Decision Making Process of Childbirth Helper and Referral for Mother Childbirth with Obstetric Emergency in Puskesmas Bandar I BatangRegency

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Abstract

Background: The high number of maternal mortality rates in Bandar-Batang (16 cases) is caused by bleeding, pre eclampsia, disruption of blood circulation system (liver, stroke) etc. Pregnancy complication urges to have next referral in a large hospital. Referral must be the planned program, not an incidental reaction. Methods: Qualitative research with descriptive analytical was used for research design. The Samples were 5 primary informants consist of childbirth mother and 2 triangulation informants: midwife of public health center and midwife coordinator. The data was collected with in-depth interviews, observation, and documentation. The data was analyzed with data reduction. Results: 80% (n = 4) of mothers having the first referral is caused by: pre-eclampsia severely, early broken amniotic fluid, the fast heart rate of fetal, and long 1 time. The decision making of referral obstetric emergency problems was dominant by the patient's family (husband). The scheme of referrals is: from midwife to public health centers to hospitals. Some obstacles occurred during maternal referral are rejection and hospital access (transportation). Conclusion: Husband plays the main role in the decision making of referral obstetric emergency problem. Referral from public health center to hospital needs to follow procedure system.

Keywords: Mother childbirth, Complication, Referral

Introduction

Maternal death and infant death are two of the urgent health problems to be solved, especially in poor and developing countries. The complications of pregnancy, childbirth, and childbirth are direct causes of maternal death. Complications as a direct cause of maternal death are still a global problem.

The maternal mortality rate in Indonesia is high among ASEAN countries. Based on the 2012 Indonesian Demographic and Health Survey (IDHS), maternal mortality rates in Indonesia are still high at 359 per 100,000 live births. This data is a reference to achieve the AKI target according to the *Sustainable Development Goals* of 70 per 100,000 live births in 2030 (Ministry of Health, 2015).

Maternal deaths usually occur because they do not have access to quality maternal health services, especially on-time emergency services which are motivated by "Late", that is, being late in recognizing danger signs and making decisions, late in reaching health facilities, and late in getting health service facilities.

The number of maternal death cases in Central Java Province in 2016 was 602 cases, a decrease compared to the number of maternal death cases in 2015 which amounted to 619 cases. Thus the Maternal Mortality Rate of Central Java Province also decreased from 111.16 per 100,000 live births in 2015 to 109.65 per 100,000 live births in 2016.

One way to deal with the low coverage of complication handling by government health workers is to launch a Planning Program Childbirth and Prevention of Complications (P4K). The support of family or relatives, especially the husband, to pregnant women to support P4K goals is needed, in this case the husband plays an active role in motivating pregnant women to check their pregnancies to health workers to get *Antenatal Care* (ANC) services according to the standard.

Obstetric complications are complications or diseases that arise in the mother both during pregnancy, association and puerperium. The

types of complications that cause maternal mortality in Central Java Province are bleeding (22.6%), infections (5.2%), preeclampsia of eclampsia (36.8%), and other causes (35.4%). (pocket health book of Central Java Province, 2018) The number of mothers with obstetric complications in the Bandar I Puskesmas Work Area in 2017 there were 298 cases and 223 referrals, in 2018 there are currently 132 cases and 115 referrals (Puskesmas Bandar I, 2018) .

Based on the data above, the researcher is interested in conducting a research study "*Decision Making Process of Labor Assistance and Maternity Mother Referral with Obstetric Emergency At Childbirth in Bandar I Health Center, Batang Regency"*.

1. Objectives General
   The objectives to be achieved in this study were to determine the decision making process of maternity assistance and maternal referral referrals with obstetric emergencies during childbirth at the Bandar I Batang District(*Handover* Health Center from FKTP to FKTL Services).
2. Specific Objectives
   a) To understand the description of the decision making process at delivery at family level.
   b) To understand the description of the process of referral of mothers with obstetric emergencies during delivery from midwives or PONED Puskesmas to PONEK Hospital.

Methods

Qualitative research with a descriptive analytic design approach. The main number of informants consisted of 5 people consisting of mothers after giving birth and 2 triangulation informants consisting of Puskesmas midwives and coordinating midwives. Retrieval of research data by in-depth interviews, observation, and documentation. Data analysis with data reduction.

Results

1) **Description of Main Informants**
   Based on the above table, it is known that the average age of the main informant is 25 years with the youngest age of 19 years. All key informants work as housewives, with junior high school graduates and some even do not graduate from elementary school. Medical diagnoses that became the reason for referral include severe pre-eclampsia, premature rupture of membranes, rapid infant heart rate, long time, and serotinus.
2) **Description of Triangulation Informants Triangulation**
   Informants in the study amounted to 2 people consisting of midwives Puskesmas. The first triangulation information was PONED midwives with work experience in Puskesmas for 10 years with educational background in D3 Midwifery. The second triangulation information as PONED midwives who worked longer at the Puskesmas namely for 27 years with D3 education background.
3) **Description of the Informant's Answer**
   a) **The Decision Making Process of Childbirth Assistance at the Family Level**
      In the implementation of antenatal care, it was found that the coverage of antenatal services (K4) from year to year increased in 2016 reaching 93.6% in 2017 reaching 97.1% and in 2018 to the month June reached 42.39%.
      Based on the results carried out in this village, a pregnant woman is accustomed to having her pregnancy checked by the village midwife for treatment, and taking part in the Posyandu every month in maintaining maternal and child health as an official government program. If there are complaints they also consult with the village midwife.

In the research that has been done 80% for the first time in labor and referral, the medical diagnosis that is the reason for referral includes severe preeclampsia, premature rupture of membranes, rapid infant heart rate, when 1 is long.20% with the remaining history of referral ie with serotine cases In many cases, the cause of serotine pregnancy is unknown. Some risk factors for serotine pregnancy are a history of

previous serotine pregnancy, women who are pregnant for the first time, maternal age over 30 years, and obesity, including genetic predisposition. A woman born with serotinus increases the risk by 49% to become pregnant with serotinus too.

The midwife's ability to identify maternal danger signs, the relatively good knowledge of pregnancy and childbirth, and having relatively much experience in assisting childbirth, shows that the quality of midwives helping maternity mothers is relatively good. These qualities encourage midwives to make quick decisions in referring maternity and act accordingly when handling high-risk delivery mothers. All informants who will be referred to the hospital either through the village midwife or directly come to the Puskesmas all do the initial handling in the delivery room (PONED).

Decision-making referral by the family dominated by the husband is done quickly, because the husband already knows or knows the high risk of childbirth delivery. This raises the attitude of the husband to accelerate the process of referral to the hospital, with the hope that his wife receives optimal service during labor.

The decision-making process carried out in patients with severe preeclampsia (informant 1) is normal delivery but was brought to the hospital because of hypertension. Patients from the house to the private midwife practice after hypertension has been detected, the midwife tells the family to be referred to the Puskesmas, the patient's family agrees to be taken to the Puskesmas This decision-making is carried out by the husband and the patient's parents, after arriving at the Puskesmas the patient is given first aid ie infusion and injection. Families and Puskesmas staff prepare the administration needed for referral. Patients are taken using Puskesmas ambulances, midwives and families accompany them to the hospital. These patients are taken to the PONEK Hospital located in Batang District, the Kalisari District Hospital.

In the second patient (second informant), namely in the case of Early Emergency Amniotic Disease, mothers with cases must be immediately referred to the Hospital. Having no previous history, was the 3rd delivery, this patient was a referral from a village midwife who was taken to the Bandar I Public Health Center, in the Community Health Center given assistance in the form of infusion, the decision maker to be referred was made by her family (her sister) because her husband worked outside the city but approval from the husband too. Midwives and families accompany them to the hospital.

For the third informant, this had a first-time emergency with a young age as the first delivery. This patient came directly to the Bandar I Public Health Center. The baby had asked to leave but the opening had not changed after one night at the Puskesmas. After the midwife decided to be referred to the Hospital from the family immediately agreed, all administrative preparations were prepared and then brought to the PONED Hospital Kalisari Regional Midwife Hospital and the family accompanied to the hospital.

In the fourth informant who experienced an emergency heartbeat, a fast baby was the first delivery. This patient is a patient who came directly to the health center, this patient also had stayed at the health center before it was decided to be referred. The decision was made by the husband and parents. After preparing the administration to make the referral this patient was taken to the PONEk Hospital Kalisari Regional Hospital accompanied by midwives and their families.

In this fifth informa- tion, serotinus emergencies, ie pregnancy past the patient's previous time, have the same history of seizures. This patient is a referral patient from the village midwife, after knowing that the patient has serotinus referred to the PONED Bandar I Puskesmas, the decision maker is made by her husband and family. To be referred paien and midwives must prepare the administration needed for the referral process, during the preparation the patient is given first aid ie giving an IV then brought to the hospital accompanied by the referring midwife and family.

In rural communities, traditions and customs are strongly held by mothers, where the role of parents, husbands and grandmothers

plays an important role in decision making, especially in the selection of birth attendants. Decision making is 100% dominated by husbands. From the results of this study it can be seen that the husband has carried out his responsibilities as a head of the household in the household, namely by making decisions on the circumstances that occur with his wife. The informant's attitude shows that he will follow whatever results are decided in the referral process by the husband.

The difficulty factor of transportation distance to the hospital which is relatively far (± 20 km), roads that cannot be passed by cars and the availability of cars owned by the village, and relatively long distances, are factors that cause delays in finding help and delays in getting transportation , so the mother was late referred to the hospital. Previously the family contacted the husband to inform and provide input which results the husband agreed the wife was referred to the hospital. On this basis the family then answers to the midwife and at the same time prepares everything related to the reference, namely tabulin, transportation, companion (which is believed to accompany the mother during labor), prospective donors and clothing.

b) **The process of referral from Puskesmas toHospital**

Bandar I Puskesmasis a PONED Puskesmas. This is stated in the Local Level Policy. There is already a decree for the determination of PONED from the regent, namely Batang District Decree No. 441/389 of 2014 concerning Determination of Puskesmas Capable of Basic Obstetric and Neonatal Emergency Services (PONED) in Batang Regency.

PONED Puskesmas Bandar I, there is a team that has been trained consisting of a doctor and two midwives. In addition to the core team, there are 13 midwives who serve as PONED executing officers with all minimum education D3.

For the adequacy of the number of officers it is sufficient to schedule 3 - 4 midwives on duty each shift, but if there are many patients and there are still often officers who leave, permission due to other duties, did not arrive on time or only came when notified if there was a patient (*oncall*). Doctors are also only in the morning shift or at official hours so alertness is not fast if there are emergency patients who need treatment or consultation with a doctor. For the availability of non-health workers, there are security and sanitation personnel and ambulance drivers, but these officers are still concurrently employees of the puskesmas so they are not special staff at the PONED. For ambulance drivers, picket schedules are also made, but they are only at the puskesmas at official hours, if outside office hours use thesystem *oncall*, so they are not always on standby if needed. For administrative staff, there are no special staff who take care of administration in the PONED, administrative staff come from midwives who also work together.

There is no problem with distance and access to PONED, there is no distance of more than 1 hour, this is in accordance with the 2013 Ministry of Health's PONED Handbook which states the distance from the target settlement location, basic services and non-PONED Puskesmas to the longest PONED able Puskesmas 1 hour. Because the PONED Puskesmas is still in the same area as the Bandar I Puskesmas.

The referral process that has been carried out has also been listed in the Standard Operating Procedures contained in each Puskesmas, even though the SOP has not been installed, the SOPs are socialized for each coaching.

If the patient cannot be served at the first level health care facility according to the need to deal with the problem / disease, but can be resolved completely at the referral health service facility, it must be returned to the referring health care facility, accompanied by a resume of the process and results of the service and recommended actions he continued.

One reason that patients were referred to this study was that premature rupture of membranes. Premature rupture of membranes is a rupture of the membranes before delivery. If premature rupture of membranes occurs before 37 weeks' gestation, it is called premature

rupture of membranes in premature pregnancies (Purwoastuti and Walyani, 2015). In addition, patient referral complications with late medical diagnosis in childbirth or dystocia. Dystosia is an abnormal delivery characterized by slowness or absence of progress in labor in a certain time unit size (Nugroho, Taufan, 2010). Another reason for labor referral patients experiencing severe preeclampsia, marked by the onset of hypertension 160 / 110mmHg or more accompanied by proteinuria and / or edema at 20 weeks' gestation or more (Nugroho, Taufan. 2010).

The method of service is in accordance with the FKTP referral flow, that is, the patient arrives then is examined and diagnosed according to competence, then the treatment is performed and the patient can return home if during the treatment there is no change, a referral is made to the intended hospital. If the patient's diagnosis is out of competence and FKTP is unable to match their capacity, then it can be directly referred to FKTL until healed or even died, the referral is carried out in stages. In accordance with Regulation of the Minister of Health No.001 of 2012 concerning the referral system of individual health services in article 4 paragraph 1 which reads health services are carried out in stages according to the medical needs of the first level health care. If the FKTL is considered to be able to handle FKTP, then it can be referred back to FKTP. Referral must not be at the request of the patient himself must be in accordance with the medical indication of his illness. This is not in accordance with Yandrizal's (2013) study regarding referral from the puskesmas to the hospital because of his own request.

Procedure or process of referral process that is carried out from the house to the Puskesmas with the first handling at the Puskesmas before being referred to the hospital, such as giving infusion and injection. After the basic treatment is done at the Puskesmas then it is referred to the hospital.

For clinical procedures, everything has been carried out, while administrative procedures, there are some that have not been implemented, namely: 1) Standard procedure for receiving referrals, namely recording in the register for receiving patient referrals; 2) Standard procedure for returning referrals, namely the provision of letters of referral reply to the referring facility or health worker, which is entrusted to the patient's family; 3) The standard procedure for accepting back referrals has not been implemented because there has been no back referrals from hospitals (hospitals) or referral health centers.

For the case of normal childbirth, the Bandar I Health Center serves childbirth at PONED. For the case of Obstetric Emergency, the referral is directly addressed to Kalisari Regional Hospital which is the PONEK Hospital. Before making a referral, the Puskesmas contacted the referral destination hospital by telephone, to submit the case to be referred and to guarantee the availability of a place in the hospital. If the Kalisari Hospital is full, the telephone officer to the hospital in Pekalongan can handle emergencies, if it is also full, the official will still look for the hospital until out of town, but in this study the patient will be referred to Kalisari Regional Hospital.

Based on the results of the interviews, several obstacles in the process of childbirth referral experienced by Puskesmas midwives, one of which was due to transportation. This is in accordance with previous research which states that the availability of transportation equipment in Puskesmas PONED needs to be an important consideration in order to improve the quality of patient services. Long distances, poor road conditions, and insufficient transportation are one of the indirect causes of delay in emergency cases to be handled in health facilities (Mujiati, Lestari & Laelasari, 2014).

The absence of hospital feedback to the Puskesmas is in accordance with research (Iswanto, 2015) which shows that hospitals often neglect feedback to the Puskesmas, this is due to the actions taken by Regency and City Hospitals considered complete in the healing process (Iswanto, 2015). However, it should must be returned to the Puskeksmas (Purwati, 2017) with a resume of the process and results of the service and a follow-up plan according to the National Referral System Guidelines

(Purwati, 2017). Postpartum delivery in the hospital, the role of the puskesmas midwife in reviewing the condition of mothers who have given birth, so you can make sure the mother is in good condition.

Conclusions

1. Institutions of Health Services
   a) The existence of policies that support the prevention and early detection of high risk pregnancies and the potential for obstetric complications, especially complications of pregnancy and childbirth so that prevention efforts can be done optimally.
   b) There is integration between the Puskesmas and hospitals in the labor referral process and post delivery referral feedback.
   c) It is expected that Puskesmas can educate and motivate by providing effective and efficient counseling to cadres, completing facilities and personnel to reduce the number of puskesmas referrals that are not appropriate.
2. For the Community
   There is an increase in the role of husband and family in planning safe delivery so as to prevent high risk delivery or complications.
3. For Other Researchers
   There is further research related to internal and external causes as well as the impact of the labor referral process and obstetric emergencies within the Hospital.

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