

The Importance of Socializing Maternity Waiting Home in the Attempt of Reducing Maternal Mortality Rate in Wonogiri Regency

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Abstract: Maternal Mortality Rate (MMR) is still high in Indonesia compared with that in other ASEAN countries. One under-five age baby dies every three minutes in Indonesia. In addition a woman dies during giving birth or due to other pregnancy-related cause every one hour. Entering into delivery period is a critical period to pregnant women because any possibilities can occur before ending up safely or with death. Facilities and resource related to delivery place are determinants for parturient women. Generally, the decision to select medical treatment made in rural areas should be based on the elder relative or husband's decision. Thus, it results in to the delayed delivery help leading to fatality. Therefore, in Wonogiri regency, Maternal Mortality Rate (MMR) has been established in 2017, aiming to reduce Maternal Mortality Rate. However, socialization about Maternity Waiting Home has not been adequate; as a result the facility provided to poor people with high-risk pregnancy was utilized less maximally by the citizens.

1 INTRODUCTION

Indonesia is one of developing countries still finding difficulty in lowering Maternal Mortality Rate to achieve the specified target in MDGs 2015. Likewise, a half of global maternal death occurs in Ethiopia, with the expected maternal death risk of 470 per 100,000 live births (Shiferaw et al, 2013). Maternal death is concentrated in Africa and South Asia, simultaneously contributing 87% to the world's maternal mortality rate (Unicef Indonesia, 2012). Meanwhile Indonesian Demographic and Health Survey in 2015 shows that MMC in Indonesia is 305 deaths per 100,000 live births.

Maternal mortality and infant mortality is a health problem highly affecting the public health quality or degree and becomes indicator of a successful national development constituting the mutual responsibility of related sectors and health sector as the coordinator because healthcare service quality is the parameter of development performance in health sector, indicated with the achieved target of Standard Minimum Service in health sector (Ministry of Health, 2016).

World also pays special attention to the attempt of lowering MMC since the end of MDGs in 2015 and the enactment of SDGs. Fundamental change brought by SDGs is more comprehensive in nature compared with that brought by MDGs, only a half (50%) of it. The

commitment to lowering MMC and IMC has been mentioned globally in the target of Sustainable Development Goals (SDGs), that is, to reduce Maternal Mortality Rate to 70 per 100,000 live births.

Indonesian Maternal Mortality Rate is so far still the highest one compared with that of other ASEAN states, in 2007, when MMC is only 6 per 100,000 live births in Singapore, 33 in Brunei, 160 in Malaysia and Vietnam (Ministry of Health, 2015).

Currently many health development programs in Indonesia intended to solve maternal and child health problems. Basically, those programs emphasize more on the attempt of lowering infant and child mortality rate, gross mortality rate and maternal mortality rate. It can be seen from the result of survey showing insignificant decrease of Maternal Mortality (MMR) in the last two (2) decades.

Law Number 36 of 2009 has elaborated clearly that the responsibility for health development falls down to many parties, including Central Government through Health Office and its technical executive unit in the field. However, the responsibility has not been implemented well by government, for example, in the term of providing facilities, healthcare infrastructure to community, particularly at village level. It makes the problems the villagers face more complex.

Among uneducated mothers, only 15 percents of them give birth in healthcare facilities. This proportion increases over times with the increase of status education, in which 71 percents of mothers have medium-high education status. The proportion of delivery with trained health workers' help also increases with the increase of mothers' income and education status. In 2010, UN's General Secretary, Ban Ki-moon, launches Global strategy for women and children health. These goals involve more trained midwives, access to contraceptives and skillful maternal treatment, better nutrition, prevention of infectious disease and stronger community education. Indonesia, according to UNICEF, should focus more on entire approach system dealing with all components – human resource, education, health and nutrition, access to treatment, service quality, regulation and service standardization, government, and adequate level and funding targeting (Unicef Indonesia, 2012).

Another attempt taken to lower maternal and infant mortalities is to encourage every delivery to be helped with trained workers, obstetrician and gynecologist, general practitioner, and midwife, and to be conducted in healthcare facility. Childbirth assistance is a delivery service process starting from 1st to 4th term. This successful program is measured through indicator of percentage delivery in healthcare facilities.

Since 2015, the safe delivery has emphasized on the one with health workers' assistance in healthcare facility. Therefore, Ministry of Health's Strategic Plan of 2015-2019 establishes the delivery in healthcare facilities to be an indicator of maternal health effort, replacing the delivery by health workers (Indonesian Health Profile, 2016).

Wonogiri Regency's Health Office in 2017 has realized Maternal Waiting Home program. Maternal Waiting Home is a form of community-based health attempts constituting the place, house, or room to be used temporarily by pregnant women and those accompanying them (husband/cadre/dukun or other relatives) located close to healthcare facilities for several days waiting for delivery process until delivery time. The target of maternal waiting home is primarily pregnant women coming from the less accessible areas with high risk. This maternal waiting home is intended to get the healthcare access closer to pregnant, parturient, post-partum women and newborn (Indonesian Health Profile, 2016).

For that reason, this research aims to see how the process of socializing Maternal Waiting Home is in suppressing Maternal Mortality Rate in Wonogiri Regency. Recalling MMC of 105/100,000 live births or 13 per 12,376 live births in Wonogiri Regency in 2013, there is an increase compared with that in the last 4 years: 101.5/100,000 live births in 2012, 75.25/ 100,000 live births in 2011, 86.9/100,000 live births in 2010 and 98.88/100,000 live births in 2009. Compared with the national target in 2010 (150/100,000 live births), this figure has achieved the target. However, compared with the local target of 2012 (90/10,000 live births), it has not achieved the target (Health Profile of Wonogiri Regency, 2012).

Meanwhile, the theory used in this study was Parsons' structural functional theory. The fundamental functional requirement is any thing to be fulfilled by community or social system, in order to survive as a system and how these functions can be met (Johnsons, 1986).

Furthermore, basic assumption of Functionalistic theory is that community is a unity based on its members' agreement with certain values that can deal with difference so that the community is considered as a system integrated functionally into a balance. Thus, community is interrelated and interdependent social systems.

2 THEORETICAL

Kasnodihardjo (2015) and Willa (2014) [6] suggest that the role of dukun (indigenous medical practitioner) is still very desirable to the community. Kasnodiharjo's study found that in Bantul Regency despite high Human Development Index, dukun is still very desirable to the community to help delivery process. Similarly, Willa's (2014) study conducted in Manggarai found that maternal mortality is due to difficult access to healthcare service, pregnant women helped with dukun, and unavailable hospital at regency level. Aceh Tamiang's BPS (2013) states that in Aceh Tamiang 4.03 delivery is conducted with dukun's help. The result of a study conducted by Titaley, Hunter, Dibley & Heywood (2010) found that culture and belief, poor perception on village midwife's skill, economic difficulty and difficult access to healthcare facility are the factors leading the dukun bayi (traditional midwife) to remain to get place amid villagers. Even a study conducted in Niger by Yaya S et al (2017) found that 35.6% respondents stated that delivery facility is unnecessary, because of bad unusual transportation and high cost. Manuaba (1998) stated that delivery with dukun bayi's assistance often results in problems, ending up with death.

Milhan (2017) says that the factors causing maternal mortality in Indonesia are hemorrhage, eclampsia or gestational hypertension-related disorder, long partum, abortion complication and infection. Unexpected suddenly hemorrhage results in 28% maternal mortality. About 8,200 public health center (Puskesmas) have been available throughout Indonesia, but some of its health workers, particularly clinician or doctor, have not been available yet.

Meanwhile, Directorate of Maternal Health Building proved that maternal mortality is closely related to childbirth assistant and place/facility in 2010. The childbirth with health worker' help evidently contributes to the lowered risk of maternal mortality. Similarly, when the delivery is conducted in healthcare facility, the risk of maternal mortality will be minimized.

Ministry of Health keeps consistently implementing a policy stating that every delivery should be helped by health workers and supported to be conducted in healthcare facilities. Special Allocation Fund for Health Sector suggests that Puskesmas development should be

integrated into one package along with Health Worker's official residence (Indonesian Health Profile, 2016).

In high risk obstetric case in less accessible area and needing referral to hospital, mothers are expected to be close to healthcare facilities. In this case, Maternal Waiting Home (MWH) has an important function to be temporary residence for pregnant women until delivery time (WHO, 1996). Pregnant women detected to have high risk are recommended to dwell the maternal waiting home close to Poskesdes or Puskesmas Poned (Basic Emergency Neonatal Obstetric Services) (Ministry of Health, 2012). Meanwhile, pregnant women with high risk presumably will need special medical action during their delivery should be sent to maternal waiting home located close to Hospital.

3 METHOD

This research was conducted using descriptive qualitative and analyzed using qualitative data analysis. This research was conducted in Wonogiri Regency because this regency has had Maternal Waiting Home program. In Wonogiri Regency, 5 (five) sub districts have Maternal Waiting Home: Pracimantoro, Baturetno, Purwantoro, Wuryantoro and Wonogiri kota (Wonogiri City). This research was intended to the sub districts having Maternal Waiting Home (MWH) successfully undertaking MWH program with several patients using MWH being an indicator. In addition, we could choose the sub districts where their MWH programs do not work well. Thus, we chose 2 Puskesmas representing the sub districts based on the performance of MWH program. Puskesmas we chose were: Pracimantoro and Puwanto. The selection was conducted after we made mapping by conducting Focus Group Discussion (FGD) to explore the data on sub districts successfully running MWH program. In fact, from the result of FGD, it can be seen that Puskesmas successfully holding MWH program is Pracimantoro; beyond it, MWH program is not fruitful as expected. Data collection was conducted using in-depth interview method, in addition to using FGD. The result of in-depth interview was recorded on the notebook/. To complement the result of interview, recorder available in HP was also used to record the potentially missed result. In addition in-depth interview, observation was also conducted on the objects related to maternal and child health. Furthermore, the result of in-depth interview as analyzed using an interactive technique of analyzing data (Sutopo, 2002).

Meanwhile, the criteria used to select informant refer to Spradley's criteria, including: 1) the informants should come from the culture becoming the research setting, 2) the informants are participating directly in the culture studied during the research process, and 3) informants have adequate time to be interviewed (Spradley, 1997). The informants selected in this study were MWH users, family using MWH, midwife dealing with MWH, and pregnant women not using MWH.

4 RESULT AND DISCUSSION

4.1 Maternal Waiting Home in Pracimantoro

MWH existing in Pracimantoro got patients successfully based on the geographical location of Pracimantoro Sub District that is wide with hilly contour of land. It of course will lead to the high transportation cost to go from population's house to Puskesmas or hospital. Thus, to wait for childbirth process, people are willing to use MWH. Despite high cost, they keep using MWH facilities. It is in line with Atuoeye's (2015) study finding that transportation cost is a very important factor to pregnant women to utilize healthcare service, but they are willing to use transit home. Pracimantoro is the broadest area compared with other areas located in Wonogiri, with 14.412 km² width (7%), followed with Eromoko on the second rank with 12.035 km² (6.60%). However MWH is not established in Eromoko, so that the author focuses on Pracimantoro sub district only.

People's poor understanding on this MWH is indicated with pregnant women living in Pracimantoro accidentally not using MWH, and newly knowing MWH when we conduct FGD. From 10 informants we selected to be the participants of FGD, only 5 know the presence of MWH in their sub district.

Meanwhile, viewed from stakeholders' opinion, the Camat (head of sub district) of Pracimantoro said: "we hold monthly meeting to socialize all activities to be conducted and to evaluate the activities existing in the sub district in previous month, including the socialization about Maternal Waiting Home". Similarly, Puskesmas' clinician assigned in Pracimantoro, Dr. Dwi Candra, said that when pregnant women have their pregnancies examined in Puskesmas, they will be observed to find out whether or not they can be referred to MWH, and if they can be, midwife and clinician assigned in Puskesmas will consider to refer them to MWH in Pracimantoro. Based on this consideration, the pregnant women are required to have childbirth insurance or *Jaminan persalinan (JAMPERSAL)*, because every MWH users should have *Jampersal* fund, in order to absorb the fund that has been allocated from *Jampersal*. However, because this MWH program has been newly launched since 2018, only few people know MWH or even use MWH. The clinician or doctor in charge of managing Puskesmas Pracimantoro said that if there is no precondition of *jampersal* ownership to use MWH, many more pregnant women will be able to use it.



Figure 1 Maternal Waiting Home in Pracimantoro in 2018

4.2 Maternal Waiting Home in Purwantoro

Maternal Waiting Home (MWH) existing in Purwantoro has been newly established on April 2018, just like the one existing in Pracimantoro. The socialization about MWH has actually been conducted through midwives when they practice in Puskesmas so that most patients who have their pregnancy controlled have known the existence of MWH in their region. Or a midwife has often communicated the existence of MWH to another in their region. However, the constraint encountered in reaching inpatients is that most patients do not want to stay in MWH for a long time, and even they want to go home as long as they have given birth. There is a case where the patient that should be treated during delivery period with hypertension condition, instead should take care of the properties she leaved such as their cattle or children when they stay in MWH. Meanwhile, the inpatient regulation in MWH should instead reach the patients whose locations are far from Hospital and in high risk condition. The high risk condition of patients living in Purwantoro requires the direct referral to Hospital existing in Ponorogo due to more complete facilities and infrastructure there. For that reason, MWH existing in Purwantoro is used by patients very rarely because of its location too close to Ponorogo having hospital with more complete facilities compared with MWH with simple facilities. It is in contrast to Wild K et al.'s (2012) and Sundu S et al.'s (2017) studies finding that traveling distance correlates to the utilization of MWH. Wild's study found the increase in MWH utilization among people with less than 5 km distance, while those with more than 25 km distance tend not to use MWH.

The facilities existing in Purwantoro include, among others: 4 medical workers, 1 cleaning service officer, 3 patients' ward, 1 treatment room, and 1 guard room. In the treatment existing in MWH, the prioritized patients are those with *Jampersal*. It is in line with the objective of *Jampersal* to increase the number of childbirths in competent healthcare facilities and to lower the complication case in parturient and post-partum women, and newborns (RI's Ministry of Health, 2011). Thus, the constraint found in accessing the delivery with health workers' assistance in healthcare facilities can be deal with using *Jampersal* program. For example, in the case occurring in Pracimantoro, most pregnant women come to MWH have had BPJS so that they use MWH without getting food and beverage facilities, but those with *Jampersal* will get food and beverage facilities costing IDR 35,000. Although some facilities have been provided in such a way, people's interest in using MWH is still very low, as indicated with only 10 patients using MWH along the year. Parturient patients feel more comfortable to go to Hospital existing in Ponorogo with traveling time of 30 minutes only from Purwantoro.

4 CONCLUSION

The result of research showed that Maternal Waiting Home (MWH) existing in Pracimantoro has been acceptable to the community. It can be seen from more than 10 patients treated in MWH, despite only about 10 patients using *Jampersal* fund. Such condition is due to MWH use is intended to those having no any insurance, recommended to register to be patients with *Jampersal* insurance. In contrast to the condition of MWH existing in Pracimantoro, the MWH existing in Purwantoro has not been functioned as expected, because this region is closer to Ponorogo having more complete facilities than MWH. Thus, the MWH established has not worked as expected as the house used as the temporary shelter to patients with high risk.

REFERENCES

- Kemenkes RI., 2015. *Profil Kesehatan Indonesia 2014*. Kementerian Kesehatan Republik Indonesia. Jakarta.
- Undang-undang Nomor 36 Tahun 2009 Tentang Kesehatan. *Lembaran Negara republik Indonesia tahun 2009 Nomor 144*. 13 Oktober 2009. Jakarta.
- Kemenkes RI., 2010. *Profil Kesehatan Indonesia 2009*. Kementerian Kesehatan Republik Indonesia. Jakarta.
- Shiferaw S, Spigt M, Godefrooij M, Melkamu Y, Tekie M., 2013. *Why Do women Prefer Home Births in Ethiopia ?*. Bio Med Central 2013, 13-5.
- Unicef Indonesia., 2012. <https://lifestyle.kompas.com/read/2012/06/14/1729404/UNICEF.Kematian.Ibu.dan.Anak.Indonesia.Masih.Tinggi>
- Profil Kesehatan Indonesia Tahun 2016., 2017. Kementerian Kesehatan Republik Indonesia. Jakarta.
- Titaley, C.R, Hunter, C.L, Dibley, M.J & Heywood. P., 2010. *Why di Some women Still Prefer Traditional birth Attendants and Home delivery ? : A Qualitative Study on Delivery Care service in West Java Province, Indonesia*. BMC Pregnancy and Childbirth. 10-43.
- BPS Aceh Tamiang., 2013. *Statistik daerah Seruway. Aceh Tamiang*: BPS
- Yaya S, Amouzou A; Ekholuenetale M., 2018. Choosing Not to Give Birth at a Health facility in Nigeria : Where and Why ?. *Journal women's Reproductive Health*. 5 (2).
- Milhan, 2017. *Formula Baru Turunkan Kematian Ibu (Studi lapangan Kebidanan dan Kandungan Ke Vietnam*. Banjarmasin Post kamis 27 April 2017.
- Willa, Ruben Wadu dan Mading, *Majematang*. 2014 . *Determinan kesehatan Ibu dan anak di Kabupaten manggarai barat Provinsi Nusa Tenggara timur*. *Buletin Penelitian Sistem Kesehatan* Vol 17 No 3 Juli 2014
- Manuaba, I.G., 1998. *Ilmu Kebidanan, Penyakit Kandungan dan keluarga Berencana Untuk Pendidikan Bidan*, EGC. Jakarta.

- WHO. Maternity Waiting Homes: A review of experiences. *Geneva WHO [Internet]*. 1996;96(21):1–44. Available from: http://apps.who.int/iris/bitstream/10665/63432/1/WHO_RHT_MSM_96.21.pdf.
- Kementerian Kesehatan RI. 2012. *Pedoman Pelayanan Rumah Tunggu Kelahiran*, Kementerian Kesehatan. Jakarta :
- Dinas Kesehatan Kabupaten Wonogiri. *Profil Kesehatan Kabupaten Wonogiri 2012*. Dinas Kesehatan Kabupaten Wonogiri 2013.
- Atuoye KN, Dixon J, Rishworth A, Galaa SZ, Boamah SA, Luginaah I., 2015. Can she make it? Transportation barriers to accessing maternal and child health care services in rural Ghana. *BMC Health Serv Res [Internet]*.15 (1), 333. Available from: <http://www.biomedcentral.com/1472-6963/15/333>
- Kementerian Kesehatan Republik Indonesia. 2011. *Buku Saku Jampersal*. Pusat Promosi Kesehatan.
- Spardley, JP., 1997. *Metode Etnografi*. Terjemahan oleh : Misbah Zulfa Elizabeth, PT Tiara Wacana Yogya. Yogyakarta.
- Sutopo, H.B., 2002. *Metodologi Penelitian Kualitatif*. Surakarta, Sebelas Maret University Press.
- Johnson, Paul D., 1986. *Teori Sosiologi Klasik I*, Gramedia. Jakarta
- Wild K, Barclay L, Kelly P, Martins N., 2012. The tyranny of distance: Maternity waiting homes and access to birthing facilities in rural Timor-Leste. *Bull World Health Organ*. 90 (2), 97–103.
- Sundu S, Mwale OG, Chirwa E., 2017. Women ' s Health & Gynecology Scient Open Access Antenatal Mothers ' Experience of Staying in a Maternity Waiting Home at Malamulo Mission Hospital in Thyolo District Malawi : A Qualitative, *Exploratory Study*. 3 (1): 1–10.