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DECISION-MAKING MATERNAL IN MALAKA EAST NUSA TENGGARA: HOW DO THE DEMOGRAPHIC FACTORS?

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ABSTRACT

The Maternal and Child Health program receives special attention in health development efforts because women and children are the most vulnerable targets for morbidity and mortality. In some areas, it still shows high mortality cases. One of the provinces that has a high mortality rate in Indonesia is the Province of East Nusa Tenggara (NTT).

Keywords: Maternal mortality, WHO etc.

1. INTRODUCTION

The Maternal and Child Health program receives special attention in health development efforts because women and children are the most vulnerable targets for morbidity and mortality. Maternal death according to the World Health Organization (WHO) is the death of a woman during pregnancy or within 42 days after the end of pregnancy without regard to the duration and place of pregnancy due to anything related to or aggravated by pregnancy or handling of pregnancy, but not due to accident or injury[2,3,4,5]. Maternal mortality is an indicator of the degree of public health and an indicator of the quality of health services in general. MCH has also been established as part of the Sustainable Development Goals (SDGs), namely ensuring a healthy life and promoting welfare for all people of all ages, including reducing MMR and ending preventable infant and under-five mortality. The maternal mortality rate in Indonesia is still the highest in Southeast Asia and is still far from the global target of the SDGs to reduce the MMR to 183 per 100,000 births in 2024 and less than 70 per 100,000 births in 2030[5]. During 2018-2020, maternal mortality cases in Indonesia experienced a decline, from 4226 cases (in 2018) to 4197 cases (in 2019), but increased again to 4627 cases in 2020[3,4,5]. In some areas, it still shows high mortality cases. One of the provinces that has a high mortality rate in Indonesia is the Province of East Nusa Tenggara (NTT).

Factors that influence maternal decision-making are: Objectives, Knowledge, Attitudes, Environment, Socio-Cultural, The labor Guidance that Health workers must have competence according to WHO Labor Guidance, namely Empathy and respect – communicating courtesy, maintaining privacy and confidentiality, and showing respect, Providing support, encouragement, and reinforcement[6]. Decision-making is not an easy thing due to many factors that influence it. The more factors that support decision-making, the faster and more accurate the decision-making of families and health workers in referring, and vice versa. In general, these factors include biological, psychological, and socio-cultural factors. The impact of delays in decision-making on delivery assistance that is not appropriate and not following the procedure will have a fatal impact, such as the loss of the life of the mother in labor and the fetus that is born[5].

Apart from the central government making efforts to reduce MMR, local governments are also making the same effort. In particular, the Demak District Government has established policies to reduce MMR, such as by increasing the number of community health centers and midwives in remote villages, placing midwives in villages, establishing GSI (Gerakan Sayang Ibu), Tabulin (Savings for Maternity Mothers) in each region. along with her husband on standby and the midwife on standby. From the program in 2007, the number of antenatal visits was good, namely K1 and K4 reaching the target as well as delivery and neonatal coverage.

2. METHOD

This study is a qualitative study that uses in-depth interviews, Focus Group Discussions (FGD), observations, and field notes, regarding decision-making on maternity care at the family level in a matriarchal/matrilineal culture in Malacca District, NTT province. This study uses an ethnographic approach. Qualitative analysis according to Spradley[7] through four stages of analysis, namely domain analysis, taxonomy, componential analysis, and cultural theme analysis. Participants among women giving birth in Malacca Regency, NTT province were 37 participants. The variables characteristic of maternity mothers include age, education, occupation, parity, financing, social support, access to health facilities, choice of place and birth attendant, decision-making for maternity care, delivery of health facilities, delivery of non-health facilities, and delivery), Postpartum/postpartum care, Traditional delivery practices, Birth position, Costs, Perceptions of the quality of health services, Maternal care, and postpartum mothers with a Timorese cultural

3. RESULT

The results of the study show the distribution of the characteristics of the informant Maternity in the Malacca District

Table 1 Distribution of Informant Characteristics of Maternal Maternity

No	Informant Characteristics	Total	%
1	Age of Maternal Maternity (years)		
	< 20	7	18.9
	20 – 24	5	13.5
	25 – 29	14	37.8
	30 – 34	5	13.5
	35 – 39	4	10.8
	40	2	5.4
	Total	37	100
2	Maternal age at risk and not at risk		
	20 - 35 (No risk)	24	64.9
	< 20 and 40 (at risk)	13	35.1
	Total	37	100
3	Husband's age		
	< 20	7	18.9
	20 – 24	4	10.8
	25 – 29	15	40.5
	30 – 34	5	13.5
	35 – 39	4	10.8
	40	2	5.4
	Total	37	100
4	Length of household (years)		
	1 - 5	21	56.8
	6 – 10	9	24.3
	> 10	7	18.9
	Total	37	100
5	Number of children		
	1 – 2	18	48.6
	3 – 4	7	18.9
	>4	12	32.4
	Total	37	100

Primary Data: 2021

Based on the results of the study, it was found that the characteristics of informants for maternity mothers were almost half of the mothers aged 25-29 years as many as 14 (37.8%), Maternal Age at risk as many as 13 (35.1%) and no risk as much as 24 (64.9%). Meanwhile, for husbands of mothers who gave birth, almost half were aged 25-29 years as many as 15 (40.5), for the length of household mostly 1 year - 5 years as many as 21 (56.8%), As for the number of children almost half had 1-2 children as many as 18 (48.6%).

Table. 2 Distribution of Informant Characteristics of Maternal Maternity

No	Informant Characteristics	Total	%
1	The educational level of Maternal Maternity		
	Basic	26	70.3
	Middle	9	24.3
	High	2	5.4
	Total	37	100.0
2	Husband's education level		
	Primary	19	51.4
	Middle	13	35.1
	High	5	13.5
	Total	37	100.0
3	Employment Maternity mother		
	Not working	25	67.6
	Labor	2	5.4
	Farmers/Fishermen	2	5.4
	government employees	1	2.7
	Private	3	8.1
	Self	2	5.4
	Others	2	5.4
	Total	37	100.0
4	Employment of Husband		
	Not working	2	5.4
	Laborer	4	10.8
	Farmers/Fishermen	22	59.5
	government employees	2	5.4
	Private	4	10.8
	Self	2	5.4
	Others	1	2.7
	Total	37	100.0

Primary Data: 2021

Based on the results of the study, it was found that the characteristics of informants for the education level of maternity mothers were found to be almost half of mothers giving birth with 26 (70.3%) elementary education levels, 9 secondary education levels (24.3%) and the level of Higher Education was 26 (70.3%). Meanwhile, the education level of husbands who gave birth was found to be almost half of the husbands of mothers who gave birth, the level of Basic Education was 19 (51.4%), the level of Secondary Education was 13 (35.1%) and the level of Higher Education was 5 (13.5%). As for the work of maternity mothers, 25 (67.6%), labor 2 (5.4%), farmer/fisherman 2 (5.4%), government employees1 (2.7%), private sector 3 (8 ,1%), Self-employed 2 (5.4%), Others 2 (5.4%), While the work of husband and mother in labor found not working 2 (5.4%), Labor 4 (10.8%), Farmer/Fisherman 22 (59.5%), ASN/TNI/POLRI 2(5.4%), Private 4 (10.8%), Entrepreneur 2 (5.4%), Others 1 (2.7%)

Delivery Aid Decision Making and Postpartum Care at the family level in the matrilineal culture of the Malacca District.

Based on the results of the study, the factor that contributed to the biggest decision-maker in the family for seeking delivery assistance and postpartum care and postpartum care was the wife followed by a decision with the family or provide a vehicle if the mother and family decide to give birth in a health facility and accompany and accompany the mother to carry out delivery care at a health facility. Meanwhile, the roles of family and other family relatives when a mother gives birth include: preparing hot water, cloth, and all the necessities needed during the delivery process. As excerpts from this interview:

> *"Mama, kakak perempuan dan saudara lainnya siap aer (air) panas, untuk saya mandi dan kasih mandi ade mea (bayi baru lahir) kalau sudah lahir… kalo saya punya suami membantu panggil mama dukun, cari mama kader atau jemput ibu bidan, kalau mau lahir di puskesmas atau rumah skait maka, atau suami cari oto untuk kami pi (pergi) rumah sakit. (P1). (by Bahasa)*
>
> *"Mama, older sister and other siblings are ready for hot water (water), for me to take a bath and give me a bath ade mea (newborn baby) when it is born… if I have a husband to help call a dukun, look for a cadre or pick up the midwife, if you want to be born at the community health centers or hospital, or your husband will find a car for us to go to the hospital. (P1).*

The birth process carried out by the shaman is: praying, as quoted below:

"Saya mohon doa pada Nai Maromak (Tuhan) dan memohon doa leluhur untuk bantu hamba agar persalian yang akan hamba tolong berjalan lancar, ibu dan anaknya sehat selamat" (P2) (by Bahasa)

"I ask for prayers to Nai Maromak (God) and ask for the prayers of the ancestors to help me so that the delivery that I will help goes smoothly, the mother and child are healthy and safe" (P2)

4. DISCUSSION

According to education, both wife's and husband's education shows an inverse relationship, where in families with low levels of education the person who makes the most decisions in seeking delivery assistance and postpartum care is the wife, while in families with higher education levels it is the husband. Likewise, the role of parents, the proportion who make decisions to determine delivery assistance and postpartum care for their children is more in families with a high level of education than in families with a low level of education. This may be caused by a situation where the level of family education does not directly influence the decision-making to determine delivery assistance and postpartum care, but it is related to the socio-cultural community and socio-economic conditions. The main source of family income shows that families whose main source of income comes from the husband or family decision-making by the wife and husband appear dominant, on the contrary, in families whose main source of income comes from parents/in-laws, the parents who dominate decision making in the family are parents. 80% more). The type of decision-making based on the main source of income or based on parties who contribute more in the economic field is also called the type of decision-making based on contributions. followed by a decision with the family. Decision-making by husband and wife is a type of unitary decision making, ie husband and wife act as a unit in making all decisions without speculating which party should act to make a decision[8]. Reinforced Studies exploring the dynamics between lineage and female autonomy have focused on specific dimensions of female autonomy. While it is important to understand the dimensions of women's autonomy, these dimensions are interdependent and when considered together would provide more insight into whether matrilineal lineage provides women with a greater degree of autonomy in household decision-making than patrilineal systems in general. That said, the literature strongly suggests constructing summary variables incorporating the various dimensions of women's autonomy[9]. The research by Fuseini & Sabiti (2016) found that matrilineal women appear to be more independent concerning decisions about the number of children to have, seek health care and then mobilize women, enable them to access economic resources and provide them with support to challenge traditional norms that underlie gender inequality[10]. In addition, efforts to increase female autonomy must be designed to meet the specific needs of lineage groups, as different sets of factors influence female autonomy in different lineage systems. While there is evidence of matrilineal advantages across multiple domains of household decision-making, there is little empirical evidence of whether matrilineal lineages generally provide greater autonomy across multiple domains compared to patrilineal lineages.

At almost all levels of education and the economic level of the community, it is customary for parents to carry out the ceremony as an effort that is believed to be able to expel evil spirits and remove impurities from the body of a mother who has just given birth and it is believed that "tatobi and hatuka ha'I" can help. recovery of maternal health after childbirth, Constraints that shape the decision to seek care are factors involved in decision making (individual, spouse, sibling, family), the status of women, characteristics of the disease, distance from health facilities, costs, demographics and socio-culture (mother's age, length of marriage, education, and income). mother and husband, occupation and parity), previous experience with the health care system, and perceived quality of care[11]

The results of the study stated that the proportion of decision-makers in the family to seek delivery assistance and postpartum care and postpartum care according to socio-economic background is also one of the factors that influence decision making to seek delivery assistance and postpartum care, namely those who have higher income tend to have a higher contribution. more in decision-making to seek delivery assistance and postpartum care. The results of previous studies stated that economic status influences decisions to seek delivery assistance and postpartum care where the party who can pay the delivery costs is the party who makes decisions regarding the location of delivery[12,16,17,18]. Decision-making in determining delivery assistance and postpartum care show differences according to the length of the family, whether they have been married for 5 years or more. The proportion of wives who make decisions is greater (62.4%) than those whose marriages are not even 5 years old (37.6%). On the other hand, the proportion of parents/relatives and husbands who make decisions is greater for those who have been married for less than 5 years than those who have been married for 5 years or more.

Traditionally/culturally, most of the Timorese society, especially the Malacca community, adheres to the 'marriage-in' concept in which the husband enters and becomes part of the woman's family. The husband who does not have a permanent or independent job will live and work in his wife's family environment, working in the in-laws' fields. So often in everyday life husbands become just like guests or symbols. Even though he has a wife and children, because he lives and is economically supported by his parents, the decision-making is dominated by his parents/in-laws. On the other hand, families with stable incomes choose to live separately from their parents so that they have full authority in making decisions for their families. This can be seen more clearly if the husband concerned has not paid 'belis', namely the money or ransom that must be given by the male family to the female family. If the "belis" has not been paid, the husband does not have the 'Flak' to manage family affairs and make decisions in the family. Even in such circumstances the child who is born will be given the name "fam" of his wife and become part of his wife's extended family until the “belis” is paid[13, 14, 15, 16, 17, 18]. Although quantitatively the proportion of wives and husbands who make decisions to determine delivery assistance and postpartum care seems large the role of parents is greater. This is particularly evident during 'emergency' times when the mother needs immediate treatment and in the holding of traditional ceremonies after delivery. There is a custom when the gestational age is high, many wives return to their parents' homes to give birth in their hometowns. In Timorese society (as well as other regions of NTT) it is known that there are several ceremonies that a mother must go through after giving birth, namely bathing using hot water (tuhik/tatobik) and heating on coals (hatuka ha'i). Decision-making is based on the experience of their ancestors and the experience that has been received by the family from generation to generation. A family is a group of individuals who are related to each other emotionally, cognitively, and behaviorally through shared commitments regardless of legal, sexual orientation, gender, or physical attachment[19], the family is a unique unit because it consists of members who come from different generations with needs are different too. Decision (decision) is the behavior of choosing between two or more alternative Actions[20]. Decisions always require different behavioral choices. Family decision-making is a complex, situational and dynamic process that needs to be understood as a unified whole As for decision-making, it can cause disturbed feelings or psychological stress because every decision carries a risk for the recipient of the decision and the decision-maker, stress conditions[22,23,24,25,26, 27,28] can occur due to new situations in the decision-making process. Families are faced with several decisions, including the selection and utilization of maternal health care facilities. Decision-making is an unavoidable daily process. Family decision-making is a process that can be filled with tension, very enjoyable, and rewarding. In the decision-making process, families can overcome differences among members[29]. If the family is trapped in a psychological disorder in the study, it can cause psychological stress due to new situations and burdens[30,31,32]

5. CONCLUSION

- The education of the wife and husband shows an inverse relationship, where in families with low levels of education people make the most decisions in seeking help wife in labor and postpartum care is the wife, while in families with a higher education level the husband is the husband.
- Culture makes a very large contribution to maternal decision-making in choosing delivery assistance.

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