DETERMINANTS OF MATERNAL MORTALITY IN BUTON DISTRICT SOUTHEAST SULAWESI PROVINCE

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ABSTRACT

This study aims to assess the determinant factor of maternal mortality in 2016 in Buton. The method used in this study is a qualitative case study approach. The data was collected through library research, interview and observation. Data analysis used Content Analysis that after the data was categorized; the data were coded and analyzed. The results of the study showed from 5 death identified in the District during the year 2016 obtained the result that 2 death caused by Retention placenta, 2 death due to Eclampsia and 1 death due to Pre-eclampsia. For the status of the health of the mother, to 5 the mother has a history of built-in disease before pregnancy and more severe during pregnancy and the existence of delay factor 3 that was 3 deaths due to late decision and 2 deaths due to late get adequate handling and right.

Keywords: Maternal mortality, maternal death Determinant.

INTRODUCTION

Maternal health is still an international issue. In almost every hour and every minute, every day a woman dies due to complications related to pregnancy, childbirth and post-natal (Garg, 2006; UNICEF, 2012). Program Millennium Development Goals (MDGs) were launched in 1990 that one of its goals is to improve maternal health has come to an end in 2015. By the UN general assembly in New York, September 2015 resume the MDG program with a new program called Sustainable Development Goals (SDGs) or the Sustainable Development Program. With this program, the SDGs will automatically be valid for the next fifteen years (2016-2030) for developed countries and developing.

Many factors lead to high rate of maternal mortality. According to the WHO report in 2015, maternal deaths due to complications during and after pregnancy and childbirth. The major complications are reported to contribute to nearly 75% of all maternal deaths are hemorrhage, infection, high blood pressure during pregnancy (pre-eclampsia and eclampsia), complications of childbirth and unsafe abortion (WHO, 2015).

In Indonesia, maternal mortality has the same pattern that is caused by bleeding, eclampsia and infections are a direct cause of maternal death. While the indirect factor is due to factors of late and too. These factors are all related to access, social, cultural, educational and economic. This clearly shows that maternal mortality is a very complex problem (GIZ, 2011; Ministry of Health, 2014)

Percentage of factors that a direct cause was the caseHemorrhage (42%), eclampsia / Preeklampsi (13%), abortion (11%), infections (10%), long Partus / obstructed labor (9%) and other causes (15%) (WHO, 2015), Similarly, in Indonesia the largest percentage as the number one MMR in Indonesia is bleeding between 20-50 percent of deaths are caused by

uncontrolled bleeding. The bleeding is postpartum bleeding and during childbirth. According to research conducted Masrida Sinaga in the province of East Nusa Tenggara (NTT), the incidence of bleeding in the mother caused by anemia and KEK (Chronic Energy Deficiency) caused by the problems of poverty, poor education,ignorance about sexual development and reproductive processes, culture, gender bias conditions in society and the family as well as the location of isolated dwellings (Sinaga, 2007).

Factors late to be a factor that is not directly but contribute to maternal mortality. Described by Thaddeus and Maine in the model of "Too Far Walk" in 1994 (Belton et al., 2014), which identifies three types of delay, namely the late first took the decision to get treatment, the second one was late arriving at the health facility and the third late getting adequate treatment and proper (Nour, 2008; Belton et al., 2014).

Leading cause of death in Buton is also due to hemorrhage, eclampsia and infections. Most maternal deaths occurred in the group of mothers aged 20-34 years is 57.1%. While for K1 Coverage, in the year 2013 by 87.0% increased to 99.4% in 2014. And the K4 coverage decreased from 81.2% in 2013 to only 75.1% in 2014. This figure is still under target of Minimum Service Standards (SPM) or indicators K4 national coverage of 95%. The percentage of births attended by skilled health personnel did not experience a substantial increase of the data as much as 75.7% in 2012, and then declined to 74.7% in 2013 and by 2014 as much as 78.1%. More mothers delivered at the shaman. When compared with the SPM then this figure is still far from the target which amounted to 90% (Buton District Health Office, 2014).

For reference the case of high risk (high-risk), and treatment of complications, in 2014 discovered 193 pregnant women who have a high risk / complications and receive treatment by midwives and doctors in health centers / health centers care. This figure only reached 13.9% of the target high-risk pregnant women / complications is estimated at 20% of target pregnant women (Buton District Health Office, 2014).

Government programs are also implemented in Buton Southeast Sulawesi, but the results have not reached the target SPM national due, among other factors birth too young, high parity, and maternal knowledge about health care utilization is not maximized although Childbirth insurance already enacted, some pregnant are late to deliver in health facilities besides that it still met the mother gave birth assisted by a shaman this is due to public confidence in the shaman is still there, a lack of understanding of pregnant women about the importance of delivery by health personnel, high deliveries in non-health facilities, empowering families to use the book KIA is not optimal (Buton District Health Office, 2014). Based on this background, it is the purpose of this study is to examine the causes of maternal death in Buton 2016.

RESEARCH METHODS

This research was conducted in Buton in Southeast Sulawesi province of Indonesia, which consists of 7 districts. The area selected sample areas that the district has happened death in 2016 that there are two sub-districts Pasarwajo (4 maternal deaths) and the District Wolowa (1 death of mother). The research is a qualitative research with case study approach. The main instrument in this study is the researchers themselves. Informants in this study is the family of the deceased mother and midwife in the location of death. Data was collected by

literature study, interview and observation. Data were analyzed using content analysis, i.e. the data is categorized, coded and analyzed.

RESULTS AND DISCUSSION

Mother's death according to the limits of the Tenth Revision of the International Classification of Diseases (ICD-10) is the death of a woman during pregnancy up to 42 days after the termination of pregnancy, irrespective of the time and place of the occurrence of pregnancy caused by or triggered by pregnancy or, handling her pregnancy, but not because of an accident (WHO, 2015; Nieburg, 2012).

Based on the understanding of the ICD-10, maternal deaths can be divided into two groups: (1) Direct obstetric death (direct obstetric death) is death arising as a result of complications of pregnancy, childbirth and postpartum, caused by the acts, omissions, inaccuracies handling, or from a series of events arising from the circumstances mentioned above. Complications include bleeding, antepartum and postpartum hemorrhage, preeclampsia / eclampsia, infection, obstructed labor and death in early pregnancy. (2) Death obstetric indirectly (indirect obstetric death) is death caused by diseases that have been suffered prior to pregnancy or childbirth or illness arising during pregnancy is not associated with the cause of obstetric directly, but exacerbated by the effects of physiologic consequence of pregnancy, so that the person's condition becomes more bad. These indirect obstetric death caused, for example due to hypertension, heart disease, diabetes, hepatitis, anemia, malaria, tuberculosis, HIV / AIDS, and others (Ronsmans & Filippi, 2008). However, according to According to McCarthy and Maine (1992), the risk factors that can lead to maternal death caused by three determinants, namely: (1) Determinants near the pregnancy itself and complications in pregnancy, childbirth and post-partum period. Women who are pregnant are at risk for complications, both complications of pregnancy or childbirth, while the non-pregnant women do not have that risk. (2) Determinants of which is the direct cause of the determinant close as maternal health, reproductive status, access to health care and behavioral health facilities use. (3) Determinants far is the influence of other factors such as socio-cultural factors, economic and other factors to be considered have affected the incidence of maternal deaths include late factor (Fibriana, 2007). The results of research in the field to get the results as follows:

Case 1

The 32-year-old woman. 3. The age of pregnancy was first married less than 18 years. ANC history either. Mothers give birth at home and only rescued by shamans. Babies born but the placenta is not born. Mom would not survive in referred to RS. Mothers living in a society that is still strong culture and taboos. Giving birth at home is considered a necessity and should not give birth outside as a disgrace to the family. Trust in the community if there is difficulty giving birth mother, there is a problem with the husband. Husband during the recall and admit "mistakes", the mother and the baby would survive. Failure here has to do with the "affair" or associated with another woman. So that is considered a disgrace, they embarrassed the neighbors if caught birth to resistance. About 3 hours after the baby is born, approved a new family for referrals. Mother was weak. Mother died on the way to the hospital. The most likely possibility is to delay making a decision and mother died because of bleeding (retained placenta).

Case 2

37-year-old woman. 5. Mother of pregnancy was first married at age less than 20 years. She felt intense pain in the back of the waist and out of waters. The midwife came to the rescue

and suggested referenced but the mother survived to give birth at home. The mother's blood pressure continues to rise. Mothers experiencing great pain and spasms. The midwife advised the family should be immediately referred to the hospital. Babies born through surgery. An hour later my mother died at the hospital. She also did a bit heavy physical labor during pregnancy. Consuming less nutritious foods during pregnancy because of economic limitations. The most likely possibility is to delay making a decision and mother died of eclampsia.

Case 3

34-year-old woman. pregnancy to 4. First married at ages less than 20 years. Family economy is limited, the mother opened a small shop in his house. Mothers know the pregnancy in gestational age 4 months. Antenatal midwife and doctor. Water out of the birth canal, but no pain. Day 5 since the water pumped out and then felt sick. The midwife came to help labor but the placenta is not born. About 3 hours after the baby is born to wait placenta is born, the mother looked limp. No longer found nerves when infusion going. Referred to the hospital. Mother died in the hospital. The most likely possibility is a delay in getting adequate and appropriate handling and mother died because of bleeding (retained placenta).

Case 4

25-year-old woman. Mother died in pregnancy 28 weeks (7 months) in pregnancy to 2. The first time was married at the age of less than 20 years. Mother came from a family that has economic limitations. ANC bad. Bleeding. Midwives recommends referred to the hospital because the mother suffered severe edema (swelling almost the whole body to face). Mother was treated for three days in the hospital. Test results have proteinuria high mother and the mother had a history of kidney disease. delays in getting adequate and appropriate handling and mother died of preeclampsia.

Typical signs of preeclampsia is high blood pressure, the presence of protein in the urine and swelling of tissues (edema) during the second trimester of pregnancy. In some cases, the situation remains light throughout the pregnancy, but in other cases, with increased blood pressure and the amount of urinary protein, can be severe circumstances. Occur headache, vomiting, visual disturbances, and then anural. In the later stages of the most severe and eclampsia occurs, the patient will experience seizures. If preeclampsia / eclampsia is not treated quickly, there will be loss of consciousness and maternal deaths due to heart failure, kidney failure, liver failure or brain hemorrhage. Predisposing factors preeclampsia and eclampsia is nullipara, maternal age less than 20 years old or over 35 years, less economic status, pregnancy.

Case 5

37 year old woman. Pregnancy 2. Age married less than 20 years. ANC history quite well. However, pasty-faced mother and yellow just before delivery. Coming from a family that has economic limitations. Mother was working during pregnancy. Mother had psychological problems marital relationship is not harmonious and trauma due to pregnancy are attended by midwives before surgery. Poor mother's pregnancy history. Never SC, miscarriage and wine pregnant. When births assisted by a shaman, but the mother remains very weak, the family call the midwife. Diimpus after the baby is born. Shortly after the baby is born, the mother show symptoms of signs of shock, the mother seemed uneasy. Mother suffered convulsions and foaming mouth. The family did not directly refer still looking for another family. Mom died when will be approved to be taken to hospital.

CONCLUSION

The determinant factor of maternal mortality in Buton 2016 due to: (1) Determinants near: the majority of maternal death in Buton 2016 due to retained placenta and Eclampsia. (2) Between determinant: the majority of maternal deaths in Buton 2016 due to the health status of mothers in which almost all the mothers who experienced death before pregnancy have congenital diseases and worsens during pregnancy. (3) Determinants far: the majority of maternal deaths in Buton 2016 due to the delay factor that is overdue decision.

REFERENCES

Belton S, Myers B, Ngana FR. 2014. Maternal deaths in eastern Indonesia: 20 years and still walking: an ethnographic study. BMC pregnancy and childbirth. Vol. 14, No. 1.

Buton District Health Office. 2014. Health Profile of Buton District.

Fibriana, A.I. 2007. Faktor – Faktor Risiko Yang Mempengaruhi Kematian Maternal (Studi Kasus Di Kabupaten Cilacap). Tesis, Universitas Dipanegoro.

Garg, B.S. 2006. Safe Motherhood: Social, Economic, And Medical Determinants Of Maternal Mortality. Women and Health Learning Package: Safe Motherhood.

GIZ. 2011. Persalinan Sebagai Urusan Desa German Health Practice Collection 2011.

McCarthy J, Maine D. 1992. A framework for analyzing the determinants of maternal mortality. Stud Fam Plann. 1992 Jan-Feb;23(1):23-33.

Ministry of Health, 2014. Maternal Health Situation. Data and Information Center Ministry of Health Republic of Indonesia.

Nieburg P. 2012. Improving Maternal Mortality And Other Aspect Of Women's Health The United States Global Role. Csis Center Of Strategic & International Studies.

Nour, N.M. 2008. An Introduction to Maternal Mortality. Reviews In Obstetrics & Gynecology, Vol. 1 No 2.

Ronsmans C, & Filippi V. 2008. Maternal Mortality in Developing Countries. Springer http://www.springer.com/978-1-934115-24-4. 2008.

Sinaga, M. 2007. Beberapa Faktor Sosial Demografi Yang Berhubungan Dengan Tingginya Angka Kematian Ibu Di Propinsi Nusa Tenggara Timur. Jurnal MKM. 2007;Volume 3 Nomor 2.

UNICEF. 2012. Ringkasan Kajian Kesehatan Ibu dan Anak. UNICEF Indonesia.

WHO. 2015. Trends in maternal mortality: 1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. WHO Library Cataloguing-in-Publication Data.