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Autonomy of High-Risk Pregnant Women in an Effort to Prevent Complications during Childbirth

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ABSTRACT

***Background**: Maternal mortality is a health problem that has not been resolved until now. Based on data from January-September 2020 from the Public Health Center of Panti District, most pregnant women with high risk are those who have a risk of preeclampsia. Pregnant women have an important role and personal autonomy in decision-making during the process of pregnancy. **Objective**: To analyze the autonomy of high-risk pregnant women to prevent complications during childbirth **Methods**: **Q**ualitative research with a case study approach. Determination of the main informants using a purposive technique consisted of five pregnant women at risk of preeclampsia who were under 20 years old and above 35 years old. Data collection using in-depth interview guide and documentation. Data analysis using inductive thematic analysis. **Results**: intentions, affordability of information, situations in preparing blood donors and maternity funds can form the negative autonomy of high-risk pregnant women in decision-making. Husband's social support can form positive autonomy of high-risk pregnant women in decision-making. High-risk pregnant women have negative autonomy in choosing a place for maternity care to practice a midwife even though they have been advised to carry out routine checks at the primary healthcare. High-risk pregnant women have negative autonomy in choosing the place of delivery by not changing their choice and making the primary healthcare or hospital the second and last choice. **Conclusion**: The autonomy of high-risk pregnant women that is formed is a negative autonomy in making decisions about childbirth planning and preventing complications.*

***Keywords**: Autonomy, High-risk pregnant women, Preventing complication.*

INTRODUCTION

Maternal mortality rate (MMR) is still a health problem that has not been resolved until now. It is estimated that, between 2000-2017, around 295,000 women died, both during pregnancy and childbirth. Nearly 94% of maternal deaths occur in developing countries such as low-income and lower-middle-income countries (WHO, 2019). One of them is in Indonesia the maternal mortality rate in Indonesia is still quite high, as indicated by several regions experiencing an increase in maternal mortality from year to year, one of which is in East Java.

Based on the health profile of East Java Province in 2019, the Maternal Mortality Rate in East Java Province tends to be high at 91.97 per 100,000 live births in 2017, amounting to 91.42 per 100,000 live births in 2018 and in 2019 to 89, 92 per 100,000 live births and is still far from the SDGs target. Based on the 2019 East Java Provincial Health Profile, Jember Regency ranks the 5th highest maternal mortality rate in East Java. Based on data from the Jember District Health Office, cases of maternal mortality in 2017 were 43 cases, decreased in 2018 to 41 cases and in 2019 increased to 47 cases. In 2019, the highest maternal mortality cases were in the working area of the Panti Health Center with four cases of maternal deaths.

Based on the Health Profile of East Java Province in 2019, the highest maternal mortality rate in East Java is caused by pregnant women who have a high risk such as preeclampsia/eclampsia by 31.15%, bleeding by 24.23%, other causes such as diseases that accompany pregnancy by 23.1%, metabolic disorders by 13.85% and infection by 6.73%. Based on data from January - September 2020 from the Panti Health Center, the majority of pregnant women with high risk in the Panti Health Center work area are those who have a risk of preeclampsia. Therefore, the researchers chose pregnant women at risk in their

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pregnancy because it was a factor in maternal mortality and the research site was in the working area of the Panti Public Health Center, Jember Regency.

The government provides various programs to fulfill the right to a healthy life for every pregnant woman and as an effort to prevent complications for pregnant women, one of which is the Delivery Planning and Complications Prevention Program which is usually shortened to P4K with the aim of reducing MMR caused by pregnancy complications by monitoring carefully all pregnant women who are facilitated by the midwife and assisted by cadres. The main activities of P4K are data collection and target mapping of pregnant women, preparation of blood donors, preparation of maternity savings/maternity funds, preparation of transportation/ambulances, and introduction of danger signs of pregnancy and childbirth (Kemenkes RI, 2014).

Implementation of delivery planning and prevention of complications (P4K) will not succeed without the compliance of pregnant women. Maternal compliance in the implementation of P4K is very important because the possibility of complications during pregnancy and childbirth is smaller in pregnant women who apply P4K (Werdiyanthi *et al.*, 2017). P4K makes it easier for pregnant women to plan delivery as an effort to prevent complications. Planning for delivery of pregnant women cannot be separated from the participation of their husbands and closest family, but pregnant women themselves also have an important role and personal autonomy in making decisions in the process of pregnancy.

Autonomy is a very broad and difficult concept to measure and refers to the freedom to take an action or not (Aprilianti, 2017). Women's autonomy in healthcare decision making is an ability to obtain information and make decisions about their own problems. Autonomy is considered functionally important for decision-making in a variety of healthcare situations, from seeking and utilizing health services to choosing the care to be obtained. Research conducted in Bangladesh found that women's higher autonomy status was significantly associated with maternal health-seeking behavior (Aziz, Mitra and Rahman, 2017). Several studies in Indonesia also have similar results, such as a study conducted in Palangka Raya City which showed that pregnant women had a 1.59 times greater chance of accessing birth attendants by health workers if they had high personal autonomy than those with low personal autonomy (Aprilianti, 2017). Furthermore, research conducted in the Kutai area revealed that most pregnant women already have autonomy in choosing a place and birth attendant. However, there are still decisions that are negotiated with husbands and families, causing differences in desires between husband and wife and there are cultural factors in their environment that planning delivery at health facilities is the same as expecting a problematic delivery which will eventually result in delays in handling during delivery (Nurrachmawati *et al.*, 2018).

Time-consuming decision-making can cause delays in handling complications during childbirth, such as research conducted in the work area of the Padediwatu Health Center, Manukaka District, West Sumba Regency, finding that the culture of negotiation that develops in the community also often influences decision-making to refer mothers to the hospital. Decision-making in negotiations is dominated by the husband, but in the negotiation process still collects opinions from other family members and can take quite a long time so that it results in delays in decision=-making (Bata *et al.*, 2019).

Delivery planning and prevention of complications during pregnancy have an important role in preventing delays in handling complications. In addition, access to information regarding maternity care services and delivery management by health workers for high-risk pregnant women is an important factor that can influence decision-making on delivery planning and prevention of complications, so that health promotion and the approach taken by midwives and cadres are very important to pregnant women. high risk, family and community.

The autonomy of pregnant women is very necessary as an effort to raise awareness of the importance of planning for childbirth and prevention of complications during pregnancy so as to reduce complications in pregnant women and maternal mortality. Therefore, this study aims to analyze the autonomy of

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high-risk pregnant women in an effort to prevent complications during childbirth in the working area of the Panti Public Health Center, Jember Regency.

METHODS

This research is a qualitative study with a case study approach. The main informants of this study were determined using a purposive technique, namely five main informants, pregnant women who are at high risk, pregnant women who are under 20 years old and/or above 35 years old and pregnant women who are diagnosed as having a risk of preeclampsia and are in the work area of the Panti Health Center. Jember Regency. This research was conducted from March 10-10 April 2021. This research was carried out in a pandemic situation so that face-to-face contact with informants was carried out using health protocols. Data collection was using in-depth interview guide and documentation. The data analysis of this research used inductive thematic analysis. The credibility test uses source triangulation and method triangulation. This research has passed the ethical test by the Health Ethics Commission at the Health Faculty of Jember Regency with a certificate number 10/KEPK/FKM-UNEJ/III/2021.

RESULTS AND DISCUSSION

In-depth interviews were conducted on five high-risk pregnant women with the characteristics of the informants as shown in Table 1 below:

Table 1. Characteristics of Research Informants by Age, Pregnancy, and Diagnosis

Informants	Age	Gestational Age	Diagnosis
IU1	38	35	Hypertension, history of PE
IU2	36	34	Hypertension, history of PE
IU3	38	30	PE history
IU4	36	36	History of Hypertension, DM
IU5	18	31	Hypertension

In terms of access to information regarding delivery planning in the form of preparing blood donors, all key informants only get information and actions to check blood type from key informants, without preparing and checking the blood groups of prospective donors. This situation is the main informant's decision-making factor. This situation and access to information can also make the main informant of high-risk pregnant women not have the intention to prepare the subject of blood donors from the family and only check blood type for pregnant women themselves. The following is an excerpt from an in-depth interview with one of the key informants:

> *"…Yes, I checked the blood for O. If the child was not tested. Yes, maybe later if needed, it will be there…" (IU1, 38 years)*

> *("…Iya saya diperiksa darahnya O. kalau anak enggak diperiksa. Ya mungkin nanti kalau dibutuhkan udah ada disana…" (IU1, 38 tahun))*

High-risk pregnant women only rely on blood supplies at PMI without any intention to prepare blood donor subjects because there is no blood type examination for the family. The lack of information received by high-risk pregnant women in preparing blood donors can form negative autonomy in decision-making for delivery planning and prevention of complications.

Access to information regarding the preparation of maternity funds is only in the form of submitting a BPJS application without any motivation and approach to key informants to prepare BPJS or other social security. This situation makes high-risk pregnant women have the intention of preparing maternity funds in accordance with the choice of place of delivery. The following are excerpts from in-depth interviews with key informants:

> *"…BPJS is a parent from the government, because it has BPJS so you can give birth at the puskesmas…" (IU1, 38 years)*

> *"…Used general. There is BPJS but it is no longer active, other money can be made. Moreover, I want to be a midwife so I don't use BPJS ..." (IU2, 36 years)*

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("…BPJS itu nduk yang dari pemerintah, karena punya BPJS jadi bisa lahiran di puskesmas…" (IU1, 38 tahun)

"…Pakek umum. Ada BPJS tapi udah enggak aktif, bisa dibuat yang lain uangnya. Apalagi saya pengen di bu bidan jadi enggak pakek BPJS…" (IU2, 36 tahun))

Lack of motivation and approach to preparing maternity funds in the form of BPJS or other social security makes the intention of pregnant women to be at high risk in preparing maternity funds in accordance with the choice of place of delivery. This shows that high-risk pregnant women have negative autonomy in making decisions to choose a place of delivery.

There are three informants (IU2, IU3, IU4) who have the same intention from the beginning of pregnancy to the current gestational age, namely to give birth at a village midwife practice even though they have been directed by the village midwife and cadre to give birth at the puskesmas. The following are excerpts from in-depth interviews with key informants:

"…just want to give birth at the midwife, if you go to the midwife who usually handles it, it is better but the midwife is advised to go to the puskesmas, rather than at the puskesmas, I am more comfortable with the midwife myself…" (IU2, 36 years)

("…mau melahirkan di bu bidan saja, kalau ke bidan yang biasa menangani lebih enak tapi sama bu bidan disarankan ke puskesmas, dari pada di puskesmas saya lebih nyaman di bidan sendiri..." (IU2, 36 tahun))

High-risk pregnant women have autonomy, which is indicated by their unchanging intention to give birth by a village midwife, both at the beginning of pregnancy and before delivery, on the grounds that they feel confident and comfortable. This is in line with research conducted in the work area of the Kaliangkrik Health Center, Magelang Regency which showed that pregnant women would feel safer and more comfortable when giving birth at home because they would be more freely attended by traditional birth attendants and their families (Puspitasari, 2019).

"…It is recommended to give birth at the puskesmas with cadres and midwives. Can't be at home. I just obeyed if I was told to go to the puskesmas, I went to the puskesmas…" (IU1, 38 years)

("…Disarankan lahiran di puskesmas sama kader dan bidan. Enggak boleh dirumah. Saya ya manut aja kalau disuruh ke puskesmas ya ke puskesmas…" (IU1, 38 tahun))

The state of pregnancy health and information and advice from midwives and cadres regarding the condition of pregnant women who can experience complications during childbirth can shape the autonomy of decision-making for high-risk pregnant women in planning childbirth. This is in line with research whose results show that there are differences in delivery plans in which pregnant women initially refused to be referred to the puskesmas; after receiving education from the midwife about pregnancy problems and the risk of complications, pregnant women and their families were willing to be referred to the hospital (Amdad *et al.*, 2018).

In intention to prepare transportation to the delivery place, all the key informants plan to use private vehicles in the form of motorbikes with a ride. However, if a car is needed, all key informants and the family already have a village ambulance driver contact who can be contacted to take them to the place of delivery. The following are excerpts from in-depth interviews with key informants:

"…If you can still be detained, use a bicycle, your husband will accompany you. Later, when you are in a hurry, you can use an ambulance that is in the center of the hospital..." (IU5, 18 years)

("…Kalau masih bisa ditahan pakek sepeda aja dianter suami. Nanti kalau udah mepet bisa pakek ambulan yang di pustu…" (IU5, 18 tahun))

The intention of high-risk pregnant women in preparing transportation to the place of delivery is a form of freedom of decision-making in

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planning delivery and preventing complications.

High-risk pregnant women also received information about high-risk pregnancies from midwives directly during pregnancy check-ups, along with excerpts from in-depth interviews with key midwives:

> *"…patients are our first contact, we always screen them. I have a high risk pregnancy... I've been to the hospital before, my blood pressure was suddenly found to be 200, and I've had seizures in the past. Do you want something like this to happen again? Ma'am, screening is high risk, high risk is in the order you have to consult a doctor at the puskesmas…" (IK1, 46 years)*

> *("…pasien kontak pertama ke kita, kita kan selalu mengs-screening. Mbak kehamilannya jenis risiko tinggi…. dulu pernah ke rumah sakit, dulu pernah tiba tiba tekanan darahnya ditemukan 200, dulu juga pernah tiba tiba kejang. Mbak mau kejadian seperti dulu lagi? Mbak itu - screening risiko tinggi, risiko tinggi itu urut-urutannya mbak harus konsul ke dokter puskesmas…" (IK1, 46 tahun))*

Information is obtained directly (orally) from the village midwife and/or submitted back by village cadres personally orally by coming to the residence of high-risk pregnant women. Information that can be received well by high-risk pregnant women can be caused by the close relationship that is well-established between cadres and high-risk pregnant women. Access to information that is easy and well-accepted by high-risk pregnant women can shape decision-making autonomy during their pregnancy. This is different from research in the coastal area of Palu city on decision-making behavior by pregnant women in seeking health services which states that the information obtained by mothers when visiting health services is very limited. Mothers only get information by being shown the MCH handbook without informative explanations from health workers or cadres (Syam *et al.*, 2019).

Pregnant women at high risk get emotional support in the form of attention and instrumental support in the form of action, assistance, and financial support from their husbands. The following are excerpts from in-depth interviews with key informants:

> *"…My husband told me to check his blood pressure, he was told to do it routinely, he took medicine regularly. I'm afraid, sis, that it's bleeding, I think I'm afraid…" (IU 2, 36 years)*

> *"…I never do anything at home. Every day cleaning up husband's house before leaving for work…" (IU 5, 18 years)*

> *"…Yes, I went to check with my husband if I didn't work, sometimes with my nephew if my husband worked…" (IU 4, 36 years)*

> *("…Suami nyuruh periksa tok tensinya kan polae tinggi disuruh rutin itu aja, obat juga rutin diminum. Takut mbak katanya pendarahan yo nurut ae takut…" (IU 2, 36 tahun)*

> *"…Saya enggak pernah ngapa-ngapain di rumah. Setiap hari yang beres-beres rumah suami sebelum berangkat kerja…" (IU 5, 18 tahun)*

> *"…Ya dianter periksa sama suami kalau enggak kerja kadang sama ponakan kalau suami kerja…" (IU 4, 36 tahun)*

Emotional support is in the form of attention and instrumental support in the form of taking action by the midwife, helping with homework and financially by preparing maternity funds in accordance with the wishes of the pregnant woman's place of delivery. Social support from husbands in this study in the form of emotional and instrumental support has its own value for high-risk pregnant women and can form positive autonomy in decision-making for high-risk pregnant women regarding delivery planning and prevention of complications. This is in accordance with research conducted by Amelia and Darmadja (2019)_ that giving attention and support has special value for the wife as a sign of a good bond, so that it can assist in decision-making.

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The autonomy of all key informants in choosing a place or facility for maternity care chooses to carry out prenatal care in their respective village midwife practices on the grounds that they are close to home. The following are excerpts from in-depth interviews with key informants:

> *"… since the beginning of pregnancy, I have checked with the midwife here, close to home, right, if you don't check with the midwife, where else do you want to go…" (IU5, 18 years)*
>
> *("… dari awal hamil sudah periksa ke bu bidan sini, deket dari rumah juga kan, kalau enggak periksa ke bu bidan mau periksa kemana lagi…" (IU5, 18 tahun))*

The autonomy of key informants seen in determining the place of maternity care is different from the autonomy of pregnant women in other developing countries such as the study in Ethiopia which also shows that, although every woman has the right to participate in making her own healthcare decisions, more than two-fifths of them have no role in making healthcare decisions about their own health. Husbands play a major role in making healthcare decisions about their wives (Alemayehu and Meskele, 2017).

The results of the research from Alemayehu and Meskele are different from the results of this study which shows that husbands give full freedom to high-risk pregnant women to determine the place of pregnancy care during that time for the comfort and safety of pregnant women and fetuses, according to excerpts of in-depth interviews with key informants:

> "…consult first, yes, say that the midwife gave this direction. You said yes, if you were directed to the puskesmas, my husband said it was up to me…" (IU 2, 36 years)
>
> *("…berunding dulu, ya bilang kalau bidan memberi arahan gini. Bapak langsung iya, kalau diarahkan ke puskesmas, kata suami saya terserah saya…"(IU 2, 36 tahun))*

This is in accordance with research which states that husbands leave the decision entirely to their wives and support their wives' choices for comfort and to make wives more aware of their health conditions (Nurrachmawati *et al.*, 2018).

There is one main informant (IU2) who also has personal autonomy in determining the place for pregnancy check-ups by not continuing the routine check-ups at the puskesmas and not checking with specialists and prefers to continue the pregnancy check-up at the village midwife practice for reasons of fear and thinking. The following are excerpts from in-depth interviews with key informants:

> *"…At the puskesmas, I was directed to refer to a specialist, it was up to me where I wanted to refer, but I didn't go. If I'm told to do that, my mind will go all over the place, let me just go naturally. ….. Just believe in the power, Ms. the birth was smooth…"(IU2, 36 years)*
>
> *("…di puskesmas diarahkan untuk rujuk ke spesialis, terserah saya mau rujuk kemana, tapi saya tidak berangkat. Kalau disuruh gitu pikiran saya jadi kemana-mana, biar secara alaminya saya saja. ….. Yakin sama yang Kuasa saja mbak lahirannya lancar…"(IU2, 36 tahun)*

This shows that high-risk pregnant women have negative autonomy in prenatal care by not having examinations to specialists as directed by midwives. This is in accordance with research on the choice of place of delivery, where most of the pregnant women informants have the autonomy to make decisions on the choice of place and birth attendant. Women do not want to plan a delivery at the health facility because the perception of planning for delivery at the health facility is the same as expecting a problematic delivery (Nurrachmawati *et al.*, 2018).

Delivery carried out in health facilities with the assistance of health workers is an important step to prevent complications in childbirth (Aprilianti, 2017). The results showed that all key informants (IU1, IU2, IU3, IU4, IU5) had autonomy in planning and determining

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the place of delivery in health facilities and being assisted by health workers. Seeing the condition of the main informants who are high-risk pregnant women, midwives and cadres have provided advice and suggestions for giving birth at the puskesmas. However, there are still key informants (IU2, IU3, IU4) who have the autonomy to plan deliveries in their respective village midwife practices for reasons of close proximity, comfort and trust in the village midwife. The following are excerpts from in-depth interviews with key informants:

> *"…more comfortable in their own field, like their parents, if you don't know the staff at the puskesmas, you've never been there…"(IU2, 36 years)*
>
> *("…lebih nyaman di bidannya sendiri, kan seperti orang tua sendiri, kalau di puskesmas tidak kenal dengan petugas disana, kan tidak pernah kesana…"(IU2, 36 tahun))*

The closeness and comfort of the main informant with the village midwife is influenced by the intense interaction and communication that occurs every month during pregnancy care. The main informant's decision to plan childbirth in the village midwife's practice is in accordance with research which shows that the choice of place of delivery is influenced by the proximity of the midwife and pregnant women. The high trust of pregnant women to midwives can affect the autonomy of pregnant women in choosing a place of delivery (Amdad *et al.*, 2018).

There is a key informant (IU 4) who remains with her stance in choosing to plan delivery in the practice of the village midwife and make the puskesmas or hospital the second and last option if the village midwife does not handle it at the time of delivery. Following are the statements made by key informants:

> *"…I want to go to the midwife normally, I don't need to go to the hospital, but if the midwife can't handle it, maybe I'll be referred to a cesarean hospital…" (IU4, 36 years)*
>
> *("…Saya pengen normal ke bu bidan enggak perlu ke rumah sakit, tapi kalau tidak bisa ditangani bidan ya mungkin dirujuk kerumah sakit sesar…" (IU4, 36 tahun))*

The main informant's statement shows negative autonomy by still choosing to give birth in the practice of village midwives and making puskesmas and hospitals the second and last option. This is in accordance with research which states that puskesmas are the second choice of pregnant women for delivery services after midwives and hospitals are the last option if the results of observations and follow-up examinations from midwives and puskesmas do not show better conditions (Amdad *et al.*, 2018).

In addition, there are two main informants (IU1, IU5) who have the autonomy to plan deliveries at the puskesmas according to the advice of the village midwife and cadres due to a history of complications in previous pregnancies, previous delivery experiences and for safety reasons. The following are excerpts from in-depth interviews with key informants:

> *"...just go to the puskesmas, ma'am, the situation is like this for safety's sake, so you don't have to worry about it later, just go to the puskesmas. The midwife and the cadre also suggested going directly to the puskesmas if you really want to give birth…" (IU 5, 18 years)*
>
> *"…to the health center. I obeyed if I was told to go to the puskesmas, I went to the puskesmas. The second is also at the nursing home health center…" (IU 1, 38 years)*
>
> *"…what did I say, the main thing is safe…"(IU1, 38 years)*
>
> *("…ke puskesmas aja wes mbak, keadaannya juga gini demi keselamatan, biar enggak riwa-riwi nanti sekalian aja ke puskesmas. Bu bidan sama kader juga menyarankan langsung ke puskesmas kalo memang sudah mau lahiran…"(IU 5, 18 tahun))*
>
> *("… ke puskesmas. Saya manut kalau disuruh ke puskesmas ya ke puskesmas. Yang kedua juga di puskesmas panti…" (IU 1, 38 tahun))*

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("…apa kata saya pokok nya selamat…"(IU1, 38 tahun))

Awareness of the main informants (IU1, IU5) regarding the history of complications they have and the state of their pregnancy which is at risk and can experience complications during delivery will make the main informants have positive autonomy in choosing a place of delivery in adequate health facilities such as puskesmas. This is different from research conducted in the work area of Kaliangkrik Public Health Center, Magelang Regency which showed no significant relationship between the history of complications in pregnancy and childbirth with the choice of place of delivery (Puspitasari, 2019).

The facts obtained in this study indicate the need for education and assistance to high-risk pregnant women in preparing for delivery by carrying out P4K, especially before delivery, as well as assistance in preparing administration for referrals even though high-risk pregnant women have normal KSPR, so as to facilitate the referral process if complications occur. This cannot be separated from the role of midwives and cadres to increase the knowledge of high-risk pregnant women about the importance of planning delivery assistance with health workers so that childbirth can run smoothly and safely. In addition, high-risk pregnant women also need to increase their willingness to take an active role in planning delivery by complying with P4K and preparing administration for referrals before delivery even though they do not plan to give birth in a hospital so as to avoid delays in referral and treatment.

Increased knowledge and husband's support for high-risk pregnant women can shape the compliance of pregnant women in implementing P4K. P4K socialization and implementation also need to be aimed at the wider target community to indirectly establish partnership relationships with the community so that it can be one of the factors that can influence pregnant women to plan childbirth with the P4K program. Sustainable relationships between health workers, cadres, pregnant women, families and communities can be a promotive and preventive effort in preventing complications during childbirth so as to reduce maternal mortality.

CONCLUSION

Two of all high-risk pregnant women have negative autonomy in planning delivery intentions, namely they still choose to give birth at a midwife's even though there are risks in childbirth. Emotional and instrumental support from husbands has its own value for high-risk pregnant women and can shape decision-making autonomy for high-risk pregnant women in planning delivery and preventing complications. In addition, the lack of information from midwives and cadres regarding the preparation of blood donors and maternity funds can form a negative autonomy of high-risk pregnant women.

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