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WOMEN'S AUTONOMY TO IMPROVE QUALITY OF MATERNAL HEALTH By Hilmi Yumni

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Innovative Journal of Medical and Health Science 6: 6 November – December (2016) 171 – 175. Contents lists available at www.innovativejournal.in INNOVATIVE JOURNAL OF MEDICAL AND HEALTH SCIENCE Journal homepage: http://innovativejournal.in/ijmhs/index.php/ijmhs Research Article WOMEN'S AUTONOMY TO IMPROVE QUALITY OF MATERNAL HEALTH Hilmi Yumni1, Fendy Suhariadi2, Oedojo Sudirham3 1Doctoral Degree Programs, Faculty of Public Health, Airlangga University, Surabaya Indonesia 2Faculty of Psychology, Airlangga University, Surabaya Indonesia 3Faculty of Public Health, Airlangga University, Surabaya Indonesia ARTICLE INFO ABSTRACT Corresponding Author: Background: Reducing the number of maternal mortality ratio (MMR) in Hilmi Yumni Indonesia has one of the targets of Sustainable Development Goals that Doctoral Degree Programs, Faculty of launched in 2015-2030. Surabaya, as one of the biggest cities in Indonesia Public Health, Airlangga University, has still recorded have highest MMR, such an ironic for a city with adequate Surabaya Indonesia resources and facilities. Late in making the decision has been noticed as ags158@yahoo.com indirectly caused. Social dimension of pregnant women is one caused to be resolved, that is the women's ability to take decision for herself or called Key words: Women's autonomy, women's autonomy. Objectives: The purpose of this study was to explore maternal health, decision making. women's autonomy in improving quality of reproductive health in the family. Methods: The method used qualitative with obtaining information through indepth interview. Participants were pregnant women in the work area of Puskesmas (Health Center) South Krembangan Surabaya as many as 15 (fifteen) participants who were selected by purposive. Results: This DOI:http://dx.doi.org/10.15520/ijm study resulted four (4) topics, namely decision making at the household hs.2016.vol6.iss6.143. level,

women’s independence to access financial resources, women’s independence in mobility, women's decision making related to maternal health. The 4th (fourth) topics consisted three (3) meanings, namely women's autonomy to implement antenatal care, women's autonomy over delivery planning and women's autonomy to deal with emergency situations during pregnancy. Based on the discussion showed understanding that conservative culture, social construction, gender biased and strong patriarchal ideology conditioned women became dependent, determined and controlled by the authorities, in this case family, the husband and parents. Conclusion: The proposed recommendations were creating efforts for men’s involvement who can improve maternal health started since early adolescent reproductive processes and made education improvement programs and women’s empowerment programs to increase credible women's autonomy. INTRODUCTION Improvement on maternal health has become a part of Sustainable Development Goals which prevailing in 2015-2030. Indonesia is a country in Southeast Asia that have failed in achieving the target to reducing maternal mortality ratio (MMR). MMR which was based on the result of Indonesia Demographic Health Survey (IDHS) in 2012 increased significantly by 359 per 100.000 live-births.1 Surabaya city has still recorded to have the highest MMR in East Java Province. In 2014, MMR in Surabaya reached 39 cases. Meanwhile, until September 2015 there were 32 mothers died due to childbirth. The Local Government of Surabaya’s had trying to overcome this issue and resulted in decreasing number of maternal mortality, and by 2013, MMR in Surabaya reached 60 cases.2 The causes of maternal mortality can be categorized as direct and indirect. The direct caused was mostly pre eclampsia (34.88%). Indirect caused including late to hospitalized (13.64%), late to take decision (22.73%) and late detected (40.91%).3 A high MMR described the condition of less favorable maternal health for women. The problem on high MMR was not only involved medical events but also social events. The phenomenon existed was pregnant women with late handling complication due to waiting for her husband. It showed that the women’s reproductive rights are still under controlled by husband. Husband played important role, 171 especially in decision making related to his partner’s reproductive.4 The existence of women was often positioned as second being thus she had no right to argue or take decisions, even those concerning the right for herself, she had no authority.5 The results showed that the strength factor in decision making played important role towards improvement of maternal health.6 The phenomenon often seen is that family faced problems in making important decision concerning maternal health like hospitalizing bleeding women to the health facilities and giving medical treatment’s approval for urgent treatment. Seeing the social phenomena, the low involvement of women in decision making towards maternal health could lead to her death. Changes in women's behavior was mediated by their acquisition towards autonomy (independence). Self autonomy or women’s empowerment in general was conditioned by gender stratification and authority of the social patriarchy in which they live, in addition the education also could improve the independence or women’s autonomy .7 This study aimed to explore women's autonomy including the ability of pregnant women to make good decisions related to decision making at the household level, women's ability to access to financial resources, mobility and decision making to improve women's reproductive health. METHODS This study used qualitative approach with phenomenological approach. Participants in this study were 15 women with criteria: pregnant women, ever do antenatal care in health facilities and have a household. This study took place in work area of Puskesmas Krembangan

Selatan Surabaya with reason of choosing was the existing cases of maternal mortality, not yet achieved target on visit coverage of pregnant women to Puskesmas, and based on data from the Head of Puskesmas and Midwife Coordinator on Maternal and Child Health (MCH) that the factors affecting maternal mortality and not achieving target on visit coverage of pregnant women were late decision making by women, socioculture that considered taboo for doing antenatal care less than 3 months. Initial survey found that as much 62% of the decision made if there was something related to pregnancy, was decided by the husband, 30% decided by the family and 8% decided by woman herself. The study was conducted in January-February 2016, by providing informed consent to participants and applying the ethics principles namely privacy, anonymity, confidentiality and protection from discomfort during study. Data collection technique used indepth interview. The instrument used in collecting data was the authors themselves. Interviews' supporting tools were interview's guideline, field notes and tape recorder. Data analysis used a cyclic approach, meant to conduct since the initial data collection up to the stage of writing report and drawing conclusions. Data analysis stage included data reduction, data presentation and drawing conclusions. RESULTS AND DISCUSSION Participants Characteristics Table 1. Characteristics Distribution of participants in Puskesmas Krembangan Selatan Surabaya in January- February 2016. Variabel n % Age < 25 years 25 – 35 years 9 6 40 60 Education SD (Elementary School) SMP (Junior High School) SMA (Senior High School) PT (University) 4 2 9 - 27 13 60 - Occupation Occupied Not occupied 3 12 20 80 Ethnic Javanese Madurese 8 7 53 47 Pregnant Status Primigravida Multigravida 3 12 20 80 Antenatal care Regular Irregular 12 3 80 20 Resident Status Rent Live with parents 12 3 80 20 Total 15 100 Table 1 explained that from 15 participants were mostly classified as healthy reproductive age, high school graduates, do not have occupation, some are Javanese and some Madurese, mostly (80%) rented house, multigravida and visit antenatal care regularly. Results of the study have found some topics to be discussed as follows: Decision Making at Household Level The process of decision making at household level was made through collaboration, compromise and persuasion, often involving variably negotiation. The decision making in this case included two domains: treatment of sick children and household purchased .8 Decision making is one of social power indicators which dominant in the family and based on legitimized power. Some of family members, the husband / father has prerogative to make more decisions related to women necessities. In normative, patrilineal social structure illustrates man has a prominent position and role in the family and household .7 The results showed that from 15 participants, the decision makers at the household level were mostly the husband / father, while a small portion decision makers were women through discussion process and agreed together. It was consistent with the statement of the participants as follows: "…….household's necessities was all submitted to husband ....." (P1, P2, P3, P4, P5, P7, P8, P12, P13, P15). For participants who making decision process together, were expressed their statements as follows: "…… discussed it with husband and parents or in-laws ....." (P6, P10, P11.) The results of literature studies explained that the dominant decision maker in the family is husband, even though during the process there is input from wife or grandfather / grandmother, men are more dominant in decision making.7 Women's Ability or Independence to Access Financial Resources Access to financial resources is a central dimension when measuring the position of female gender on the improvement of maternal health.9 The realization of gender equality in the family are the access and control.10 Access is the ability to use the resources fully active and productive. Control is the capacity of men and women to have the same controls on the use of

family resources. The results showed that from 15 participants were mostly housewives. The ability to access financial resources and to control were still low. It was consistent with the statement of the participants as follows: "……..I am not working, so I should get husband permission whenever having activities that need money....." (P1, P2, P3, P6). "……delivery plan is also decided by husband, because it involves the cost ....." (P2, P3, P6, P7). "……medical treatment of children and wife also decided by husband....." (P2, P4, P6, P7). A small number of participants had balanced control as expressed statements by participants as follows: "……family's expenses is agreed together with husband ....." (P6, P10, P11). For working women participants had direct access to livelihood, since she had same income thus had authority on productive aspect. Occupation related to the dimension of women's autonomy in terms of financial control.11 Revenue was considered as the most important predictor towards women status in the household.12 Family profiles which hold dominantly more by husband would plant the family with values and traditional attitudes towards the role of marriage. Higher income from husband impacted on more financial strength possessed by husband in the family, in contrary, if the husband's income was less, then wife could participate in the family's decision making.7 Based on the above explanation, it can be concluded that the ability of women to access financial resources for the improvement of maternal health are influenced by occupation, income and position of women in the family Women's Ability or Independence in Mobility The ability of mobility means that women are free to interact with others.13 Women's mobility can be a barrier to women's access to maternal health services, like to utilize health services for antenatal care.8 The results showed that pregnant participants had limitation in mobility and ability or lack of mobility independency. The mobility were travel to visit friends, relatives, meet the needs of household appliances, do antenatal care, take children for medical treatment. It was as expressed by the participants as follows: "……husband will accompany to check pregnancy, if he cannot accompany then the schedule is postponed ...." (P1, P2, P3). "……traveling will not be allowed by husband if there is no one accompany....." (P1, P2, P3). "……afraid to travel alone because afraid if something happen to the baby ... ." (P1, P2, P3, P4, P5, P6). Limitations of women's mobility is also due to cultural restrictions imposed on women due to permission necessity when women are away. Empirical studies showed that education and occupation were related to the mobility autonomy. Women with higher education have more mobility autonomy than those who have low education.11 Women who occupied have the freedom on mobility than those who do not.14 Women's Decision Making on Maternal Health Maternal health in the family is a shared responsibility of men and women as a married couple. Husband and wife should support each other in maintaining and improving maternal health. Decision making in maternal health is influenced by family's dynamics, socioeconomic and response to stress. Culture plays an important role as a determinant of the maternal health quality in the family. 15 Qualified family is a form of synergy between the role of husband (male) and wife (female). Women as partner in domestic relationship, working together in an equal and balanced relationship. In other words, women have equal role in establishing qualified family.16 Maternal health which described, among others, utilization of antenatal care and delivery planning: a. Women's Autonomy Towards implementation of Antenatal Care The results showed that almost all pregnant women who come to Puskesmas were accompanied by his family, 50% accompanied by husband and 50% by relatives like mother, father, brother and neighbors. It was consistent with the statements of the participants as follows: "....I am afraid there is something happen on the way if no one accompany...."(P1, P2, P3, P4, P5, P6). "......husband will not allow if I go checking alone, there must

be someone to accompany...." (P1, P2, P3). Members of family who accompany wife to check pregnancy were not involved and not getting involved in checking pregnancy process, it was proven when a wife delivering baby, her family preferred awaited in the waiting room or outside Puskesmas. Decision of pregnant women coming to Puskesmas to do antenatal care showed that 73% (11 participants) made by their own, because it was necessary, 13% (2 participants) made at the will of the husband, and respectively 7% (1 participant) made by their family and health officers. The conditions is commonly found in pregnant women with low risk pregnancies. It is contrast with pregnancy experienced by high risks and very high risks groups. Women's autonomy in doing antenatal care's content as fulfilling the needs of balanced nutrition, pregnancy exercise activity, immunization, vitamin consumption, based on this study showed that most women had the independency to regulate such needs and activities by communicating it to their husband and their parents, especially mothers. It was consistent with the statement of the participants as follows: "……..husband gives advice to eat a nutritious food for the sake of the children conceived...." (P1, P5, P6, P7, P8, P11, P14). "……..husband supports to do pregnancy exercise ....." (P1, P2). "……..husband notified and will surely support....." (P2, P3, P4). "……husband always reminds to take medicine" (P4, P8, P11). In the Eastern World's Community, the parents, especially mothers still have an influence on the reproductive health needs of her daughter, both in pregnancy and delivering baby. It was consistent with the statement of the participants as follows: "……"having discussions with mother on maternal prenatal care .....". b. Women's Autonomy on Childbirth Planning The ultimate purpose of antenatal care is to have safe and healthy delivering baby for moms.17 One of antenatal care's content is childbirth plan decision, either the place or health officer who will assist, as written on the P4K's sticker (Childbirth Planning and Complication Prevention Program).18 The results showed that most of participants' decision as many as 13 participants (87%) delivered baby were made by husband which agreed by wife, while 2 participants (13%) made together by husband and parents. One of the women's reproductive health rights is that woman has right to decide when to deliver baby, how many children they want to have and how long the distance of each child born. Most women do not have autonomy, control and power on her body and weak bargaining position in decision making, whereas they owned their body, but it was just as medical body. Participants' opinion which mostly agreed that husband as decision maker were likely caused by social construction and cultural towards gender's patterns. The husband had a big responsibility, and as the main breadwinners who have to work hard. Wife had bigger role in the domestic sphere as childcare and household chores day. Economic dominant of men which is translated into male power has driven women into the position as the second person who is less important than the males.19 c. Women's Autonomy in Dealing Emergency Situations in Pregnancy Every pregnancies face death risk.20 It should be understood by every pregnant woman, like a complication, for example pre eclampsia, which can arise in the last trimester of pregnancy, where in early pregnancy was not found the signs but in the pregnancy developing process having complications can increase maternal mortality.21 The decision making on pregnancy condition with complications or problems, according to study results showed that most participants submitted it fully to the family, in this case the husband, then parents, especially mother. Pregnant women did not dare to decide for herself, for example the need to take treatment and urgent visit to health facilities for antenatal care. It was consistent with the statement of the participants as follows: "……..i called my husband and waiting for him to come....."(P3, P5, P11, P12, P15). "……..if my husband is not home, I go with mom....." (P4, P5, P6, P8, P13). A small number of

pregnant women took decision for herself when dealing with emergency situations in her pregnancy. It was consistent with the statement of the participants as follows: "……I can make my own decision when my husband is not home ....." (P2, P7, P9, P10). Strong dominant of patriarchal ideology in Eastern World's Community makes women are conditioned to depend, determined and controlled by other parties who considered have authorities.4 Women who have autonomy is women who has the ability to make and decide autonomously / independently related to her health problems.9 However, there are factors that affect women to have autonomy in maternal health as age, family structure, education, occupation, income, culture, religion and marriage.10,22,23 CONCLUSIONS Conservative culture on understanding the gender equality values which patriarchal has become an influenced factor that affect women's autonomy in improving the quality of women's reproductive health. The strong dominant on patriarchal ideology makes women become not autonomous. Pregnancy process and delivering baby are family development tasks which affected by sociocultural background of each individuals as partner, it contributes to how power relations are built between the couple and the family. REFERENCES 1. Saputra W. Angka Kematian Ibu (AKI) Melonjak, Indonesia Mundur 15 Tahun, Prakarsa Policy Review. 2013. 2. Hoelman MB, Parhusung PBT, Eko S, Bahagijo S, Santono H. Panduan SDGs untuk Pemerintah Daerah (Kota & Kabupaten) dan pemangku kepentingan daerah, INFID (International NGO Forum on Indonesian Development). 2015. 3. Dinkes Pemprov. Jatim. Laporan Profil Kesehatan Dinkes Propinsi Jawa Timur. 2013. 4. Palestin, B. Pemberdayaan Suami Melalui Reorientasi Dan Revitalisasi Gerakan Sayang Ibu. Jurnal Keperawatan Dan Kesehatan. 2006; 6(4) 5. Ruthven KK. Feminist Literary Studies: An Introduction. New York: Cambridge University Press. 1990. 6. Suwal J. Maternal Mortality In Nepal Unraveling The Complexity. Canadian Studies In Population. 2008;35(1): 1–26. 7. Syukri M. Model Pelatihan Ketrampilan Terpadu Untuk Peningkatan Dan Diversifikasi Sumber Pendapatan Masyarakat Pedesaan: Studi Pemberdayaan Masyarakat Petani Bersakal Rumah Tangga Di Desa Pesisir, Kabupaten Pontianak, Disertasi, Bandung: Pps UPI. 2005. 8. Mumtaz Z, Salway SM. Gender, Pregnancy And The Uptake Of Antenatal Care Services In Pakistan. Sociology Of Health & Illness. 2007; 29: 1-26. 9. Mason KO. Gender and Demographic Change: What Do We Know? International Unionfor The Scientifiv Study Of Population, Liege. 1995. 10. Petterson A, Avni M, Gay J, Firestone R, Hardee K, Murphy E, Herstad B, Welch CJ. A Framework To Identity Gender Indicators For Reproductive Health And Nutrition Programming. USAID. 2002: 5-10. 11. Bloom SS, Wypji D, Das Gupta M. Dimensions Of Women's Autonomy And The Influence On Maternal Health Care Utilization In A North Indian City. Demography. 2001;38(1): 67–78. 12. Furuta M, Salway S. Women's Position Within The Household As A Determinant Of Maternal Health Care Use In Nepal. International Family Planning Perspectives.2006;32(1) 17–27. 13. Thapa DK, Niehof A. Women's Autonomy And Husbands' Involvement In Maternal Health Care In Nepal. Social Science & Medicine. 2013;93: 1-10. 14. Acharya D, Bell J, Simkhada P, Van Teijlingen E, Regmi P. Women's Autonomy In Household Decision Making: A Demographic Study In Nephal. Reproductive Health. 2010; 7(15). 15. Lowdermilk DL, Bobak L, Perry J. Maternity Nursing, St.Louis: Mosby Year Book Inc. 2003. 16. Nur Hasyim. Menjadi Laki-laki pandangan laki-laki Jawa terhadap maskulinitas dan kekerasan rumah tangga, Jogjakarta: Rifka Annisa. 2011. 17. Kemenkes RI. Pedoman Pelayanan Antenatal Terpadu Edisi Kedua, Jakarta: Direktorat Jenderal Bina Gizi Dan Kesehatan Ibu Dan Anak-Direktorat Bina Kesehatan Ibu. 2012. 18. Kemenkes RI. Buku Kesehatan Ibu Dan Anak, Jakarta: Kementerian Kesehatan Dan JICA (Japan International Cooperation Agency). 2015. 19. Sajogyo, Pudjiwati, Sajogyo. Sosiologi Pedesaan. Yogyakarta:

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