Muslim	Horizon	Total
Male	107 (38.91)	93 (33.82)	200
Female	43 (15.63)	32 (11.64)	75
Total	150	125	275

Note: Percentage in parentheses

Table I shows that (72.73%) is male and rest of the female (27.27%). Maximum sex of the community is male.

Table II

Occupational Attainment between Muslim and Horizon Communities

Occupational Attainments	Muslim	Horizon	Total
Job Holder	37 (13.45)	13 (4.73)	50
Small Shopkeeper	23 (8.36)	8 (2.91)	31
Rickshaw Puller	34 (12.36)	32 (11.64)	66
Sweeper	0 (0)	63 (22.92)	63
Day Laborers	56 (20.36)	9 (3.27)	65
Total	150	125	275

Note: Percentage in parentheses

Table II shows that most of the Muslim participant's occupation is day laborer (20.36%) and most of Horizon participant's occupation is sweeper (22.92%). The occupation of Muslim community is better than that of Horizon community.

Table III

Age of the Muslim and Horizon Communities

Age of the Participants in Years	Muslim	Horizon	Total
10-20	12 (4.36)	8 (2.91)	20
20-30	78 (28.36)	62 (22.55)	140
30-40	41 (14.91)	35 (12.73)	76
40+	19 (6.91)	20 (7.27)	39
Total	150	125	275

Note: Percentage in parentheses

Table III shows that the maximum Muslim participants are (28.36%) and Horizon (22.55%) of age group of 20-30 years.

Table IV

Educational Status Attainment between Muslim and Horizon Communities

Educational Status Attainments	Muslim	Horizon	Total
Primary Level (i-v)	66 (24.00)	58 (21.09)	124
Secondary Level (vi-xii)	52 (18.90)	43 (15.64)	95
Tertiary Level (xiii-xvi)	32 (11.64)	24 (8.73)	56
Total	150	125	275

Note: Percentage in parentheses

Table IV shows that the maximum primary educated Muslim participants are (24.00%) and Horizon participants are (21.09%). Muslim community is dominant in educational status attainment.

Table V

Monthly Income of Participants between Muslim and Horizon Communities

Monthly Income of Participants in Tk.	Muslim	Horizon	Total
2500-5000	31 (11.27)	30 (10.91)	61
5000-7500	49 (17.82)	46 (16.73)	95
7500-10000	42 (15.27)	32 (11.64)	74
10000+	28 (10.18)	17 (6.18)	45
Total	150	125	275

Note: Percentage in parentheses (1 USD=79.75 Tk.)

Table V shows that the maximum monthly income of Muslim community that is (16.73%) and Horizon community is (17.73%). In monthly income perspective Muslim is dominant than that of Horizon community.

Table VI

Knowledge about Healthcare Facilities in pregnancy period of the Participants

Knowledge of Healthcare Facilities in pregnancy period	Muslim	Horizon	Total
Yes	112 (40.73)	85 (30.90)	197
No	38 (13.82)	40 (14.55)	78
Total	150	125	275

Note: Percentage in parentheses

Table VI shows that knowledge about healthcare facility in pregnancy period of Muslim community is (40.73%) and Horizon community is (30.90%). Knowledge about healthcare facilities in pregnancy period perspective Muslim community is ahead than that of Horizon community.

Table VII

Health Awareness Patterns of the Participants in Pregnancy period

Health Awareness Patterns in	Muslim	Horizon	Total

pregnancy period			
Good	48 (17.46)	45 (16.36)	93
Moderate	82 (29.82)	53 (19.27)	135
Poor	20 (7.27)	27 (9.82)	47
Total	150	125	275

Note: Percentage in parentheses

Table VII shows that moderate health awareness patterns in pregnancy period of Muslim community is (29.82%) and Horizon community is (19.27%). Health awareness patterns in pregnancy period aspect Muslim community is ahead than that of Horizon community.

Table VIII
Knowledge about Safe Drinking Water of the Participants

Knowledge about Safe Drinking Water	Muslim	Horizon	Total
Good	84 (30.55)	69 (25.09)	153
Moderate	52 (18.91)	34 (12.36)	86
Poor	14 (5.09)	22 (8.00)	36
Total	150	125	275

Note: Percentage in parentheses

Table VIII shows that good knowledge about Safe drinking water perspective Muslim community is (30.55%) and Horizon community is (25.09%). Knowledge about safe drinking water perspective Muslim community is dominant than that of Horizon community.

Table IX
Knowledge about Hygiene in pregnancy period of the Participants

Knowledge about Hygiene in pregnancy period	Muslim	Horizon	Total
Yes	94 (34.18)	64 (23.27)	158
No	56 (20.37)	61 (22.18)	117
Total	150	125	275

Note: Percentage in parentheses

Table IX shows that knowledge about hygiene in pregnancy period perspective Muslim community is (34.18%) and Horizon community is (23.27%). Knowledge about hygiene in pregnancy period perspective Muslim community is ahead of Horizon community.

Table X
Types of Latrine by Use of the Participants

Types of Latrine	Muslim	Horizon	Total
Sanitary	135 (49.09)	78 (28.37)	213

Unsanitary	15 (5.45)	47 (17.09)	62
Total	150	125	275

Note: Percentage in parentheses

Table X shows that types of latrine by use perspective Muslim community are (49.09%) and Horizon community is (28.37%). Types latrine by use perspective Muslim community is ahead than that of Horizon community.

Table XI

Have Any Knowledge to Get Proper Diagnosis in Pregnancy Period of the Participants

Knowledge to Get Proper Diagnosis in Pregnancy Period	Muslim	Horizon	Total
Yes	77 (28.00)	58 (21.09)	135
No	73 (26.55)	67 (24.36)	140
Total	150	125	275

Note: Percentage in parentheses

Table XI shows that knowledge to get proper diagnosis in pregnancy period perspective Muslim community is (28.00%) and Horizon community is (24.36%). Knowledge to get proper diagnosis in pregnancy period respective Muslim community is ahead than that of Horizon community.

Table XII

Any Checkup or Vaccination in Pregnancy Period of the Participants

Checkup or Vaccination	Muslim	Horizon	Total
Yes	99 (36.00)	90 (32.73)	189
No	51 (18.55)	35 (12.72)	86
Total	150	125	275

Note: Percentage in parentheses

Table XII shows that any checkup or vaccination in pregnancy period perspective Muslim community is (36.00%) and Horizon community is (32.73%). Any checkup or vaccination in pregnancy period perspective Muslim community is ahead than that of Horizon community.

Table XIII

Knowledge about Safe Delivery and Maternity of the Participants

Place of Delivery	Muslim	Horizon	Total
Govt. Hospital	80 (29.09)	53 (19.27)	133
Mother and Child Welfare Center	31 (11.27)	39 (14.18)	70
Private Hospital	20 (7.27)	10 (3.64)	30
Own Home	19 (6.91)	23 (8.37)	42
Total	150	125	275

Note: Percentage in parentheses

Table XIII shows that knowledge about safe delivery and maternity maximum go to Govt. hospital Muslim community is (29.09%) and Horizon community is (19.27%). Knowledge about safe delivery and maternity perspective Muslim community is ahead than that of Horizon community.

Table XIV
Using Family Planning Methods by the Participants

Patterns of Family Planning Methods	Muslim	Horizon	Total
Permanent	56 (20.36)	49 (17.82)	105
Temporary	79 (28.73)	56 (20.37)	135
None	15 (5.45)	20 (7.27)	35
Total	150	125	275

Note: Percentage in parentheses

Table XIV shows that using maximum temporary family planning methods perspective of Muslim community is (28.73%) and Horizon community is (20.37%). Using family planning methods perspective Muslim community is ahead than that of Horizon community.

Table XV
Have Any Communal Destitution to Get Healthcare Facilities of the Participants

Communal Destitution to Get Healthcare Facilities	Muslim	Horizon	Total
Yes	62 (22.55)	73 (26.55)	135
No	88 (32.00)	52 (18.90)	140
Total	150	125	275

Note: Percentage in parentheses

Table XV shows that communal destitution to get healthcare facilities perspective Muslim community is (22.55%) and Horizon community is (26.55%). Communal destitution to get healthcare facilities perspective in some cases Horizon community is destitute by the Muslim community people.

Discussion

Purpose of the study was to explore and compare awareness of safe motherhood patterns status attainment between Muslim and Horizon communities in the Rajshahi metropolitan city of Bangladesh. Awareness of safe motherhood patterns status attainment of Muslim community people was higher than the Horizon community people. Occupational status attainment of the Muslim is batter than Horizon community. The findings of study suggest that there were significant differences in awareness of safe motherhood patterns status attainment, occupation and income and others some variables between the Muslim and Horizon community in the study area. In addition, these variables of awareness of safe motherhood patterns attainment were significantly related to each other. Previously the author formulated four hypotheses:

(1) Awareness of safe motherhood attainment of the Muslim community is higher than that of Horizon community in the Rajshahi metropolitan city of Bangladesh.

(2) There are positive significant relationships between awareness of safe motherhood knowledge on healthcare attainment and well healthcare of mother and child on Muslim and Horizon communities in the study area.

(3) Better quality of safe motherhood knowledge enhances the better quality of healthcare outcomes of mother

and their child.
(4) Well Knowledge of safe motherhood people is very much conscious about various diseases, cured system and prevention than illiterate people of the study area.
However, the findings of the study confirm the hypotheses previously determined in the study area.
In order to examine and compare the hypotheses 275 respondents (Muslim =150 and Horizon =125 participants) from the three villages, Hetem Khan Pan Bahar, Methor Para and Karigar Para, ward no. 11 under the Rajshahi City Corporation in Boalia Thana(Police Station), Bangladesh, were randomly selected by cluster sampling . The selected respondents were singly interviewed with semi-structural questionnaire method. The finding of the study suggest that there were significant differences in awareness of safe motherhood patterns of participants on mother and child healthcare outcomes and also various socio-economic attainment were significantly related to each communities people. However, the findings of the study confirm the hypotheses previously settings in the study area. Awareness of safe motherhood patterns attainment of Muslim community was higher than that of Horizon community that was 54.55% and 45.45% respectively. There were 86.43% Muslim and 73.55% Horizon community were argued positive significant relationships between awareness of safe motherhood patterns on mother and child healthcare outcome attainment in the study area. There were 82.75% Muslim and 69.28% Horizon community people expressed their opinion that better quality of awareness of safe motherhood knowledge enhances the better quality of mother and child healthcare outcomes. There were 75.54% Muslim and 66.35% Horizon community people deeply believed that safe motherhood awareness people are very much conscious about various safe motherhood diseases, cured system and prevention than unawareness people of the study area.

Conclusion and Recommendations

Awareness safe motherhood patterns status attainment of Muslim and Horizon communities are the significantly correlated. People of the two communities were said that the knowledge of safe motherhood education positively influences over mother and child healthcare facilities and attainment not only occupy certain statuses and prestige in the family and the community but also meet human needs and solve familial problems faced in a particular socio-cultural environment. In order to compare awareness of safe motherhood patterns status attainment, including education, occupation, awareness of safe motherhood knowledge and income in this study Muslim and Horizon communities were considered. The results of the study are supported by several studies conducted in abroad and Bangladesh. Based on these studies' findings the present study argues that inequality, deprivation and dominance between the two communities influence variations among the awareness of safe motherhood patterns status attainment in the study area. Further cross-cultural study should conduct on how inter-community relations of Bangladesh influence their awareness of safe motherhood patterns status attainment.

1. Government and policy maker should made a holistic syllabus up from the class one can be framed out to give suitable information about awareness of safe motherhood knowledge , healthy habits, medicine and uses of indigenous locally herbs etc.
2. All women have access to contraception to avoid unintended pregnancies.
3. All pregnant women have access to skilled care at the time of birth.
4. All those with complications have timely access to quality emergency obstetric care.
5. Government should ensure in getting awareness of safe motherhood and healthcare attainment of the given communities.
6. Government should be given extra priority towards Horizon community on safe motherhood education and health related activities attainments.
7. Non-Government organization should be conscious as minor Horizon community primary diseases of the study area.
8. Local and national leaders should be taken necessary steps to change their fait and luck through given proper safe motherhood educational and health related scheme of Muslim and Horizon community.
9. Various workshop and training program should be arranged to make them conscious and enable to prevent their safe motherhood and children daily diseases through proper and working education.
10. Ensure the proper schooling and healthcare attainment between the Muslim and Horizon communities.
11. Improve and provides the community healthcare facilities by the Bangladesh Government.
12.Community people should awareness about basic and universal safe motherhood education and healthcare

knowledge and
13. Finally electronic and print media can play a vital role to ensure the awareness of safe motherhood knowledge through their different health conscious programs.

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Appendix One

Births and deaths

Period	Live births per year	Deaths per year	Natural change per year	CBR[1]	CDR[1]	NC[1]	TFR[1]	IMR[1]
1950-1955	1 963 000	852 000	1 111 000	48.3	20.9	27.4	6.36	165.0
1955-1960	2 252 000	921 000	1 332 000	48.2	19.7	28.5	6.62	156.5
1960-1965	2 560 000	994 000	1 566 000	47.5	18.4	29.1	6.80	151.2
1965-1970	2 950 000	1 090 000	1 860 000	47.3	17.5	29.8	6.91	144.4
1970-1975	3 193 000	1 847 000	1 346 000	46.5	26.9	19.6	6.91	175.6
1975-1980	3 381 000	1 153 000	2 229 000	44.7	15.2	29.5	6.65	138.3
1980-1985	3 670 000	1 151 000	2 519 000	42.4	13.3	29.1	5.99	122.5
1985-1990	3 767 000	1 115 000	2 652 000	38.1	11.3	26.8	5.02	104.4
1990-1995	3 709 000	1 057 000	2 653 000	33.3	9.5	23.8	4.10	90.6
1995-2000	3 598 000	986 000	2 612 000	29.1	8.0	21.1	3.41	73.8
2000-2005	3 432 000	934 000	2 498 000	25.4	6.9	18.5	2.87	59.3
2005-2010	3 107 000	905 000	2 202 000	21.5	6.3	15.2	2.38	49.0

[1] CBR = crude birth rate (per 1000); CDR = crude death rate (per 1000); NC = natural change (per 1000); TFR = total fertility rate (number of children per woman); IMR = infant mortality rate per 1000 births

Source: Demographics of Bangladesh from Wikipedia, the free encyclopedia.

Bangladesh Demographic and Health Survey

Indicator	1993-1994	1996-1997	1999-2000	2004	2007	2011
Total Fertility Rate(TFR) 15-49	3.4	3.3	3.3	3.0	2.7	2.3
Contraceptive Prevalence Rate(CPR)						
Any method	44.6	49.2	53.8	58.1	58.8	61.2
Any modern method	36.2	41.6	43.4	47.3	47.5	52.1
Pill	17.4	20.8	23.0	26.2	28.5	27.2
IUD	2.2	1.8	1.2	0.6	0.9	0.7
Injectables	4.5	6.2	7.2	9.7	7.0	11.2
Condom	3.0	3.9	4.3	4.2	4.5	5.5
Female sterilization Male sterilization Implants Any traditional method	8.1 1.1 no 8.4	7.6 1.1 0.1 7.7	6.7 0.5 0.5 10.3	5.2 0.6 0.8 10.8	5.0 0.7 0.7 8.3	5.0 1.2 1.1 9.2

Source: Bangladesh Demographic and Health Survey 2011