Community Participation in Improving Maternal Health:
A Grounded Theory Study in Aceh Indonesia

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LIST OF FIGURES AND TABLES

LIST OF FIGURES

LIST OF TABLES

LIST OF APPENDICES

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LIST OF ABBREVIATIONS

CHW	Community Health Worker
CMACE	Centre for Maternal and Child Enquiries
CP	Community Participation
CPD	Continuing Professional Development
DFID	Department for International Development
FGD	Focus Group Discussion
IDHS	Indonesia Demographic Health Survey
IEC	Information, Education and Communication
MDGs	Millennium Development Goals
MH	Maternal Health
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
PHO	Provincial Health Office
PPC	Papuan Presidium Council
RCOG	Royal College of Obstetricians and Gynaecologists
RCT	Randomised Control Trial
SIAGA	Siap Antar Jaga
TBA	Traditional Birth Attendance
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency International Development
VM	Village Midwife
WHO	World Health Organisation

ABSTRACT

THE UNIVERSITY OF MANCHESTER

ABSTRACT OF THESIS submitted by Suryane Sulistiana Susanti for the degree of Doctor of Philosophy and entitled:

Community participation in improving maternal health: a grounded theory study in Aceh, Indonesia

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Indonesia has one of the highest rates of maternal mortality in Southeast Asia. Community participation has been known to reduce maternal mortality in some areas in Indonesia. However, in Aceh Province, the prevalence remains higher than the general Indonesian maternal mortality rate.

The aim of this research was to gain an understanding of pregnancy and childbirth experiences from multiple perspectives, in relation to the use of maternal health services in Aceh, Indonesia. The conceptual framework was based on the importance of community engagement in improving maternal health. A qualitative study design with a grounded theory approach was utilised. This approach was chosen in order to gain an understanding of the social processes and ways in which experiences of pregnancy and childbirth are related to maternal death incidents. The process inherent in the method enabled the emergence of important theoretical concepts. A theoretical sampling strategy was employed. The data collection used multiple methods that involved a series of in-depth interviews, observations and focus group discussions with women, family members, a village leader and health professionals. The sample size was determined by data saturation (19 women, 15 family members, 7 health professionals, 3 kaders, 4 student midwives and 1 village leader participated). Ethical approval was gained and the research setting was in the two villages of Aceh Besar District, Aceh Province, Indonesia. Data were coded and analysed by following a constant comparison process.

The emergent core category, entitled "maternal death: the elephant in the room" explains the views of the community about maternal death incidents in the research setting. The research findings highlighted that despite the maternal mortality rate still being high in the region, maternal death was not focused upon, as a problem within the community. The research findings revealed that maternal mortality was a hidden problem within the community, and was related to inadequate maternity practices in the village. The core category "maternal death: the elephant in the room" was found to consist of four interrelated categories. The categories of *the value of midwifery in the community, desicion-making of maternity care, social control of the childbearing* and *distancing of maternal deaths;* explain maternity practices in the community. Understanding of social processes related to maternal health can assist in informing strategies to improve the quality of maternal healthcare in Aceh Indonesia.

DECLARATION

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other institute of learning.

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CONFERENCES AND SHOWCASE

During the development of this thesis, a number of conferences and showcase have been registered and attended.

CONFERENCES

Susanti, S., Furber, C., Lavender, T. (2012). Community Participation in Improving Maternal Health: A Grounded Theory Study in Aceh, Indonesia. Abstract accepted at the 31st Annual International Nursing & Midwifery Research & Education Conference. 22 – 23rd February 2012. Dublin. Ireland.

Susanti, S., Furber, C., Lavender, T. (2012). Community Participation in Improving Maternal Health: A Grounded Theory Study in Aceh, Indonesia. Poster presented at the Global Women's (GLOW) International Research Conference. 23rd October 2012. Liverpool. UK.

Susanti, S., Furber, C., Lavender, T. (2013). 'Maternal Death: The Elephant in the Room' A Grounded Theory of Community's Perceptions and Experiences of Maternal Death in Aceh Indonesia. Poster presented at the 2nd Global Women's (GLOW) International Research Conference. 1st November 2013. Birmingham. UK.

Susanti, S., Furber, C., Lavender, T. (2014). 'Maternal Death: The Elephant in the Room' A Grounded Theory of Community's Perceptions and Experiences of Maternal Death in Aceh Indonesia. Oral presentation at the International Conference of Urban Health 2014. 5th March 2014. Manchester. UK.

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SHOWCASE

Qualitative Study: A Grounded Theory of Community's Perceptions and Experiences of Maternal Death in Aceh, Indonesia.
Faculty of Medical and Human Science (FMHS) Postgraduate Society Showcase-July 2013.

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DEDICATION

This work is dedicated to my loving, trusting and supporting family.

My parents, for their patience, understanding and

providing me their love more than I deserved.

Also my two beloved sisters, niece and nephews,

who have been sources of inspiration, encouragement

and make me learn to be a better sister and auntie everyday

Love you all

BACKGROUND TO THE AUTHOR

The author is a practising nurse and educator in community health nursing. She obtained a Bachelor degree in Nursing from the School of Nursing, Faculty of Medicine, Syiah Kuala University, Indonesia in 2006. She also obtained a Master degree in Health Management, Planning and Policy from the University of Leeds, United Kingdom in 2008.

After completing her first degree, the author deployed to teach undergraduate programmes in the School of Nursing, Syiah Kuala University, Indonesia. The author had been working as an educator in the university and was involved in the community health nursing field until gaining admission into the University of Manchester to undertake the PhD degree.

CHAPTER 1

CONTEXT OVERVIEW AND STUDY BACKGROUND

1.1. Introduction

In this chapter, a general overview of the research and the background of the research setting are provided. The scope of the research is provided, along with the research problems and questions. Various definitions of maternal mortality and the existing knowledge related to the problem are also provided.

1.2. Overview of the Research Context

Indonesia is a country located in Southeast Asia and has the highest prevalence rate of maternal mortality in the region (WHO 2013). According to the Ministry of Health (MoH) of Indonesia, during the period of 2004–2008, the maternal mortality rate (MMR) was 228 maternal deaths per 100.000 live births, with around 13.778 maternal deaths occurring each year in Indonesia (MoH 2009).

In a maternal health survey conducted by the Indonesian MoH in 2008, the direct causes of maternal deaths in Indonesia were found to be associated with complications in pregnancy, childbirth and the postpartum period. The survey found the greatest causes of pregnancy complications in Indonesia to be postpartum haemorrhage, hypertension in pregnancy (eclampsia), prolonged labour and complications associated with miscarriage (MoH 2009).

The Indonesian government established a safer motherhood programme called 'Siaga campaign' during the period 1998 – 2002 (Shefner-Rogers and Sood 2004). This programme was established as one of the government's efforts to reduce the maternal mortality rate in the country (Shiffman 2003). *Siaga* means 'alertness' in Indonesian language. A maternal health policy was established within this campaign, in order to increase the alertness of communities and to improve the participation of community members in maternal health issues. It also targeted the midwives in order to improve their skills in providing maternal health services (Shiffman 2003).

The concept of community involvement in health is historically strong in Indonesia (Shefner-Rogers and Sood 2004). The Siaga campaign was adapted and implemented from concepts related to Indonesian values of sharing

15

responsibility and community self-help (Shefner-Rogers and Sood 2004). Participation from the community is important in order to make sure the health services meet the needs of the people and consequently increase the ownership of the health programme in the community (Rifkin 1990).

1.3. The Emergent Research Problem and Questions

The prevalence of maternal mortality in Aceh Province remains higher than in other provinces; despite the maternal health programmes that have been conducted by the Indonesian government. This research was conducted in order to gain an understanding of pregnancy and childbirth experiences from multiple perspectives in Aceh, based on some of the following research questions:

- What are the contributing factors to the continuing level of maternal death incidence in Aceh Province, Indonesia?

- What are the roles of community members in maternal health practices in Aceh Province, Indonesia?

- What are the factors promoting and hindering engagement with maternal health services in Aceh Province, Indonesia?

1.4. Choice of Methodology

This research was conducted by utilising the grounded theory research method. Grounded theory is a methodology that enables the researcher to understand the perceptions and ideas within people's experiences (in this case, experiences of pregnancy and childbirth). It is used to discover new information where little is known about the subject (Heath and Cowley 2004). Grounded theory also focuses on the social processes (how people think and behave) related to the issues and experiences of the subject (Glaser and Strauss 1967; Glaser 1998). This approach is useful in assisting theory generation and identification of the interaction between participants in their own environment (Glaser and Strauss 1967; Dey 1999; Bryant and Charmaz 2007).

1.5. Background Information on the Research Setting

Within this background information, demographic features of both Indonesia and Aceh province as the research setting are provided. A brief description about demographic features and community context in the research setting is also explained.

1.5.1 General Information on Indonesia

Indonesia is the largest archipelago in the world and is located in Southeast Asia and Oceania (WHO 2013). It consists of more than 17.500 islands, with five major islands and 30 smaller groups (MoH 2009). Indonesia has a tropical climate because of its proximity to the equator. It is divided into two distinct seasons: dry and rainy seasons. Indonesia is also known for its susceptibility to natural disasters such as earthquakes and volcanoes. This is due to its position in the 'Pacific Ring of Fire': an area where large numbers of earthquakes and volcanic eruptions occur in the basin of the Pacific Ocean (Paris et al. 2007). The most well-known tsunami happened in 2004 in part of Sumatra Island, Indonesia. This devastating tsunami followed a series of massive earthquakes of around 9.1 magnitude in the country (Paris et al. 2007).

Across its many islands, Indonesia consists of diverse ethnic communities, linguistic and religious groups. It has more than 300 ethnic groups (using more than 300 native languages) spread across the whole archipelago. Indonesia is the world's fourth most populous country, with a population of around 247 million (WHO 2013). *Bahasa Indonesia* is the main and official language in the country, and the Javanese (a population living on Java Island) are the largest and most politically dominant ethnic group. Indonesia has one of the largest Muslim populations (88.58%) in the world. Other religions include Protestantism (5.79%), Roman Catholicism (3.10%), Hinduism (1.73%), Buddhism (0.61%) and others (0.11%) (Statistics Indonesia (Badan Pusat Statistik) 2010).

Administratively, Indonesia's regions are divided into 33 provinces (MoH 2009). These provinces consist of 349 districts, 91 municipalities, 5.263 sub districts and 69.929 villages (Statistics Indonesia (Badan Pusat Statistik) 2010). Similar to other developing countries, poverty has become an economic burden in Indonesia. In 2007, the proportion of the population living under the poverty line in Indonesia was estimated to be around 20 percent (MoH 2009). The government has committed to working towards the attainment of the Millennium Development Goals (MDGs) established by the United Nations (UN). This is reflected in the country's National Development Plan (WHO 2013), which involves various plans and strategies to reduce poverty and improve the health of Indonesia's population (MoH 2009).

1.5.2   General Information on Aceh Province

Aceh is a province on the northern tip of Sumatra Island, western Indonesia. The province covers a total area of about 58.375,63 km^2, and it is divided into 21 districts/cities, 227 sub districts and 5.254 villages (PHO 2012). It spans approximately 119 islands, including small islands and three main islands to the north (MoH 2009). Aceh Province is directly adjacent to the Malacca Strait to the north, North Sumatra Province to the east and the Indian Ocean to the west and south. Its provincial capital is Banda Aceh. Aceh's total population in 2011 was estimated to be over 4.5 million, with the ratio of males to females at about 1:3 (PHO 2012).

The Aceh people (or *Acehnese*) speak their own language and most also speak the Indonesian language. Of the total population, around 70 percent live in rural areas and most of their livelihoods are centred on agriculture and fishing (PHO 2012). Women typically run the households, including childrearing, while men tend to stay out of domestic affairs (Basri 2010). All children, even the youngest, are expected to help with the family work. Around 90 percent of the Aceh population is Muslim and the Acehnese are known throughout Indonesia as devout followers of Islam (Basri 2010). Aceh Province was the first area in Indonesia (even the first in Southeast Asia) to receive the influence of Islam, so Aceh is often called 'the gate of Mecca' (Basri 2010). The people's lives are strongly influenced by Islam and the inhabitants make every effort to establish Islam in all aspects of their lives. The province even has special autonomy to apply Islamic law in certain cases instead of Indonesian national law. However, the Acehnese are not religious extremists, since they share common virtues and cultural values with the entire Indonesian community (Basri 2010).

There is a traditional democratic organisation in Aceh society called a *Gampong* (or village). Beside the head of the Gampong and his assistants, there are also representatives elected from senior people in the village. These senior people are called *Tuha peuet* and have vast experience, which allows them to be members of the Gampong organisation and be involved in the society's affairs. These organisations are still established, especially in rural community areas (PHO 2012).

Aceh was the province in Indonesia that was most affected by the devastating tsunami in 2004, with more than 200.000 people being lost (Paris et al. 2007). It is considered to be one of the deadliest natural disasters in recorded history, and the earthquake that prompted the tsunami (with a magnitude of

approximately 9.1) is the third largest earthquake recorded using seismographs (Paris et al. 2007).

During 1976–2005, Aceh was also known as the province that had the *Aceh Free Movement* separatist activity. The Acehnese freedom fighters (AFF) believed that the Indonesian government had poor management over their region (PPC 2001). This made the Acehnese suffer from a long conflict between the Indonesian government and the AFF. The tsunami incident in December 2004 ended the conflict, along with the special autonomy that the Indonesian government had given to Aceh in 2001. As well as the devastating impact and the staggering loss of life due to the tsunami, this loss of autonomy was a great blow to the province (Basri 2010). However, the Acehnese have now renewed their sense of hope and are healing from the conflict and tragedy. Together with the funding organisations, the government is helping the communities in establishing reconstruction and development. This activity includes focusing on the health system, especially maternal healthcare, where safer motherhood and childcare programmes had already been underway before the tsunami happened (PHO 2006). The Maps of Indonesia and Aceh Province are shown in the following figures:
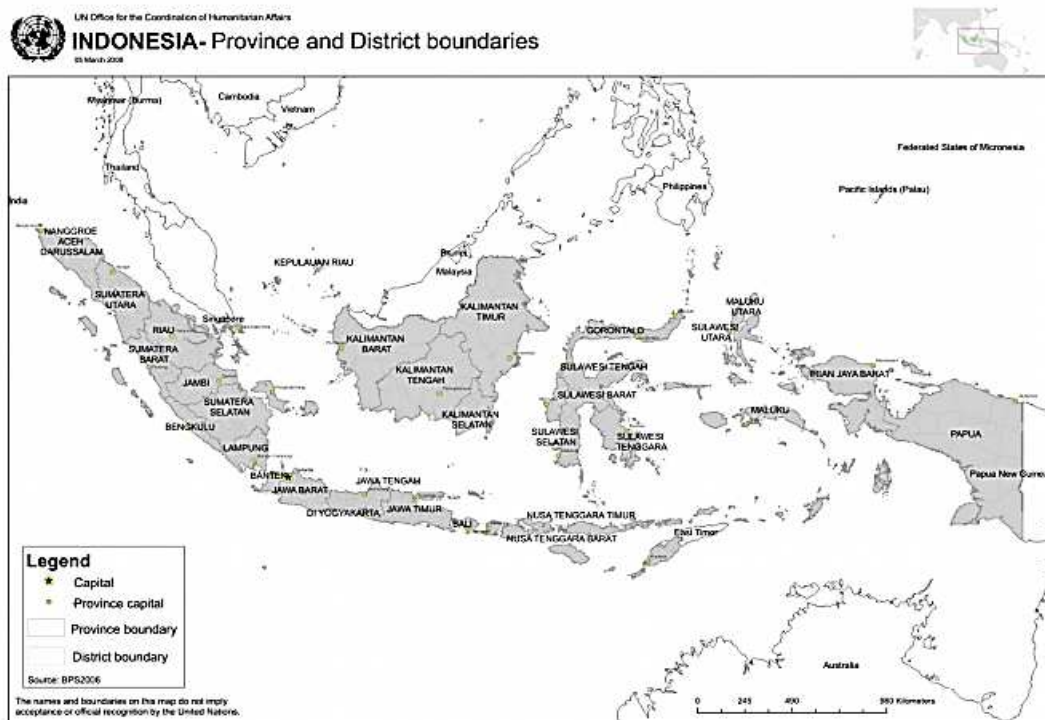
Figure 1.1: Map of Indonesia

1. Source: http://reliefweb.int/map/indonesia/indonesia-province-and-district-boundaries-05-mar-2008

19

Figure 1.2: Map of Aceh Province

Source: http://www.docstoc.com/docs/44749453/Map-of-Aceh-Indonesia

1.5.3 Healthcare Provision in Indonesia

Almost all the systems in Indonesia, including healthcare are moving towards decentralisation (Shiffman 2003). However, some of the decisions in major policy, vertical programmes and budgeting relating to healthcare still remain centralised at the national level (Geefhuysen 2001). In each province, health services are organised at the provincial level (PHO). PHO organises the district level, whereby each district has its own offices (DHO) that are responsible for the district health centres (known as *Puskesmas*). Every Puskesmas has responsibility for the auxiliary health centres (*Puskesmas Pembantu*) in the villages. There are also village midwives' health posts and mobile clinics in order to reach out to the remote areas (Appendix 1 provides the organisational structure of the health system in Indonesia). The purpose of this national health structure is to provide healthcare in rural areas (Geefhuysen 2001). Hospitals are mostly based in the districts' capital cities. In 2007, an estimated 50.57 percent of Indonesian hospitals were owned by the government and 49.43 percent were owned by private organisations (MoH 2009).

20

In terms of the government's efforts to reduce poverty in the country, several programmes have been developed in order to help poor people access the appropriate health services. Since the year of 2000, the Indonesian MoH has implemented 'the Healthcare for Poor People Programme' (*Askeskin*). In 2008, its name changed to 'Public Health Insurance' (*Jamkesmas*). *Jamkesmas* is basically an aid for poor people so that they can afford to access health services. It covers inpatient and outpatient healthcare and emergency care (MoH 2009).

The maternal mortality rate (MMR) is one of the indicators used to measure the public health status of communities and significantly, may describe the achievements of health development programmes (Azwar 2004). It indicates the number of maternal mortalities relating to pregnancy, childbirth and the postpartum period. Complications and subsequent maternal mortality frequently occur during births when they are not assisted by trained health personnel (MoH 2009). The amount of births assisted by health professionals in Indonesia in 2008 was 77.21 percent (MoH 2009). However, this percentage varies among provinces. This can be attributed to the uneven distribution of healthcare staff in the Indonesian provinces, which still remains a problem in the country (Geefhuysen 2001).

In Indonesia, the percentage of home-based births is still considerably high. Home-based births are more likely in rural areas, where most women give birth to their babies at home with the help of either traditional birth attendants (TBAs) or village midwives with limited health facilities (Yuliandri 2008). A recent survey showed that only 46 percent of births in Indonesia are delivered in health facilities (hospitals, health centres, midwives' private clinics, etc.), and most of these occur in urban areas (Statistics Indonesia (Badan Pusat Statistik) 2010). Meanwhile, the remaining 54 percent give birth at home, especially in rural areas, where access to health facilities is still limited (Yuliandri 2008; Statistics Indonesia (Badan Pusat Satistik) 2010).

1.5.4 The Impact of Maternal Mortality in Indonesia

Maternal health conditions are the largest contributor to the global disease burden of women of reproductive age (WHO 2008). The tragedy of a maternal death is compounded by the severe consequences it can have for her remaining or surviving children. In developing countries, a maternal death or a mother's chronic poor health increases her children's risks of death and poor growth and development. In one study of developing countries, it was reported that children whose mothers died during childbirth were 52 times more likely to die between

the 4th and 24th week of life, than children whose mothers survived in childbirth (USAID 2010). Surviving children face consequences of family collapse (due to the absence of the mother) and malnutrition. In addition, it also decreases their educational opportunities, as older children may have to leave school to earn money or care for their homes and younger siblings (USAID 2010).

In Indonesia, maternal deaths are not only affecting the diminished resources for the children but also for the entire family. In most rural areas in Indonesia, women also have to take part in income generation, due to poor economic conditions and financial problems. Apart from being responsible for their households, they also help their families or assist their husbands through working, mostly in agriculture or fishing, as the main livelihoods in rural areas in the country. Women are considered to be the heart of the family (Neil et al. 2010). The death of the mother not only results in the loss of a 'mother figure' (who has responsibility for and ensures her children's development) but also has an effect on the general income situation and the functioning of the family (Neil et al. 2010).

1.6.   The Maternal Mortality Concept

Maternal mortality in general refers to the death of a woman due to pregnancy and childbirth (WHO 1999). The World Health Organization (WHO 1999) defines maternal mortality as 'the death' of a woman while pregnant or within 42 days of pregnancy's termination. This maternal death is caused by complications either directly or indirectly related to the pregnancy, but not from accidental or incidental causes during pregnancy and childbirth (WHO et al. 2001).

The Centre for Maternal and Child Enquiries (CMACE) in the United Kingdom (UK) has also adopted the concept of maternal mortality from the WHO. According to the CMACE, deaths during pregnancy or following birth can be classified based on time (during pregnancy and within 42 days after birth) and by cause: direct (i.e. haemorrhage), indirect (i.e. cardiac), coincidental (i.e. accident) and late deaths (CMACE 2011). This definition includes spontaneous abortion or termination during pregnancy. In the UK, the maternal mortality rate can be calculated in two ways: through death certification and through deaths reported to the CMACE. The overall number of maternal deaths from obstetric causes can also be obtained. Obstetric causes involve direct deaths related to obstetric complications during pregnancy, labour and the postpartum period. Indirect deaths are those associated with disorders or the effects of diseases

during pregnancy, while late deaths occur up to 42 days after the end of pregnancy (CMACE 2011).

The WHO (2004) also describes the concept of late maternal deaths. According to the WHO, this concept recognises maternal deaths occurring between six weeks and one year in the postpartum period. This definition is most applicable to countries with more developed vital registration systems and sophisticated technology for life-sustaining procedures. In such settings, women can survive maternal complications beyond 42 days in the postpartum period. The WHO's (1999) definition that limits maternal deaths up to 42 days in the postpartum period, mainly suits developing countries, because of the under-development of healthcare technology (WHO 2004).

There is an alternative definition of maternal mortality referred to as 'pregnancy-related death' (WHO 2004). This definition has become necessary in recognition of the fact that some home births are not attended by skilled birth attendants. This definition comprises all maternal deaths from any cause, including accidental and incidental causes during pregnancy, childbirth and the postpartum period. This alternative definition allows measurements of deaths that are related to pregnancy even though they do not conform strictly to the standard of maternal death definition. It is useful to know where accurate information about causes of deaths based on medical certificates is unavailable. In addition, it is important to be aware of the varying definitions of the concept of maternal mortality, since the statistical prevalence cannot be compared across countries. Moreover, the concept of maternal death differs based on the available evidence and health situations within countries.

1.6.1 Causes of Maternal Mortality

Maternal mortality remains a serious problem due to many direct and indirect causes. Direct obstetric complications are those arising from pregnancy, childbirth and the postpartum period, such as haemorrhage, eclampsia, obstructed labour, unsafe abortion and sepsis. These also include complications from interventions, incorrect treatment or a sequence of events resulting from any of the aforementioned complications (WHO 2007). Specific examples of the complications that contribute to maternal deaths in Aceh are (ranked by prevalence): obstetric haemorrhage, eclampsia, anaemia, obstructed labour and infectious diseases. This situation is also found in most developing countries, where haemorrhage, hypertensive disorders, sepsis and abortion are the largest contributors to maternal deaths (Khan et al. 2006). Although these

complications are responsible for 80 percent of maternal deaths, all of these complications can be prevented [Royal College of Obstetricians and Gynaecologists (RCOG) 2007)]. The figure below shows the causes of maternal mortality in Aceh, Indonesia.
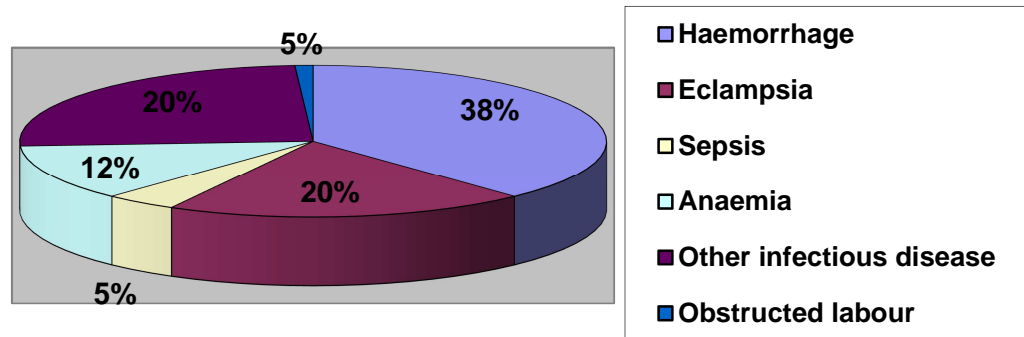
Figure 1.3: Causes of maternal mortality in Aceh, Indonesia

Source: PHO (2011)

Indirect obstetric deaths result from previous existing diseases that developed during pregnancy but are not due to direct pregnancy causes. These diseases are exacerbated by the physiological effects of pregnancy. Such diseases include malaria, hepatitis, heart diseases and HIV/AIDS (WHO 2007). Some of the causes of maternal mortality also relate to non-medical direct and indirect causes. Early pregnancy and poor maternal health are considered to be contributors to maternal deaths. Since maternal mortality is a complex problem, it involves not only medical factors but also social, educational and economic factors (Shiffman 2003). The poor condition of social and economic factors combined with the lack of education, contribute to inadequate access to health services especially in maternal healthcare (Rifkin 1990, Shiffman 2003).

1.6.2 The Incidence of Maternal Mortality

The largest contribution to global maternal mortality mainly comes from developing countries. There are more than 500.000 maternal deaths occurring each year around the world, and almost 98 percent take place in developing countries (Donnay 2000). According to the WHO report (2008), over 90 percent of maternal deaths occur in Asia and Sub-Saharan Africa, with one third taking place in Southeast Asia. A large proportion of the maternal deaths in Asia occur in India (25%), followed by Bangladesh, Nepal, Myanmar and Indonesia (Donnay 2000).

The current maternal mortality rate in Indonesia is the highest in Southeast Asia, with no significant reduction evident over the last decade. Although the Indonesian maternal mortality rate decreased from 360 deaths per 100.000 live births in 1990 (IDHS 1994) to 228 during the period 2007–2009 (Statistics Indonesia (Badan Pusat Statistik) 2010); the decrease is too slow to achieve the MDG's target of reducing maternal mortality rate to 100 deaths or fewer per 100.000 live births by 2015 (DFID 2007).

Aceh is one of the provinces in Indonesia that is currently trying to develop many of its sectors, especially after the disastrous tsunami in 2004. This development includes health systems, particularly maternal health services. In terms of health services, Aceh is one of the most advantaged provinces in Indonesia. The special autonomy that the Indonesian government gave to Aceh in 2001 provided this province with special attention. Moreover, 70 percent of Aceh's resource income is managed by itself (PPC 2001). Nevertheless, the maternal mortality rate in the province was estimated to be 354 deaths per 100,000 live births in 2008 (MoH 2009), which is very high compared with the overall maternal mortality rate in Indonesia. The rural areas are recognised as having the highest maternal death rates. This is mostly due to the fact that in very remote areas, health facilities are not available or are inaccessible (PHO 2006).

1.7. Maternal Health and Community Participation

Community participation has been regarded as the key to health improvement in Indonesia since the late 1970s, mainly where there is limited health services coverage (Yuliandri 2008). Support from the community, especially from family members, is very important in order to achieve healthy pregnancy and safer childbirth. Most women consider the need for family members' support during pregnancy and childbirth (Hodnett et al. 2007). Their support may increase women's willingness to seek maternity care (Wahn and Nissen 2008). Positive interaction and support from the community, family members and maternity services may improve the efficacy of the safer motherhood programmes in the community (Shefner-Rogers and Sood 2004).

Maternal mortality is caused by various factors; however, reducing its prevalence is not impossible. Most deaths from pregnancy complications can be prevented. Safer motherhood programmes are important not only for women but also for their families and society (Lule 2005). Since achieving the independence in 1945, Indonesia has put a great deal of effort into developing

its health services, including maternity care. Many health programmes have been implemented, taking into account community participation (Shefner-Rogers and Sood 2004). In 1952, the government focused on maternal health by establishing 'Centres for Mothers' and Children's Welfare' in each district (Leimena 1989). These centres provided assistance to pregnant women, babies and infants through health education, vaccination and simple curative practices. Following this, in 1965, these centres merged with the polyclinics in community health centres (Puskesmas). Puskesmas became the primary health centres for each sub district (Geefhuysen 2001).

The involvement of the community in maternal health programmes enhances the ownership and continuity in the community (Rosato et al. 2008). The community might develop a sense of ownership during the programme, since the people will try to improve their communities by planning and implementing the programmes based on their needs and with their own efforts (Kyasiimire 2003). This will improve their willingness and responsibility in providing and participating in maternal health programmes and services in their communities (Rifkin 1990). Based on this framework, the Indonesian government established several programmes related to maternal and child healthcare programmes in the country. Some of these programmes are explained in the following sections.

1.7.1. The *Posyandu* Programme

An integrated health service post (*Posyandu*) is a health activity that is run by the community in a village (Saito 2006). Posyandu is a special programme that was introduced in 1984, with a focus on decreasing the rates of maternal and infant mortality in the country (Leimena 1989). It works under the responsibility of a community health centre (Puskesmas). It is a community–based and community–organised healthcare programme for mothers and children. Posyandu is run by the community and led by the community health workers (CHWs) known as *kaders;* who receive about a week of training by the health centre staff. They work under the supervision of trained midwives or community health centre staff (Yuliandri 2008).

Most health centres in Indonesia have Posyandu activities, and it is held once or twice a month in a villager's house or in one of the public places in the village. The Posyandu's services consist of five priority services: family planning, antenatal and postnatal care, child healthcare and nutrition, immunisation and diarrhoeal disease control. Posyandu activities are supplied and supervised by the health centre staff (Leimena 1989).

Posyandu introduced the concept of including several activities in the community post; in order to improve the coverage, effectiveness and to accelerate the impact on the reduction of maternal and child mortality rate. The five Posyandu priority services are part of the three types of integration activities in Posyandu (Leimena 1989). Firstly, the integration among programme activities that has a direct impact on the women and children's health status (Family planning counselling, antenatal and postnatal care, child health care and nutrition, immunisation and diarrhoeal disease control). Secondly, the integration between professionals and community services to improve the health status of women and children. Finally, the integration among sectoral activities concerned with health, nutrition and welfare of the family and community (information, education, religion, agriculture and other income generating activities). The first and second integration activities are under direct supervision or provided by the village midwives; whilst the last integration activities usually involved the community members in the village such as the village leader and the religious leader or the *imam*).

1.7.2. Village Midwives in Rural Areas

The Indonesian government launched a village midwife (*Bidan desa*) programme in 1989 by placing the midwives in rural areas (Shankar et al. 2008). The aim of the programme was to provide the women in the village with skilled medical care during their pregnancies, since not all villages have the auxiliary health centre (Shankar et al. 2008). The MoH aimed to place one midwife in each village in Indonesia, to ensure that pregnant women have medical access during their antenatal, birth and postpartum periods. In order to enhance the village midwifery programme, the Indonesian government provides further midwifery support for rural communities by establishing the village midwives training programme (Hennessy et al. 2006). Starting in 1989 and finishing in 1996, the government established a midwifery training programme consisting of a one year basic midwifery programme for graduates of junior high school nursing programme, which lead to a health certificate for conducting midwifery service (Hennessy et al. 2006). This programme was then replaced by a three year post high school Diploma Programme (D3) for midwives for current midwifery education in Indonesia.

The government is strengthening the village midwifery programme by recruiting and emphasising more students to study in midwifery education; and placing the newly graduated student midwives to serve in the villages for the minimum of

two years. The midwifery education curriculum in Indonesia requires two years midwifery service experiences, as part of their post midwifery education training programme. After finishing a two year midwifery service in the village, the midwives have the option to remain working in the village or applying to work in other midwifery practices. This programme was very helpful in delivering the health services (especially maternal health services) in the place where limited health services are provided (Shiffman 2003).

However, according to Ronsmans et al. (2009), even though the village midwives are presented in most villages in Indonesia nowadays, maternal mortality rate still fails to decrease. The programme has faced many difficulties, since those midwives trained under the system require regular updating, in order to enhance their skill base (Hennessy et al. 2006). Moreover, many village midwives do not intend to stay in villages and prefer to be in urban areas (Ronsmans et al. 2009). According to Makowiecka et al. (2008) only 29 percent of villages in Indonesia actually have resident village midwives. Some villages have village midwives who are not based in the village, and some villages have no village midwives at all. Thus, in very remote areas, a village midwife may have to cover more than one village (Makowiecka et al. 2008). Moreover, in some remote areas in Indonesia, only around 20 percent of women give birth with a skilled birth attendant. The remaining 80 percent still give birth with the assistance of TBAs, who sometimes have minimal skills (Statistics Indonesia (Badan Pusat Statistik) 2010).

Additionally, in many cases in Indonesia, a village midwife is not the first choice for women when seeking maternity care (Achadi et al. 2007). This is related to the issue of the availability of the village midwife, as some villages do not have a resident village midwife and share a midwife with a neighbouring village (Ronsmans et al. 2009). Furthermore, many village midwives are perceived as being too young, expensive, inexperienced or unfriendly, and had spent less time in the village (Heywood et al. 2010). This makes women in most rural areas in Indonesia still prefer to seek traditional birth attendances for birth assistance (Graham et al. 2001).

1.7.3. The Community Alert (*Siaga*) Programme

The *Siaga* programme was launched by the Indonesian government during the period of 1998 – 2002, as part of a safer motherhood programme (Shefner-Rogers and Sood 2004). A description of the Siaga programme can be found earlier in this chapter (section 1.2). The programme was started by conducting

the 'Suami Siaga' campaign. Suami means husband in Indonesian, while Siaga describes alertness. This campaign established a maternal health policy, in order to increase the alertness of the husband and improve their participation in maternal health issues. In 2004, this campaign continued with 'Bidan Siaga' which targeted the midwives (Bidan), this was followed by 'Warga Siaga' which targeted the community (Warga) and 'Desa Siaga' which targeted the whole village (Desa). The Bidan Siaga campaign was initiated in order to improve the midwives' skill quality in providing maternal health services. Meanwhile, the Warga Siaga and Desa Siaga campaigns aimed to develop and engage the community in terms of alertness towards obstetrical emergencies and to play a part in saving the lives of mothers (Shiffman 2003). It is worth mentioning that the term Siaga was formed from three words in Indonesian: SIap (readiness), Antar (to bring or contribute), and jaGA (watchful). In some remote areas in Indonesia, community members play an important role in maternity care. They assist in preparing for the birth of the baby and in facilitating the women to seek health services. This programme focused on promoting community participation in pregnancy, increasing birth preparedness, and any potential emergency in pregnancies (Shefner-Rogers and Sood 2004).

1.8. Justification for the Study

In Indonesia, the community plays an important role in the preparation for birth support and in facilitating access to maternal health services. Therefore, maternal health programmes in Indonesia have focused on promoting the involvement of the community during pregnancy, childbirth and any potential emergencies (Shiffman 2003). Since pregnancy and childbirth are very important experiences for women, appropriate support is required (Neil et al. 2010).

The involvement of family members and other community personnel is very important to maternity care. Their involvement may improve the awareness and increase the knowledge of the danger signs in pregnancy that contribute to maternal mortality (Shefner-Rogers and Sood 2004). Moreover, family and community support is also valuable in terms of assisting women in accessing health services (Rifkin 1990). Thus, this research is based on related literature that provides information on the involvement of the community, family members and relevant health professionals, in order to improve and create safer childbirth experiences.

This research is based on the premise that engaging the community has the potential to improve maternal health in Indonesia. Community participation has been known to be effective in reducing maternal mortality in some areas in the country. Studies conducted by Shefner-Rogers and Sood (2004) and Palmer and Sood (2004), have demonstrated the effectiveness of community participation in maternal health through the Siaga campaign in reducing maternal mortality in West Java Indonesia. This campaign has been applied in all of the provinces in Indonesia, including Aceh (MoH 2009). This maternal health programme, which based on community participation has been effective in reducing maternal mortality in some areas in the country (Shefner-Rogers and Sood 2004). However, in Aceh province, the prevalence remains higher than other areas in Indonesia (PHO 2006). Therefore, this study was conducted to provide information with the potential to improve maternal health in Aceh, Indonesia.

1.9.   Purpose of the Study

The purpose of this study was to generate a grounded theory of pregnancy and childbirth experiences from multiple perspectives; in relation to the incidence of maternal death in the research setting. This was based on the continuously high incident of maternal mortality in Indonesia, despite the government's efforts in reducing maternal mortality rate in the country. The purpose was to explore and gain an understanding of maternity experiences from the perspective of pregnant women, relevant community members and health professionals in Aceh; and to identify how they contribute to pregnancy and childbirth. It also focused on investigating the social processes within an established community. In addition, the participants' experiences provide insightful information that may be used for the development of maternal health programmes by applying community participation in reducing maternal mortality in Indonesia.

This study evolved from personal interest in women's and maternal healthcare. Interest in this area began when the researcher worked on a project of 'Community Development post-Tsunami 2004'. The project aimed to improve the maternal and child health sector after the 2004 tsunami in Aceh, Indonesia. During the period of the researcher's work, her interest was developed on the issue of maternal mortality, which was considered to be high in the area. A high prevalence of maternal mortality had existed in the province even before the devastating tsunami happened (PHO 2006). The lack of education among pregnant women and limited access to maternity services had captured the researcher's attention on these issues. As this interest matured, the researcher

began to raise this topic for her postgraduate studies. From her studies, she discovered the importance of community participation in improving maternal health, especially in developing countries where health access is limited. Even though some maternal health programmes involving the community have been implemented, the prevalence of maternal mortality in the study setting is still considered to be high. Assessing and understanding this situation needs to be completed, in order to improve safer motherhood in the country.

1.10. Summary

In this chapter, background information and a general introduction to maternal mortality and maternity care (especially in Indonesia) have been provided. The community involvement in maternity care and the reasons for conducting the research have also been described. In order to understand the factors contributing to this phenomenon, in the next chapter, a literature review of the various aspects of maternal mortality and the involvement of the community in maternal health services is provided.

CHAPTER 2

LITERATURE REVIEW

2.1.   Introduction

In this chapter, the relevant literature is described and subjected to a detailed critical analysis. The review of the literature has been used to identify empirical studies concerning community participation in maternal health, in the context of reducing maternal mortality. The discussion of additional literature related to the experience of women and the community during pregnancy and childbirth is provided. Finally, the identification of gaps in the literature is also discussed in this chapter.

2.2   Literature Review Debate in Grounded Theory

The purpose of reviewing the literature is to identify any gaps in existing knowledge related to the research topic (Hart 1998). This research study adopts a grounded theory approach, which aims to generate a theoretical concept based on the emerging data. Within grounded theory, substantive differences in terms of the nature and purpose of the literature review are apparent from the perspective of its founders, Barney Glaser and Anselm Strauss. However, both Glaser and Strauss (1967) agree that the researchers should be careful in conducting a literature review on the topic of interest, since it may lead to the limitation of gathering information related to the study focus. Moreover, they suggest that one should avoid a detailed and focused literature review, instead emphasising that a few pre-concepts related to the topic should be the starting point (Glaser and Strauss 1967).

According to Glaser (1992), it is not necessary to review the literature in the substantive phase of conducting the study. On the contrary, Strauss and Corbin (1990) emphasise that the literature review should inform the study. Further discussion about the literature review debate in grounded theory will be explained in the next chapter of the methodology. The literature review utilised reviews from previous research on maternal mortality and community participation in maternal health in order to inform the design of this study. Moreover, Guba (1990) also suggests that the acknowledgement of previous work is necessary in order to maintain an open mind and avoid bias with

preliminary concepts. The literature review in this study was also conducted pragmatically as a necessary progression through the early stage of the PhD programme. Furthermore, one of the requirements of gaining a favourable ethics opinion was to present the research proposal together with the background context of the study in the literature review.

2.3 Literature Search strategy

The aim of a literature search is to provide a comprehensive list of primary studies that will be used to approach the research question. It also aims to build the structure and to plan the ideas for the study. Studies found were systematically reviewed and critically analysed to obtain a better understanding of how the research questions, aim and objectives could be achieved.

2.3.1. Broad Aim of the Literature Review

The aim of this literature review was to identify the relevant papers in order to understand the research area and fill the gaps in previous studies. This included papers related to the involvement of the community, family members and health professionals, in relation to maternity services and women's experiences during pregnancy and childbirth. It also covered studies on community participation in maternal health.

2.3.2. Research Objectives

- To identify the contributing factors of the on-going incidence of maternal mortality rate (MMR).

- To investigate the involvement of the community in maternal health programmes in Indonesia and worldwide.

- To identify factors that can contribute to the engagement with maternal health programmes.

2.3.3. Research Questions

- To what extent do the contributing factors create a situation where maternal death still occurs?

- What are the levels of support and involvement from the community, family members and health professionals in maternal health during pregnancy and childbirth?

One of the difficulties of conducting the literature review is that there is little information on women's experiences in seeking maternity care in the context of a high incidence of maternal death in Indonesia. Furthermore, the information and statistics about the prevalence and incidence of maternal mortality rate in Indonesia are also often unreliable. In the past, *Badan Pusat Statisitik (BPS) Indonesia*, or the Indonesian Central Bureau of Statistics, has tried to investigate the prevalence of maternal mortality rate. However, the actual numbers are still varied due to under-reporting of maternal deaths, especially in remote areas, and the incidence of maternal death in the community (USAID 2010). Moreover, the incidence of maternal mortality rate in Indonesia is still varied and uneven among the provinces; some have higher rates of maternal death compared to the Indonesian average. Furthermore, there are differences in experiences and in access to maternity care for women across the country. Therefore, the literature review is used to frame women's problems in experiencing and seeking maternity care during pregnancy and childbirth. Moreover, the literature search enables the researcher to present a competent level of knowledge about the subject area and becomes an aid once patterns have emerged from the data (McGhee et al. 2007).

2.3.4. Search Strategy to Identify the Studies

Based on the aim of the study, the literature review questions were divided into keywords to be used within the search strategy. These keywords included: maternal mortality, maternal death, maternal health, community participation, community involvement, maternal health programme, maternity campaign and Indonesia (developing countries). These were then searched for in Medline (from 1946 to July 2013), Cinahl, Scopus, Pub Med, Global Health (from 1910 to July 2013), Maternity and Infant Care (from 1971 to June 2013) and ASSIA electronic databases. These are the relevant electronic databases that contain the most recent information on the nursing, midwifery and obstetrics field. In order to cover broader information and material, the search also included websites such as the official websites of the WHO, UNICEF, the Indonesian Ministry of Health (MoH), Google scholar and some relevant PhD theses. The search was limited to articles published in English and Indonesian languages. All the results for each category were combined using the *Boolean terms* 'OR' and 'AND'. Appendix 2 provides more detail on research strategy.

2.4   Inclusion and Exclusion Criteria

The relevant papers were chosen by applying inclusion and exclusion criteria in order to ensure the significance of their contribution to the research question. The identification of inclusion and exclusion criteria for the study was based on the main principles of conducting a literature review – population, intervention, comparison, outcomes and study design (Bhandari et al. 2002). The inclusion and exclusion criteria are shown in the table below:

Selection Criteria	Inclusion Criteria	Exclusion Criteria
Population	Pregnant women, postpartum mothers, family members who are involved in the women's pregnancy and childbirth (husbands, mothers, sisters, etc.), community, midwives.	Family members, community and other health professionals who are not involved in or relevant to the pregnancy and childbirth.
Intervention	Community participation and involvement in maternal health services, maternal health behaviour and maternal health education.	Other forms of activities which are not related to maternal health, pregnancy and childbirth.
Comparison /Context	Experiences during pregnancy and childbirth.	
Outcomes	Studies were included if the outcomes focused on the involvement of community, family members and relevant health professionals in improving maternal health during pregnancy and childbirth.	
Study design	Qualitative studies. Quantitative studies. Review papers.	Theoretical papers Opinion papers

Table 2.1 Inclusion and exclusion criteria

2.4.1. Inclusion Criteria

This study focuses on community participation in maternal health services and programmes. Studies on the experiences during pregnancy and childbirth of women, their relevant family members and health professionals (midwives) were also included. Studies on these topics were included whether they were directly related to maternal death incidence or the general subject of maternal healthcare. Community participation in maternal health services related to maternal death incidence was included as a basis for the background of the research. Studies related to the experiences of women and their social support during pregnancy and childbirth were included as they may engage in maternal health services and programmes. Moreover, general information about the involvement of the community in maternal health programmes was very useful, in informing the maternal health services related to the high incidence of maternal death.

2.4.2. Exclusion Criteria

Investigations about community participation in general healthcare were excluded as the area of interest was focused on maternal health. Moreover, studies on specific social support other than maternal health were also excluded from the literature review process.

2.5   Data Extraction

To identify the relevant papers, the citations and abstracts were assessed in this study. The majority of papers included in this study were those which concentrate on community participation in maternal health, the involvement of the community, seeking maternal healthcare and maternal health programmes. In addition, studies that assessed experiences related to maternal health services during pregnancy and childbirth and adapted models of community participation in maternal health also played an important part in the literature review compilation of this study.

After applying the keywords, the search resulted in 279 potentially relevant papers in Medline, 86 in Cinahl, 78 hits in PubMed, 429 papers in Global Health, 40 from Scopus, 23 in ASSIA, and 57 potential papers in Maternity and Infant Care. As mentioned above, citations and abstracts were used to identify all the relevant papers. After applying exclusion criteria and eliminating duplicates, 28 papers were identified that met the inclusion criteria. Appendix 3 provides more detail about the literature review search flowchart. Twenty-eight relevant papers

were identified and assessed for quality using an appraisal tool developed by Hawker et al. (2002). This tool (Appendix 4) was utilised to assist in reviewing the papers systematically within the context of different paradigms, and it was used in this study since the selected research papers were methodologically varied. By using an assessment form, the papers were then assessed to identify their quality. This form enables dissimilarity in methodological studies to be compared by scoring nine domains. Each domain was rated on a four point scale from 1 (very poor) to 4 (good), providing a way of appraising the variation of methodology in the literature review without using multiple tools. Moreover, most sections of the research study – including abstract and title, aims and introduction, sampling, method, data analysis, ethics, finding or result, transferability, implications and usefulness – are covered using Hawker et al. (2002). Relevant information was scored in the synthesis table (appendix 5) according to the scale of Hawker et al. (2002). Finally, the quality of the papers after the synthesis (scored) process was transferred into data extraction tables, as seen in appendix 6.

2.6 Description and Assessment of the Reviewed Studies

Twenty-eight papers were identified in this review, including 22 primary papers and six review papers. The table below shows the identified studies:

Primary Papers (n=22)	Review Papers (n=6)
Abdulkarim et al. (2008)	Lassi et al. (2010)
Ahluwalia et al. (2003)	Lee et al. (2009)
Azad et al. (2010)	Orr (2004)
Emond et al. (2002)	Rosato et al. (2008)
Kazi et al. (2006)	Steen et al. (2012)
Maimbolwa et al. (2001)	Kidney et al. (2009)
Makowiecka et al. (2008)	
Manandhar (2004)	
Martin et al. (2007)	
Mullany et al. (2009)	
Mushi et al. (2010)	
Ny et al. (2007)	
Ogwang et al. (2012)	
Perreira (2002)	
Prata et al. (2012)	
Rath et al. (2010)	

Ronsmans et al. (2009)	
Shefner-Rogers and Sood (2004)	
Shehu (1999)	
Teela et al. (2009)	
Teitler (2001)	
Titaley et al. (2010)	

Table 2.2 Papers identified by type

In general, the literature scored well, with most of the studies scoring 28 or more out of a possible score of 36. During the literature search, some papers were identified as being related to the topic (Bracht and Tsouros 1990; Donnay 2000; Laverack 2001; Labonte and Laverack 2001; Allen 2007). These papers discussed the theoretical underpinnings of community participation and maternal health. However, these papers are theoretical papers, which were excluded from the review process; as they did not provide details on sampling, methods, data analysis, ethics and bias. Whilst the review process adopting the tool by Hawker et al. (2002) was effective for research studies, it was not effective for the reporting of theoretical papers. Significantly, this literature provided important concepts on the theme of 'ownership' and studies on adapting community participation models, which were considered an essential concept for examining the review papers. Therefore, these papers were utilised as the background information on the identified themes in the literature search.

Most of the reviewed papers were qualitative studies (Abdulkarim et al. 2008; Ahluwalia et al. 2003; Maimbolwa et al. 2001; Ny et al. 2007; Ogwang et al. 2012; Prata et al. 2010; Teela et al. 2009; Teitler et al. 2001; Titaley et al. 2010). Seven of these papers were mixed-methods studies (Emond et al. 2002; Kazi et al. 2006; Mushi et al. 2010; Perreira et al. 2002; Rath et al. 2010; Shefner-Rogers and Sood 2004; Shehu 1999). There were six quantitative papers in total; these papers presented case control studies (Makowiecka et al. 2008; Ronsmans 2009), cohorts study (Martin 2007) and randomised controlled trials (Azad et al. 2010; Manandhar 2004; Mullany 2009).

The reviewed studies were heterogeneous in all aspects of design, including sample, method, results and outcomes. Various research methods and participants were employed in these studies. Quantitative studies utilised a structure survey questions (Emond et al. 2002; Perreira et al. 2002), case control study (Makowiecka et al. 2008; Ronsmans 2009) and a cohort study (Martin et al. 2007). Qualitative studies used interviews with varied participants

such as family members and health professionals. Some studies also used both in-depth interviews and focus group discussions (FGD) (Abdulkarim et al. 2008; Ny et al. 2007; Teela et al. 2009; Titaley et al. 2010). One of the qualitative studies (Maimbolwa et al. 2001) used interviews as well as the observations in the maternity unit in Zambia.

The studies were also varied in the matter of the setting: five in South Asia (Azad et al. 2010; Kazi et al. 2006; Manandhar et al. 2004; Mullany et al. 2009; Rath et al. 2010); four studies were conducted in Indonesia (Makowiecka et al. 2008; Ronsmans et al. 2009; Shefner-Rogers 2004; Titaley et al. 2010); seven studies in sub-Saharan Africa (Abdulkarim et al. 2008; Ahluwalia et al. 2003; Maimbolwa et al. 2001; Mushi et al. 2010; Ogwang et al. 2012; Prata et al. 2012; Shehu 1999); two studies in Latin America (Emond et al. 2002; Perreira et al. 2002); one in Southeast Asia (Burma) (Teela et al. 2009). Most of these studies are in low resource settings, apart from one study among migrants community in Sweden (Ny et al. 2007).

The reviewed studies discussed the importance of involving the community in maternal health programmes, and access to health facilities and health professionals in order to reduce the incidences of maternal mortality. Almost all of the reviewed papers were based on studies with high incidence of maternal mortality in developing countries, including Indonesia. It was observed that most reviewed studies focus on the evaluation and the effectiveness of community involvement in maternal health programmes (Abdulkarim et al. 2008; Ahluwalia et al. 2003; Azad t al. 2010; Emond et al. 2002; Kidney et al. 2009; Lassi et al. 2010; Manandhar et al. 2004; Mushi et al. 2010; Ogwang et al. 2012; Perreira et al. 2002; Prata et al. 2012; Rath et al. 2010; Rosato et al. 2008; Shefner-Rogers 2004; Shehu 1999).

Two papers in the literature review process were comparative studies (Mushi et al. 2010; Rath et al. 2010). These studies compared and evaluated the maternal health programmes that utilised community participation in different settings. Comparative studies have the benefit of evaluating and analysing specific domains and provide the perspectives and experiences from different angles (Jochen 2004). This process enabled the reader to discover advanced approaches to the study of community participation in maternal health programmes. Both Mushi et al. (2010) and Rath et al. (2010)'s comparison studies provide clear evaluation processes. Both studies compared and evaluated the effectiveness of a maternal health programme intervention in

different villages in Tanzania (Mushi et al. 2010) and India (Rath et al. 2010). The strengths and weaknesses of maternal health programme interventions in each community was compared and evaluated in detail. However, the data analysis processes were not presented in detail. Providing detailed information about the method and analysis of the data is very important, since they present evidence of the validity of the studies (Huibers et al. 2004).

Some reviewed studies provided limited information in terms of the participants' recruitment method (Kazi et al. 2006; Makowiecka et al. 2008; Martin et al. 2007; Ny et al. 2007). Three of the reviewed studies did not explicitly provide the recruited participants' criteria (Kazi et al. 2006; Martin et al. 2007; Ny et al. 2007). Another reviewed study by Makowiecka et al. (2008) also restricted the selection criteria of the recruited participants. Makowiecka et al. (2008)'s reviewed study on midwifery provision in two districts in Indonesia, focused only on the midwives as a midwifery provider in the research setting. In several Indonesia's community settings, such as in remote areas, some traditional birth attendants are still considering midwifery practices in the community (Shiffman 2003). Therefore, Makowiecka et al. (2008) need to provide clear information on the selection criteria of their participants. Although their study provided more comprehensive understanding on the contributory factors in midwifery provision; subjects for case control study should be randomly selected for better study representativeness (Baughman et al. 2001). Focusing on selected informants and providing limited information on the participants may affect the views and interpretations of the study (Huibers et al. 2004). Providing detailed information about the recruitment method and selected participants will increase the validation of the study (Whittemore et al. 2001).

According to Gray (2004), qualitative research studies provide the understanding of the subjective experience of people; in order to value the importance of relationship in human experiences. Utilising qualitative research methods also enabled the researcher to gain more information and understanding of the research topic (Bryman 2006). Therefore, utilising qualitative studies in the review process was important to gain understanding of pregnancy and childbirth experiences. However, most of the reviewed qualitative studies were relatively different in study design. According to Maxwell (2013) one of the critical decisions in designing the research study is the research paradigm, within which the research study will be situated. Although some researchers refer to 'qualitative paradigm', there are many different paradigms within a qualitative research design depending on the aim and objectives, to

justify the research study (such as grounded theory, phenomenology, ethnography) (Maxwell 2013). Further explanation about research paradigms will be explained in the next chapter of research design and methodology. Apart from the differences in qualitative study design, the reviewed qualitative studies also provided limited detail on sampling strategies and also lack of justification for the specific design and analysis. These limitations compromise the credibility and transferability of the studies (Schwandt et al. 2007). For example, both Abdulkarim et al. (2008) and Teela et al. (2009)'s qualitative studies had shortcomings, since they provided minimum discussions on how the themes emerged. Moreover, Ny et al. (2007) also provided limited information on the sampling criteria and Titaley et al. (2010) did not discuss the data analysis process in detail, and how data saturation was achieved.

Overall, all of these reviewed papers had good quality assessments (scored 28 and more out of 36 in Hawker's tool of paper assessment); and presented a complex picture of community participation in maternal health programmes. Some of these reviewed papers also investigated the experiences and support, either from the family or the community during pregnancy and childbirth.

However, the information about women's experiences during pregnancy and childbirth, in relation to the incidence of maternal death in the community is limited. Moreover, most of the papers that discuss pregnancy and childbirth experiences are still limited from the women's and their families' points of view. The assessment and critical analysis of the reviewed papers informed the design of this current study. Furthermore, it strengthened the study rationale by identifying the knowledge gaps within the literature.

2.7   Descriptive Synthesis of the Research Findings

All the included studies were synthesised using a narrative approach. This approach provides a means to develop both interpretive and narrative synthesis from the broader literature (Uman 2011). This step was utilised in order to draw conclusions based on the findings and the evidence from the included studies. The relationships within the data were explored and the findings were organised in order to describe the patterns across the studies. Four core themes and models of community participation in maternal health emerged from the literature search. The four themes were:
- Increasing knowledge and awareness of maternal health
- Social support
- Adequate health support

- Ownership

These themes were identified in the literature on improving maternal health by conducting community participation, as well as involving family members and health professionals. According to the literature, these four themes were related to each other. The discussion of the themes and critical analysis of the included studies are presented in the following section.

2.7.1. Increasing the Knowledge and Awareness of Maternal Health

Six studies into the involvement of the community in maternal health were identified as having an impact on the increase in knowledge and awareness of maternal health. The Involvement of family members and participation of the community increase knowledge (Mullany et al. 2006; Abdulkarim et al. 2008), and increase awareness of the danger signs and obstetric problems in pregnancy may be achieved (Perreira 2002; Manandhar 2004; Shefner-Rogers and Sood 2004; Ogwang et al. 2012).

Most of the studies related to this topic were conducted in various countries, including Indonesia. These studies highlighted the knowledge gained after the involvement in maternal health activities. The involvement of family members such as husbands, in antenatal care increased their knowledge of maternal health and birth preparation (Mullany et al. 2006; Steen et al. 2012). Engaging the community could also contribute to help the women to access maternal health services, and provide knowledge on the causes of maternal mortality and prevent maternal deaths in the community (Abdulkarim et al. 2008; Ogwang et al. 2012). Studies conducted by Mullany et al. (2009) identified the importance of involving husbands during pregnancy and childbirth, in order to successfully improve women's knowledge and awareness of their maternal health. A randomised controlled trial by Mullany et al. (2009) on the impact of including husbands in antenatal health education in maternity practice in Nepal, provided strong evidence in the intervention group. This group was made up of women and their partners who reported making birth preparations, and being more likely to attend the antenatal and postnatal care during pregnancy and childbirth; compared to the control group whose husbands were not included. This study provided a strong and thorough analysis of each step of the intervention. One of the main challenges in an RCT study is having an adequate intervention, as a lot of effort is required to transfer knowledge into action (Jadad 1998). Once the interventions were applied in the group, the study

outcome showed the positive impact of involving male partners in antenatal health education during maternal healthcare.

In general, the involvement and participation of the community in maternal health activities, increases their knowledge and awareness of danger signs in pregnancy (Shefner-Rogers and Sood 2004). Community awareness of maternal health problems was evident following exposure to maternal health education (Manandhar 2004; Ogwang et al. 2012). Most community members obtained their maternal health education through health campaigns and activities in the community. Maternal health campaigns usually provide education through multimedia and support from health workers within the community. Multimedia campaigns (television, radio, print leaflets and posters), impart new knowledge about maternal health and the danger signs in pregnancy (Shefner-Rogers and Sood 2004). A study conducted by Perreira (2002) also suggests that education, communication and information from health professionals, either in the community or in health centres, increase the knowledge of the community and engages them in being alert to maternal health problems and carrying out birth preparation activities in order to reduce maternal death (Perreira 2002; Shefner-Rogers and Sood 2004). Perreira's (2002) case study identified that women who were exposed to maternal health education both in maternity clinics and in the community, successfully improved their knowledge and awareness of the danger signs in pregnancy. Although the study did not provide information on which of these two settings was more effective in imparting information, education and communication (EIC) on maternal health and the danger signs in pregnancy, the EIC campaign during maternal health programmes effectively increased the knowledge and awareness of maternal health in the community.

Some studies (Perreira 2002; Manandhar 2002; Shefner-Rogers and Sood 2004; Ogwang et al. 2012) also indicate that an increase in birth preparation activities follows an increase in knowledge of maternal health. An evaluation study conducted by Ogwang et al. (2012) identified that the community emergency support intervention programme on maternal health in Uganda, had successfully created an awareness in the community about maternal health, and further actions were undertaken when obstetric emergencies occurred. These actions included the provision of transportation and the referral of women to the nearest health facilities. This study provided a clear explanation of the community context, which was beneficial for the sustainability of the programme. Some other studies on maternal health programme evaluations (Perreira 2002; Manandhar 2004; Shefner-Rogers and Sood 2004) have also successfully

provided evidence about actions to promote maternal healthcare after the health programmes were implemented. However, most of these studies were conducted only a few months after the maternal health campaign was carried out and education was provided. This short period after the campaign may not have been enough to fully capture changes in the knowledge and behaviour of the community and family members (Shefner-Rogers and Sood 2004). Further research into how this knowledge and behaviour could be applied in the community during pregnancy and childbirth is still to be carried out.

2.7.2. Social Support

Community participation reflects support from the environment and the surrounding community (Rifkin 1990; Rosato et al. 2008). Seven studies were identified which considered the involvement of the community and family members, as providers of social support during pregnancy and childbirth (Maimbolwa et al. 2001; Teitler 2001; Kazi et al. 2006; Mullany et al. 2006; Martin et al. 2007; Ny et al. 2007; Steen et al. 2012). Six of these studies focused on the husband's involvement (Teitler 2001; Kazi et al. 2006; Mullany et al. 2006; Martin et al. 2007; Ny et al. 2007; Steen et al. 2012) as social support, while one study mentioned female family members as social support (Maimbolwa et al. 2001).

The involvement of husbands during pregnancy and childbirth is an important factor in safer motherhood programmes. Most women consider their husbands as the main person they would like to be involved during their pregnancy and childbirth (Ny et al. 2007; Steen et al. 2012). Male involvement is also related to the phenomenon of the patriarchal system in the developing world, mostly in rural areas, where the decisions about a woman's needs and activities, including maternal health, are taken by the man (Kyasiimire 2003). The involvement of the husband during pregnancy and childbirth may increase the motivation of a woman, in order to attend the antenatal and postnatal care (Mullany et al. 2006; Steen et al. 2012). A review study conducted by Steen et al. (2012) on fathers' encounters with pregnancy and childbirth, suggested that husbands should provide advice and care during pregnancy. Moreover, fathers should have the option of being involved in attending the birth in accordance with women's wishes. However, most husbands see themselves as passive supporters, since pregnancy and childbirth are identified as a motherhood journey (Finnbogadóttir et. al. 2003; Hsieh et al. 2006). Furthermore, some husbands who involved in pregnancy and childbirth described themselves as going through an uncertain

journey to fatherhood (Fägerskiöld 2008); and usually experienced exclusion from the health staff, with the main focus towards their labouring partner (White 2007). The review study by Steen et al. (2012) also identified that a father cannot support his partner effectively during pregnancy and childbirth, unless he himself is also supported, included and prepared for the pregnancy, labour and parenthood, as well as aware of his role in this context. This review study is provides the inclusion and exclusion criteria of the reviewed studies. According to the findings of this research study, involving men in pregnancy, childbirth and maternity care is likely to provide effective support and positive maternal healthcare outcomes during pregnancy and childbirth.

Pregnancy and childbirth are very important experiences in women's lives (Kyasiimire 2003). There are many social aspects – such as the social environment, social conditions (household situation, chronic illness, depression) and social relationships – that have an effect on women during pregnancy and childbirth (Kazi et al. 2006). Maintaining effective social support would not only contribute to women being more likely to seek maternity care, but also minimise their psychosocial problems, which could lead to later maternal health problems (Kazi et al. 2006; Ny et al. 2007). All of the studies described above also identified that the involvement of family members, especially husbands during pregnancy and childbirth may influence the woman in terms of maintaining or adopting healthy pregnancy behaviours (Teitler 2001; Steen et al. 2012). Another study, conducted by Maimbolwa et al. (2001) on involving social support during labour in Zambian maternities, emphasised the involvement of female relatives. The study suggested that the involvement of female family members (mothers, mothers-in-law, sisters, etc.) especially in developing countries, would increase women's confidence and provide comfort for them during childbirth (Maimbolwa et al. 2001).

The involvement of the male partner was evident during pregnancy and childbirth, most women in rural areas especially in the developing countries still wanted their female relatives' presence during their labour. The involvement of female relatives was also important for their experiences in maternity care. Most review papers in this study emphasised both male and female relatives as women's social support during pregnancy and childbirth. It is important to address the involvement of social support for women during pregnancy and childbirth in order to provide positive maternal health outcomes and better maternity services in the future. Although most studies focused on the role of husbands as family support, more research is needed in order to study the

involvement of female family members as social support during pregnancy and childbirth. Understanding the role of the community and family members during pregnancy and childbirth, would help the community to improve the quality and increase the support of maternity care.

2.7.3. Adequate Health Services

Nine studies indicated that the involvement of the community in maternal healthcare resulted in the provision of adequate health services in the region. These studies can be categorised into two sub-themes based on access to the health services (Kidney et al. 2009; Lee et al. 2009; Azad et al. 2009; Titaley et al. 2010; Ogwang et al. 2012) and access based on professional assistance (Makowiecka et al. 2008; Ronsmans et al. 2009; Lassi et al. 2010; Prata et al. 2012).

2.7.3.1. Access to the Health Services

It is clear that if women are to receive high quality maternity care, first they need to be able to access the services. In most developing countries, the availability of health services is limited, especially in remote areas and remains a problem (Titaley et al. 2010). In places where maternal health services are very limited, the community has a significant role in assisting and facilitating health services for the people (Rifkin 1990). A review study conducted by Lee et al. (2009) into linking families and facilities for care at birth provided evidence on community mobilisation with high levels of community engagement. Linking the families as well as the community to health facilities could also significantly reduce maternal and early neonatal death (Lee et al. 2009). The community plays a significant role in linking the women to the health facilities, especially when an emergency occurs during pregnancy and childbirth (Lee et al. 2009; Ogwang et al. 2012).

The need for access to maternity care has been recognised in the literature as a problem (Shiffman 2003; Azad et al. 2010). This limited access made some mothers in rural areas unwilling to attend antenatal and postnatal care services (Lee et al. 2009; Titaley et al. 2010). However, some of the key points, such as preventive intervention on maternal health, are more likely to be implemented in communities where maternal health services are limited (Kidney et al. 2009). The review study by Kidney et al. (2009) suggests that community level intervention in maternal and perinatal healthcare could bring about a reduction in maternal and neonatal mortality. Providing community education and

interventions in maternal health in their region may assist and improve the maternal health situation in the community. Early detection of danger signs in pregnancy may allow the community to help mothers to reach health services when obstetric complications occur (Kidney et al. 2009; Titaley et al. 2010; Ogwang 2012). Most of these studies also note that providing better health services in the community for safer motherhood, is usually implemented within maternal health programmes. The role of the community is very important in order to provide minor assistance and to facilitate people's access to health service providers (Lee et al. 2009; Ogwang 2012).

2.7.3.2. Access Based on Professionals' Assistance

It is important for the women to have professional health assistance during their pregnancy and childbirth (Ronsmans et al. 2009; Lassi et al. 2010). A study by Ronsmans et al. (2009) indicates the importance of giving birth with assistance from the health professionals. The study found that where women give birth without access to health professionals, has contributed to the higher number of maternal mortality cases (Ronsmans et al. 2009). The involvement of health professionals in providing maternity care and assisting the birth, could help to reduce maternal mortality especially in the community (Makowiecka et al. 2008; Ronsmans et al. 2009). However, not all rural areas, especially in the developing countries are well served by the midwives. This is due to the lack of availability of midwives, and to the fact that they are not well distributed across the area (Ronsmans et al. 2009).

The involvement of health professionals during pregnancy and childbirth is very important in order to promote safer motherhood. The provision of health professionals in rural areas would help to reduce maternal mortality in the community. The study conducted by Makowiecka et al. (2008) about the midwife provision in two districts in Indonesia, indicated that there was still limited distribution of midwives in Indonesia. Some areas have less than others, especially in remote regions. By using a case-control study approach, Makowiecka et al. (2008) provides a more comprehensive understanding of the contribution factors to particular incidents. Some village midwives in rural areas of Indonesia prefer to live in urban areas, meaning that some rural areas are not well served with health professionals in maternal healthcare services (Makowiecka et al. 2008). The study suggests in order to solve this problem would require willingness from the decision-makers to take responsibility for

providing maternal health professionals in the community (Makowiecka et al. 2008).

In addition to the literature on professional assistance, other research studies also need to be placed within wider literature on the relationship between the women and health professionals; and how it affects the women during pregnancy and childbirth. Furthermore, Lassi et al. (2010) and Ogwang et al. (2012) suggest the link between community health workers (CHWs) and health professionals in rural communities, due to the absence of the health professionals in the community. This could at least help the women to have basic antenatal care and provide adequate maternal health service in the community.

2.7.4. The Ownership

Six studies were found related to the involvement of the community in contributing ownership of the maternal health programme (Emond et al. 2002; Ahluwalia et al. 2003; Teela et al. 2009; Mushi et al. 2010; Rath et al. 2010; Prata et al. 2012). Four of these studies identify that community participation has an impact in empowering the community (Ahluwalia et al. 2003; Teela et al. 2009; Mushi et al. 2010; Prata et al. 2012), and the other two examine how community participation can reduce inequalities in healthcare (Emond et al. 2002; Rath et al. 2010).

2.7.4.1. Empowering the Community

In order to conduct maternal health programmes for safer motherhood, it is necessary for these programmes to meet the needs of the community. Therefore, the involvement of the community in the programme is very important. Moreover, some of the maternal health activities that are conducted after the discussion with the community, are also essential in order to meet their needs (Ahluwalia et al. 2003). Some maternal health programmes are also involved with and recruit voluntary health workers in order to reach out to the community and enhance the sense of ownership for the programmes (Teela et al. 2009). Active participation of the community, especially in maternal health, has the potential to improve its power and independence in providing maternal healthcare. This happens because the community has responsibility for planning, managing, implementing, monitoring and evaluating the programme (Mushi et al. 2010; Prata et al. 2012). These responsibilities come as a result of making decisions about health programmes that are based on their needs.

A community based intervention study conducted by Mushi et al. (2010) into the effectiveness of community-based safe motherhood programmes in improving the utilisation of obstetric care in Tanzania; indicates that empowerment of the community could improve maternal health. Mushi et al. (2010) evaluated the safer motherhood programme in four rural districts of Tanzania and demonstrated that active participation of each community in rural areas improved their maternal health. The project task is focused on promoting early and complete antenatal care and having safe birth with skilled health professionals. This task was implemented by trained community health workers from each village. The safer motherhood programme successfully empowered the community in maternal health as it was implemented based on the community context (Mushi et al. 2010). Mushi et al. (2010) provide a strong comparative study in each rural district, with the evaluation process that was conducted in each village explained in detail. Although there is little discussion on the methodology, the data collection process is presented clearly in the study.

Most of the studies (Ahluwalia et al. 2003; Teela et al. 2009; Mushi et al. 2010; Prata et al. 2012) indicate that participation of the community in maternal health has an impact in empowering the community in maternal health programmes. The community also has the power to run health programmes in order to provide and deliver maternal health services under the supervision of health professionals. Recruiting health workers from the local community to conduct some health programmes creates community empowerment in order to implement the programmes. This also enhances the ownership of maternal health programme, which in turn results in the programmes' sustainability in the community (Teela et al. 2009; Prata et al. 2012).

2.7.4.2. Reduce the Inequalities in Healthcare

Engaging the community in conducting maternal health interventions in areas where health services are limited is very important (Rifkin 1990; Rosato et al. 2008). The establishment of community-based interventions in maternal healthcare could reduce inequalities in healthcare, especially in poor and remote areas (Emond et al. 2002). The use of health workers recruited from the local community integrates maternal health services into the community (Emond et al. 2002; Ahluwalia et al. 2003; Rath et al. 2010). Community-based interventions also strengthen the health centre in the community and provide health services in remote and poor areas (Ahluwalia et al. 2003). This is in

accordance with other literature on the adequacy of health services (Ahluwalia et al. 2003; Ogwang et al. 2012).

Another evaluation of a community-based intervention on maternal health was conducted by Emond et al. (2002). The study evaluated the effectiveness of a community-based intervention project that aimed to reduce maternal and infant mortality in a poor urban district of Brazil. Emond et al. (2002) indicate that there was evidence that the increase in participation in antenatal care by the women, led to the reduction of maternal death incidents in the community after the programme was implemented. Some of the maternal health interventions in the programme included maternal health education and increasing the community's knowledge of the danger signs in pregnancy. Each intervention was clearly evaluated and the analysis process was provided in the study. The increase in knowledge, as well as the recruitment of health workers from the community, reduced the inequalities in healthcare in poor urban areas of Brazil (Emond et al. 2002; Rath et al. 2010).

The literature review is based on the evaluation of maternal health activities applied in the community. The ownership of community participation in maternal health would be established if a maternal health programme was conducted in the community. The study by Emond et al. (2002) was conducted directly after the programmes were implemented. Although the methods used were appropriate in evaluating the ownership of the programmes in the community, using these methods shortly after the programme is considered to be ineffective in measuring the sustainability of the programme (Rosener 1978). Further study should be carried out in order to assess, and maintain the sustainability and ownership by the community in maternal health programmes. This could be measured by assessing the role of the community in maternal health programmes.

2.8   Studies that have Used Community Participation Models in Maternal Health

Most studies into reducing maternal mortality indicate that the community plays a significant role in achieving the objectives of maternal health programmes. It is important to recognise different levels of community participation with an important health service component, in order to conduct community participation (WHO 2008). According to Laverack (2001) and Rosato et al. (2008) there are different levels of participation at which the community could engage with the activities. Participation has been used to indicate active or

passive community involvement (Rosato et al. 2008). In the past, most community participation activities have consisted of communities responding to directions given by professionals to improve their health (Laverack 2001; Rosato et al. 2008). This process usually included activities in which the communities were passively involved, such as the arrangement of the place and setting of the implementation or being involved in specific interventions (e.g. campaigns and education on immunisation or maternal health) (Rifkin and Pridmore 2001). Recently, health development workers in Indonesia have begun to act as facilitators, focusing on the improvement as well as the outcomes (Rosato et al. 2008). In this approach, the facilitators support the local communities in being actively involved, and participating in both activities and decisions that affect their own health. These activities include providing the resources to focus on health problems or concentrating on active participants who use their own development capacities to address their needs (Rosato et al. 2008). This is the highest level of community participation – where the community has built its own capacities and capabilities in order to sustain the implemented programmes (Laverack and Wallerstein 2001). However, it is important to address some problems that may occur within this level; for example the willingness of full engagement from the community within the programme. Although the level of community participation is varied among the programmes, some maternal health programmes addressed the usefulness of involving the community for the programme's effectiveness.

There are some adapting models that have been used in conducting community participation. These models were implemented based on the level of participation from the community. Some models that have been adapted in applying community participation are: an asset-based community development (ABCD) model by Allen (2007), and a community-based approach by Labonte and Laverack (2001). The ABCD model is an approach to community-based development based on the resource principles. It is based on the premise of appreciating and mobilising individual and community talents, skills and assets rather than focusing on problems and needs (Allen 2007). The community drives the development rather than an external agency, placing a priority on collaborative efforts for the development, that make best use of its own resource (Laverack 2001). ABCD's focus is community development, which has been used in planning, skill development, need assessment, as well as monitoring and evaluation (Allen 2007). It provides a flexible method that can be adapted to different forms of community development with different geographical contexts

(Allen 2007). Since the community has the self-capacity in developing this model including its monitoring and evaluation, there are some critiques on its monitoring and evaluation process. Moreover, this model might be less suitable in less developed community settings that need increased levels of effort and education from the community.

Community-based approaches are adapted from the less active community level of participation. In this model, professionals or external agencies define the problem and develop strategies to remedy it (Labonte and Laverack 2001). The professionals or agencies may involve the community members in solving the problem and implementing the programmes. However, the decision-making power lies primarily with the professionals and the external agencies. A community-based approach is important in addressing the needs of the community. However, Labonte (1994) argues that it is not community development that attempts to support community groups in resolving concerns as group members define them. Moreover, the sustainability of a community-based programme might be less effective compared with community development models that respond to building community resources and capacities, and self-sustaining programmes (Laverack 2001).

Some studies found the effectiveness of specific community interventions at the level of passive recipient (Emond et al. 2002; Perreira 2002; Shefner-Rogers and Sood 2004). At this level, the community generally received the intervention and were involved by being participants in the programme (Rosato et al. 2008). The activities included maternal health service promotion and intervention (Emond et al. 2002) and community education and promotion of maternal health (Perreira 2002; Shefner-Rogers and Sood 2004). Other studies have investigated the effectiveness of community participation either on their own or at combined levels, where the community provides the resources and is the active agent (Rosato et al. 2008). In north-western Nigeria, the 'Prevention Maternal Mortality' project conducted by Shehu (1999) showed that involving the community in recognising problems, making action plans and engaging the community in the implementation of reducing maternal death factors, led to a reduction in maternal mortality in the project's area (Shehu 1999). The Community-Based Reproductive Health Project (CBRHP) evaluated by Ahluwalia et al. (2003) in Tanzania, showed the value of upgrading a health centre to a basic hospital complete with emergency obstetric care (EMOC), with an emphasis on community participation. This intervention also included training of healthcare staff and strong links to community health workers (CHWs) and

trained the TBAs (Ahluwalia et al. 2003). The effectiveness of involving the community through the provision of trained CHWs and TBAs is also reported in a pilot randomised controlled trials (RCT) in Pakistan (Bhutta 2008) and in northern Nigeria (Prata et al. 2012). Furthermore, studies of Mobile Obstetric Maternal Health Workers (MOMs) in Eastern Burma conducted by Teela et al. (2009) and maternal health education in Uganda conducted by Ogwang et al. (2012) also show the effectiveness of community involvement in maternal healthcare, both at passive and active levels of participation.

Although evidence increasingly favours the effectiveness of community participation interventions, the comparison of the studies by Ahluwalia et al. (2003) in Tanzania and Teela et al. (2009) in eastern Burma has become a consideration in implementing the policy. The CBRHP in Tanzania suggests that community participation through delivering health services, with the establishment of EMOC in the villages, is an essential approach in reducing maternal mortality rate. On the other hand, the MOM project of Eastern Burma suggests that some EMOC services that are usually delivered only in healthcare settings might only be feasible in the community when alternatives are not available. Several other projects and studies test different combinations of interventions, also the interpretation and implementation of the findings should be considered carefully by policy makers. The important questions about the most effective models of community participation in maternal health should be based on the situations and barriers that are found in the community (Rosato et al. 2008).

2.9   The Gaps in the Literature Review

Based on the literature in this review, four themes were identified as the key messages in involving the community in maternal health programmes. The four themes, which are related to one another, are: increasing the knowledge and awareness of maternal health; social support; adequate health services; and ownership. For example, it can be argued that an increase in knowledge and awareness of maternal health could be achieved through social support during pregnancy and childbirth. This social support could also help women to access adequate health services and maintain community ownership of maternal health activities. Whilst this relationship to some extent could be seen in the literature, the exact interpretations that they provided are not yet understood. This could suggest that the involvement of the community in maternal health would lead to safer pregnancy and childbirth.

The findings also highlighted some studies that adapt community participation models in addressing maternal health problems. However, none of the studies explicitly mentioned the role of the community in maternal healthcare during pregnancy and childbirth. Moreover, the reviewed studies also provide different perspectives and interventions from the community in providing maternal health services in different places. Therefore, the understanding of maternity experiences from the perspectives of service users (pregnant women and the community) and service providers (health professionals) should be gained in order to improve maternal health with the appropriate community setting approach. Therefore, this research intends to explore the experiences of pregnant women in relation to the involvement of the community, family members and health professionals during pregnancy and childbirth in Aceh, Indonesia. Moreover, this research explores not only the views of the women but also those of the relevant community members and health professionals on their involvement during pregnancy and childbirth, which could contribute to the engagement of a maternal health programme and reduce the incidence of maternal death in Aceh.

2.10 Summary

In this chapter, relevant papers related to maternal health and community participation, including the involvement of family members in safer motherhood programmes, have been reviewed. The research literature on community participation in maternal health in order to reduce maternal mortality, both in Indonesia and worldwide, has been presented.

The review of the literature gives some valuable insights into the importance of involving the community in maternal health programmes, in order to reduce maternal mortality. Many of the studies of maternal health programmes that have been discussed, report only one dimension – from either the woman's partner's or the community's viewpoint – about the effectiveness of community participation in maternal health. Alternatively, the perceptions of health professionals (midwives) of the community's role in maternal health practices are also important. However, none of these studies explore women's, midwives' and community's perceptions of pregnancy and childbirth experiences simultaneously.

All of the studies in this literature review are focused on a different aspect, but some of the findings related to the views on the role of the community, as well as their experiences in maternal health. A study based on the perceptions and

experiences during pregnancy and childbirth in the community, would add stronger evidence to the knowledge base on maternal health. The next chapter, the methodology and research design in this study will be provided.

CHAPTER 3

THE RESEARCH PARADIGM AND METHODOLOGY

3.1. Introduction

In this chapter, a detailed account of the theoretical position and methods that employed in this research is provided. The philosophical and theoretical underpinning of the research is discussed. The selection of grounded theory as a research method and design are also covered in this chapter.

3.2. Philosophical and Theoretical Underpinning Research

Within the world of research, the research paradigm that influences the philosophical and theoretical underpinnings of research should be determined (Denzin and Lincoln 1994). A research paradigm is defined as the basic beliefs within, and develops the theories which inform the research. It fundamentally influences how the researchers see the world, determines their perspectives and forms the understanding of how things are connected (Guba and Lincoln 1994). A paradigm can be summarised based on three fundamental questions: ontology, epistemology and methodology. Ontology asks about the nature and forms of reality; while epistemology questions the basic belief about knowledge and focuses on the knowing process. Methodology points to how we gain knowledge about the world (Denzin and Lincoln 1994). The ontological and epistemological beliefs of the researcher lead to the choice of the philosophical paradigm of the research (Jupp 2006). However, Denzin and Lincoln (1994) proposed that the philosophical concepts of ontology, epistemology and methodology cannot simply be separated. They are defined as sets of philosophical underpinnings that utilise specific research approaches (e.g. qualitative or quantitative methods) (Weaver and Olson 2005).

3.3. Paradigm to this Study

Kuhn (1970) indicates that all disciplinary research is conducted within a paradigm. When a researcher build a theory, this is generated particular paradigms (Laudan 1977). The main paradigms that informed this research are positivism, interpretivism, and critical theory.

3.3.1 Positivism

The positivist paradigm came from a philosophy known as logical positivism. This philosophy based on logic and measurement, truth, and absolute principle (Weaver and Olson 2005). It is often considered as the philosophical basis for quantitative research where the reality can be generalised (Avis 2005). The goals of positivist paradigm research are predictable and controllable (Weaver and Olson 2005). Generally it aims to find the reality which is separated from the subjective imagination and it is testable, amenable to being verified and confirmed or falsified by the empirical observation of reality (Guba and Lincoln 1994). However, the criticism of this paradigm is that it is unable to address satisfactorily the nature of facts, or the interactive nature of inquiry (Denzin and Lincoln 1994).

3.3.2 Interpretivism

The interpretivist paradigm is a generic social paradigm that aims to gain understanding of social phenomena (Weber 2004; Weaver and Olson 2005; Williams 2008). It highlights understanding that the individuals assign to their actions and reactions of others (Weaver and Olson 2005). Ontologically, it believes that social reality cannot be separated from the social actors (participants and the researcher) (Weber 2004). Meanwhile, from an epistemological perspective, interpretivist recognise that knowledge is derived from socially constructed concepts and meaning (Weber 2004; Weaver and Olson 2005). Interpretivism is a theoretical basis for qualitative research where inductive strategy is used to formulate hypotheses and generate the theory (Weber 2004; Weaver and Olson 2005). Interpretivism includes many approaches that insist on the nature of knowledge such as symbolic interactionism, constructionism, phenomenology, and ethnography (Denzin and Lincoln 2000; Weaver and Olson 2005). The interpretive approach can be criticised for the objectivity lost (e.g. multiple interpretations and realities) (Weaver and Olson 2005). Therefore, interpretivism emphasises the importance of reflexivity and constant articulation for rigour, when investigating the dynamic and complex nature of society and social interaction (Denzin and Lincoln 2000). The issues of reflexivity and rigour will be presented in detail in the next section.

3.3.3 Critical Theory

The critical theory paradigm is concerned with the study of social foundations, the power issues and isolation of new opportunities (Gillies and Jackson 2002). From an ontological perspective, it is governed by conflicting underlying

structures such as social, political, cultural, economic, ethnic and gender (Weaver and Olson 2005). In an epistemological stand point, the knowledge is constituted by the lived experience and the ideologies of social process (Gillies and Jackson 2002). Some approaches which are also included in critical theory are post-modernist and the feminist paradigms.

3.3.4 Selection of Paradigm for Current Research

Researchers must choose a paradigm that is consistent with their beliefs in order to ensure a strong research design. These beliefs must explain the nature of reality and the ways of knowing (Mills et al. 2006). From an ontological perspective, the researcher believes that social reality cannot be separated from the social actors and an individual who observe the reality. In epistemological enquiry, the researcher believes that knowledge is built through social interpretation of the world. In relation to this research, it includes the maternity experiences of the women, their relevant community members and health professionals, as well as the researcher's own knowledge and experiences. Therefore, based on the ontological and epistemological enquiry, interpretivism paradigm is chosen by the researcher. Within the interpretivism stand point, the knowledge is about the way the people make meaning in their lives. It also understands individuals' actions and reactions of others which attributed to their meaning. This would then lead to the *symbolic interactionism* as part of the interpretivist paradigm, which is linked to grounded theory.

3.4.   Symbolic Interactionism

Symbolic interactionism is a theoretical perspective with the core principles on interaction and interpretation (Mead 1939). This paradigm arose from the work of George Herbert Mead, who was a major American philosopher and one of the founders of the pragmatist approach in 1939. He noted that interaction is the key point among mind, self and society. Moreover he considers mind, self and society as an inseparable process where people's selves and minds emerge from the social process (Mead 1939). His work was then developed by his student and interpreter Herbert Blumer (Cutliffe 2000). Blumer (1969) stated that symbolic interactionism is an individual action or behaviour towards things which is based on the meaning that others have for themselves. This meaning is derived from social interaction and modified through interpretation. There are three basic assumptions of symbolic interactionism: firstly human beings act towards things on the basis of the meanings that these things have for them. Secondly, the meaning of such things is derived from, and arises out of, the social interaction

that one has with others. Finally, these meanings are handled in, and modified through an interpretive process used by the person in dealing with the thing he encounters (Blumer 1969). These three core principles are concerned with meaning, language and thought. In other words, human beings base their action and behaviour based on the meaning they have constructed from external stimuli (Blumer 1969). For example, women's views of pregnancy and childbirth may be affected by their interpretation about pregnancy and childbirth, together with how they have experienced the 'world' around them. However it is not solely determined by this external view, but with the way they continue to present themselves and interact with the social world (Cutliffe 2000).

Symbolic interactionism has been frequently associated with the grounded theory approach (Glaser and Strauss 1967; Strauss and Corbin 1998). It is usefully employed in qualitative methods in order to study both aspects of social and individual interaction (Gray 2004). Individuals are active participants in creating meanings, where meaning in this context is a process and changing. This is because behaviour is based on how they define the situation and interacts as a result of this situation and interaction. Symbolic interactionism enables the researcher to explore the social process to interpret and analyse the achieved data. The association of symbolic interactionism during the research process will be explained in the next chapter.

3.5. The Methodology of Grounded Theory

The methodology of grounded theory has been developed into one of the most useful methods in healthcare research (Strauss and Corbin 1998). Since its inception in 1960s, it has attracted many debates not only from its founders (Barney Glaser and Anselm Strauss) but also from other researchers (Heath and Cowley 2004). The explanation and debate surrounding grounded theory are outlined in this section.

3.5.1 Origin and History

Barney Glaser and Anselm Strauss firstly introduced grounded theory in the early 1960s. This theory developed from their joint research on the 'Awareness of Dying' which resulted in a book entitled *The Discovery of Grounded Theory Strategies for Qualitative Research* (Glaser and Strauss 1967). They argued that many existing methods were focusing on obtaining facts to verify theories. According to the authors, most researchers tended to focus on the data which encounter their prior perspectives and predict their assumptions (Glaser and

Strauss 1967). A priori assumption may become a barrier for sociological researchers in developing categories from data, since these may limit the data generation. In order to overcome this problem, Glaser and Strauss formalised procedures that enable development of theory from qualitative data. Grounded theory focuses on data generation in order to develop a theory, rather than beginning with a hypothesis (Glaser 1978).

Grounded theory has become one of the main methods in qualitative studies that used in healthcare research (Corbin and Strauss 2008). A systematic approach is used to analyse and generate qualitative data (Thomas and James 2006). According to Glaser and Strauss (1967), grounded theory is concerned with the whole process of theory generation. The main feature of grounded theory is that, it enables the social process through an interaction between the participant and researcher, as well as the data collection and analysis process (Glaser and Strauss 1967; Glaser 1978; Glaser 1998).

In summary, grounded theory emphasises both the research process and its results (Bryant and Charmaz 2007). It is an inductive and systematic qualitative research process based on the beliefs of symbolic interactionism. It is believed that generating the theory in grounded theory should be from the 'ground' and developed through constant comparative method and simultaneous data collection and analysis.

3.5.2 The Versions of Grounded Theory

Since its development in the 1960s, grounded theory has developed into different perspectives (Strauss and Corbin 1990; Glaser 1992). The major differences and debates of perspectives came from the two originators of grounded theory, which is known as 'Glaserian' and 'Straussian' (Strauss and Corbin 1990; Glaser 1992). According to Heath and Cowley (2004) Glaserian and Straussian's perspective of grounded theory emerged after the respective publication called *Theoretical sensitivity: advances in the methodology of grounded theory* by Glaser (1978) and *Qualitative analysis for social scientists* by Strauss (1987).

3.5.2.1 Glaserian and Straussian Grounded Theory

The difference of perspectives started when Glaser (1992) developed his original approach on grounded theory. Glaser's view still remains faithful to the original approach of data analysis (substantial and theoretical coding). These coding processes are formed in order to initiate the move from empirical data to

analytical interpretations. At the same time Strauss and Corbin (1990, 1998) stated that data analysis is described very *loosely* in Glaser's explanations. This made them explicitly describe an analysis process which is more systematic, particularly in the process of analysing the data (open, axial and selective coding). However, Glaser (1992) accused Strauss of promoting a new method by being rigid in conceptual description of data analysis. Meanwhile, Strauss and Corbin (1998) pointed out that their analysis process is a suggested technique but is not mandatory. Furthermore, apart from the coding system, Glaser and Strauss also debate their grounded theory in terms of conducting the literature review. Glaser reports that the literature can be used as data once the core category has emerged (Glaser 1998). On the other hand Strauss emphasised that literature must be used before the study in order to suggest the required concepts (Strauss 1987). Nevertheless, Heath and Cowley (2004) argued that both Glaserian and Straussian approaches shared the same ontology related to the fundamental belief, that knowledge might be gained in generating and interpreting the data. Both Glaser and Strauss acknowledged that a researcher could not be completely free from the influence of past experiences (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1998).

3.5.2.2 Charmaz's Constructivist Grounded Theory

A more recent version of grounded theory is 'Constructivist Grounded Theory' which was developed by Kathy Charmaz (2000, 2006). This version made contemporary revision of the original author's version by claiming grounded theory was not just about interpreting the data. It is described as constructed through the researcher's own knowledge, perspective and interaction with people and research practice. Charmaz also claimed that her method of generating a grounded theory was more pragmatic. Charmaz adopted a relativist approach by still keeping faith to Glaserian and Straussian approaches (Charmaz 2006). Constructivist grounded theory positively encourages the researcher's views to become involved in the interpretation of data; since it claims that all knowledge is socially constructed. She believes that the researchers play a part in constructing, rather than just observing social processes. The researchers can also explore explicit and implicit social processes and meanings by including their own responses to the data (Bryant and Charmaz 2007).

The advantages of this method are that the resulting theory seems to be more representative of human experience. However, Glaser argued that the 'constructivist' way is not a grounded theory. Since the data in grounded theory

should be from the participants' viewpoints and from their perspective without construction from the researcher (Glaser 2002). Grounded theory should not construct an image of reality, but discover the reality and conceptual process as objective as possible (Glaser 2002). In addition, Glaser (2002) pointed out that in conducting grounded theory, the researcher should not reconstruct the finding based on the theoretical knowledge of the researcher, since it would not generate and interpret the reality data which would not lead to discover the reality. A criticism of this approach is that it reduces the certainty offered by an objectivist approach to grounded theory and opens up the possibility of excessive bias in the data. However, according to Charmaz (2006) several strategies can be used to account for and reduce this bias, such as: participant / member checking, peer debriefing and review, searching for deviant cases and reflective diaries (Seale 1999; Charmaz 2006).

3.5.3 Selecting Grounded Theory Method

As claimed by many scholars, it is not the intention to sensationalise the disagreement between leading scholars or to find the correct grounded theory, as both methods can produce comprehensive work. However, caution is needed so that the researcher is clear about which method is being used (Stern 1994; Melia 1996). To avoid the methodological disagreements, researchers should describe the dilemma in the study process in adequate detail, since there are different criteria for evaluating the rigour of the approach (Stern 1994).

At the beginning of the study, the researcher considered commencing purist grounded theory. However, after conducting the field work, the researcher reconsidered the paradigm of the philosophical position that positioned her inquiries. The researcher has faith in her views towards human knowledge about social matters, based on her ontological and epistemological perspectives. The researcher also believes that the knowledge that each individual has comes from interpretation of the phenomena that we all observe. The involvement of subjective characteristics during the process cannot be eliminated or ignored. The researcher shares the views that all knowledge is socially constructed and the researcher's views become involved in the interpretation of data. The researcher agrees that interactions between the meanings of symbols in human society or groups, define the meanings of certain processes for the society or group. Furthermore, the researcher believes that her relationship with the participants has influenced the focus of the researcher in the study, and the importance of writing in constructing a final text that remains grounded in the

data (Charmaz, 2000; 2006). Therefore, constructivist grounded theory was chosen to undertake this research. In order to investigate the social processes within the research, it is important to conduct in-depth interviews and keep reflective diaries in order to capture the women's experiences during pregnancy and childbirth, and understand how the family members, community and health professionals are involved during this period.

3.5.4 Sampling in Grounded Theory

Unlike quantitative research, participants in qualitative research are often sampled based on their relevance to the study topic, rather than chosen by random or representatively (Cresswell 2007). Grounded theory sampling emphasises the participants who provide the information which generates the process of theory development (Glaser and Strauss 1967). Glaser (1978) suggested a sampling method in grounded theory may commence with individuals in the research setting who are knowledgeable and could provide a rich source of data.

Therefore, a grounded theory study is comprised of purposive and theoretical sampling. Purposive sampling intends to seek and recruit respondents based on characteristics or features which identified as being of interest. Meanwhile, the theoretical sampling has been described as part of data collection process in order to generate the theory (Glaser and Strauss 1967). Glaser and Strauss (1967) emphasised that participants in grounded theory study should be chosen according to the principles of theoretical sampling.

Theoretical sampling is based on the concept which derived from data and an integral part of sampling in grounded theory (Glaser 1978; Strauss and Corbin 1998). Unlike conventional sampling, theoretical sampling is not focusing on sampling the people but the concept (Corbin and Strauss 2008). It is described as the data collection process in order to generate the theory by analysing the initial data and then using the code to inform further data collection (Glaser 1992). Theoretical sampling provides flexibility and diversity in choosing different source of data (Glaser and Strauss 1967). Glaser (1978) suggested the initial samples recruited should be those who meet the research inclusion criteria to begin developing a concept; and theoretical sampling should be utilised to generate the data and contribute to theory development.

3.5.5 Data Generation

There are various ways to conduct data collection in qualitative studies (Corbin and Strauss 2008). However, Charmaz (2000) and Cresswell (2007) suggest that interviews particularly play a central role and are very helpful in grounded theory research; as this is the useful way of understanding the social world. Morse (2001) also suggests that the interview is an ideal process in gathering the data for data generation process, particularly to allow participants to tell their views so that social process can be uncovered. Moreover, Travers (2001) describes the interview is more viable tools especially when the researcher is having difficulty gaining access to institutions to conduct observation. Furthermore, Melia (1996) also argues that the researcher with 'insider knowledge' would not enter the fieldwork as a 'ingenuous observer' and would have brought problems to the collection of observational data.

Nevertheless, there is still some disagreement about what data are best for grounded theory (Corbin and Strauss 2008); since the originators of grounded theory did not specifically define their statement of 'all is data' in grounded theory (Mason 1996). Glaser and Strauss (1967)'s original incarnation of grounded theory method was based on interviews and observation as data generation methods. Conducting observation enables researchers to understand and capture some aspects of social processes and the interaction among participants in the research process (Timmermans and Tavory 2007). Furthermore, it also provides a clearer understanding of the participants' verbal report (Charmaz 1994). Therefore, incompatibility identification between verbal reports and action could occur within the research (Charmaz 1994; Bryant and Charmaz 2007).

Apart from the interview and observation, the possibility of conducting focus group discussion (FGD) could also be made during data collection in grounded theory. The combination of these methods is suitable as part of the theoretical sampling process during the data collection and analysis (Timmermans and Tavory 2007). FGD is one of the research techniques that enables data collection through group interaction on specific issues related to the subject of the research (Robinson 1999). Usually, the participants in focus groups consist of more than two people with the average recommended size of five to eight people (Powell and Single 1996). The aim of FGD is to benefit from the group dynamics which are encouraging the participants to talk, to respond to each other, and to compare their experiences (McLafferty 2004). This method of data

collection is deemed to be practical because it can elicit data from larger numbers of participants in a short time of frame (Robinson 1999). However, one of the disadvantages from focus group is that the articulation of group norms may silence individual voice (Kitzinger 1995). It is the critical role of the interviewer to ensure the success of group interview (Morgan 1996). Many scholars have suggested the use of broad questions in order to encourage broader discussion (Beyea and Nicoll 2000). However, the interviewer needs to intervene when necessary to resolve group discussion and ensure some focus, related to the topic of interest. As part of the theoretical sampling process, the possibility of conducting observations and FGD were based on in-depth interview as the main data collection technique. The process of data collection is explained further in the next chapter.

3.5.6 Transcribing

Qualitative studies include the process of data transcription as the form of the findings presentation (Oliver et al. 2005). The transcribing process is a powerful act of presentation which can determine how data are conceptualised (Oliver et al. 2005). However, the issue of verbatim transcribing in qualitative research is still under debate on its essentiality (Stern and Coven 2001). According to Glaser (1978), fully transcribing would not be necessary in grounded theory research, unless by providing the information on body language and field note. Meanwhile, Morse (2001) emphasised that without full transcription, the research will not be truly grounded in the study. According to Stern and Coven (2001) even current researchers who utilise and have come to rely on technology in order to record all the data are not necessarily sure about this producing 'good' grounded theory research. However, Stern and Coven (2001) suggest that novice researchers may be better advised to record and transcribe all data. What is important in grounded theory according to Stern and Coven (2001) is that, data are fully recorded or transcribed together with examining the social process within the context of social interaction.

3.5.7 Analysis of Data

Data analysis in grounded theory is conducted concurrently along with the data collection process, as an indication in implementing theoretical sampling successfully. There is continuous discussion between supporters of Glaserian and Straussian grounded theory processes on data analysis (Heath and Cowley 2004); and it is here that the split between Glaser and Strauss is most apparent (*see versions of grounded theory section 3.5.2). However, the grounded theory

approach in general offers qualitative researchers clear guidelines by a detailed process of strategies. These are very useful in order to establish and maintain rigour in the research process (Heath and Cowley 2004). These strategies include: simultaneous data collection and analysis, data coding processes, constant comparison, memo writing, and sampling to enhance the emerging theory and form the theoretical framework (Denzin and Lincoln 2003). Similarly with qualitative methods in general, data analysis in grounded theory begins with immersing oneself in the data through several transcription reading, reflective diaries and field notes. This is followed by repeated sorting, coding and constant comparison which continue throughout the whole analytical process (Charmaz 2006).

The first stage in grounded theory analysis is the emphasis on coding the early data (Glaser 1978; Strauss 1987; Charmaz 1994). Different grounded theorists have different approaches in analysing the data or coding procedures (Denzin and Lincoln 2003). Glaser (1978) describes the coding process as substantive coding (the emerging code from data and compared constantly with other data to form the categories) and theoretical coding (the concept that explain the relationships between substantive codes). Meanwhile, Strauss and Corbin (1998) provide a structured method of coding the data with: open coding (the separation of data into unit), axial coding (to relate the categories) and selective coding (the integration of categories to produce a theory). Charmaz (2006)'s constructivist grounded theory analysis approach is similar to that of Glaser and Strauss (1967)'s original method of analysis. However, it implements a more flexible coding process, since according to Charmaz (2000), rigid coding procedures may be appropriate for a more objectivist than interpretivist approach. Moreover, the product of the constructivist grounded theory approach is also more open and not confined by conceptualising the data into a single category that connects to a core category, the way more objectivists develop grounded theory (Charmaz 2000). Therefore, Charmaz (2000) suggests that the researchers should be reflexive about their assumptions and preconception throughout the constant comparison method, in order to inform their analysis.

3.5.8 Constant Comparative Analysis

Constant comparative analysis is an essential element of grounded theory methodology (Glaser and Strauss 1967). Constant comparison begins with looking for key messages and comparing incident with incident, codes with other codes in order to identify the similarities and differences to facilitate the

development of concept (Strauss and Corbin 1998). Constant comparison assists the researcher in grouping the concept and identifying the patterns (Strauss and Corbin 1998). This is a repeating process by looking back continuously throughout the whole research journey and is noted to be a cyclical process (Glaser 1978; Strauss 1987; Charmaz 1994). In summary, constant comparison process during data coding and categorisation, clarifying the emergence of data. This process facilitates theoretical sampling as it may require more information to be collected which enriches and advances the theory development.

3.5.9 Theoretical Sensitivity

Theoretical sensitivity is very important for the researcher to obtain the data in grounded theory (Glaser 1978). It is considered to be the researcher's ability to interpret the meaning of data which is generated from the participant. When the researchers are interpreting the data they are becoming theoretically sensitive by immersing themselves in the data. Researchers should be aware of the meaning of their data and understand well the participants' views which are considered important and significant (Glaser 1978).

Strauss and Corbin (1998) highlight the implication of theoretical sensitivity in its ability to give meaning to the data and to separate the inauthentic important issues. When the researcher is becoming too immersed with the data, the interpretation could be presented as an unbiased result. The existing literature, and their knowledge and experience help the researcher to highlight the potential issues. These could then be useful to develop categories. However, these categories do not always have to fit with the existing literature in order to create categories. Furthermore, Glaser (1978) also notes that the theoretical sensitivity process could provide insights into the meaning of the data and allow this sensitivity to occur.

Being sensitive to the data should begin with predetermined ideas particularly hypotheses of the data during data analysis (Corbin and Strauss 2008). This is because sensitivity to data is developed by being aware of the literature and the topic area (Glaser and Strauss 1967; Glaser 1978). Strauss and Corbin (1998) also indicate the use of knowledge and experience, in order to inform the data analysis rather than to direct it. This is what may be seen as an open mind but not *empty head*, which means the researcher should have the idea on the data that they will be collected, but not to use it in order to direct for generating the data (Dey 1999). An objective stance will be enhanced by the critical thinking of the researcher, in order to stimulate thought and increasing the ability to

recognise the data (Strauss and Corbin 1998). Moreover, memo writing could be used to examine pre-existing and developing knowledge. By being critical and using the field notes as well as memo writing, the identified data could develop into categories.

3.5.10 Field Notes and Memo Writing

Writing field notes aims to capture the 'real situation' of the research and to facilitate the research process through recording observation and thoughts (Wolfinger 2002). However, field notes often remain hidden in the final published work, therefore researchers are advised to write theoretical memos which form the basis of writing the publication (Newbury 2001). Charmaz (2006) explains that memo writing is considered a key component of grounded theory, which is the pivotal intermediate step between data collection and drafting the theory. It allows the researchers to analyse their data in the early process which is continued until the completion of the work related to the findings (Charmaz 2006).

Writing the memo is an important part of data analysis and relates to the data coding within the first draft of completed analysis (Green and Thorogood 2009). The memos enable the development of the categories' characteristics, which are incorporated to create theory (Strauss and Corbin 1998). Memos include the operational notes about data collection and theoretical memos. Theoretical memos include the initial ideas about the data, emerging hypothesis and relationships between codes (Green and Thorogood 2009). Operational memos enable the researcher to explore the process of each category and how the categories are connected with each other in order to generate the theory (Charmaz 2006).

3.5.11 Saturation

Glaser and Strauss (1967) define *saturation* as no new additional data being found. The process of theoretical sampling continued until the categories, their dimensions, and also the relationship between the categories were saturated. Glaser (1978) and Strauss and Corbin (1998) also mentioned that there are two phases of data saturation, which are: category saturation and theoretical saturation. The process of category saturation is described when the researcher finds that no new categories are emerging during the coding process. Meanwhile, theoretical saturation is the phase during the data analysis where the researcher has continued sampling and analysing, until no more data

emerged and the concepts are well developed (Morse 2004). Theoretical saturation is elevated when Glaser and Strauss (1967) discussed 'theoretical sampling'. The theoretical sampling strategy was not only developed to saturate the categories but also to ensure that new concepts would not be dismissed (Glaser 1978).

However, Glaser and Strauss (1967) also identified that saturation is mainly related to the conclusion of theoretical generation, but not as the confirmation of the theory. Furthermore, Morse (1989) also argues that both data and participants as the source of information, will always evolve along with the questions that may continue to raise during the research process. This makes saturation difficult to achieve. Charmaz (1994) stated that it is difficult to achieve saturation, since the researcher continues to ask questions about the data; which are not always answered by sticking to the procedures of theoretical sampling. Dey (1999) suggests the development of core category during the coding process would bring the new data into some form of conclusion.

3.5.12 Rigour for the Study

It is a common perception that the quality of qualitative studies should not be judged by the same criteria as quantitative studies, as they are underpinned by different epistemological assumptions (Seale 1999). The method that is utilised, the research purpose and the researcher who is carrying out the research, all influence the quality of the research (Corbin and Strauss 2008). The method of triangulation is one additional way of increasing the trust and robustness of the research (Casey and Murphy 2009). Triangulation refers to the use of multiple sources of data within the research.

Furthermore, in order to evaluate the validity of qualitative research, there are various criteria that can be used. Guba (1990) emphasized the idea of 'trustworthiness' by drawing a principle of credibility, transferability, confirmability, dependently and auditability (Lincoln and Guba 1985). Meanwhile, Charmaz (2006) addressed four criteria such as credibility, originality, resonance and usefulness (see appendix 8). The interpretivist paradigm, within which this research is positioned, has influenced the development of these criteria.

Credibility is an evaluation to measure whether the research findings represent suitable interpretation which is drawn from the participants (Schwandt et al. 2007). According to Lincoln and Guba (1985), the strategies of member

checking, peer-debriefing, prolonged engagement, persistent observation and audit trail are used in demonstrating the research credibility. *Member checking* is the process of clarifying whether the analytical result represents participants' views by returning to them (Tobin and Begley 2004). Lincoln and Guba (1985) considered this technique as the most critical part in maintaining credibility of qualitative study. However, Hammersley (1992) and Morse et al. (2002) argued that this process is part of a verification strategy, and Glaser (2002) warned against the use of participants of the research to evaluate the analysis as a test of validity. Moreover, Mason (1996) also argued that people are unable to comment and have true insight of the interpretation into their experiences; and this may cause unbiased in the result. Furthermore, *peer-debriefing* is a process of reviewing analysis and conclusion to a colleague or other peer in order to clarify and uncover the bias of data interpretation (Brown et al. 2000). According to Holloway and Wheeler (1995), academic supervisors have a key role in ensuring rigour in their students' studies. Therefore, this step is beneficial to be taken by the research student. *Prolonged engagement* involves understanding and familiarity with the research setting as well as building the trust with participants in order to represent the 'voice' of the research (Onwuegbuzie and Leech 2007). Meanwhile, *persistent observation* is to identify the characteristic which is relevant to the research investigation in the research setting (Onwuegbuzie and Leech 2007). In addition, developing an *Audit trail* is a process of providing the evidence for peer review in order to verify the research result (Wolf 2003).

Originality is associated with addressing new questions, providing new evidence and insights also developing new synthesis of existing works (Johnston 2008). Meanwhile, *resonance* enables the readers to experience or feel the effect of reading the research findings (Manen 1997; De Witt and Ploeg 2006). It also provides the understanding of the research meaning with self-understanding (Ray 1994).

Usefulness refers to how far the application of research findings can be transferred to the wider context in order to derive useful theories (Gasson 2003). Transferability can be obtained through thick description and reference to social context which enables people who are interested in the research to compare and apply the findings to their own area of practice (Streubert and Carpenter 2011). All of these criteria were applied during the research process, which will be explained in the next chapter.

3.5.13 Reflexivity

In terms of validating the quality of the study, the researchers must also be aware of their own reflexivity when conducting the research (Finlay 2003). Reflexivity is defined as the awareness from the researcher in influencing the study. The experiences, beliefs, interests and assumptions from the researcher can impact the findings of a study (Finlay 2003). Moreover, Chambliss and Schutt (2006) mentioned that the way the researchers resolve the problems and interact with the subject in the field are expressed as their own reflexivity within the research process. In qualitative methods, the researchers' sensitivity and their influence on the research process are reviewed. Therefore, reflexivity is adopted during both data collection and analysis process (Corbin and Strauss 2008).

According to Murphy et al. (1998), reflexivity is also about the researchers' sensitivity in which their presence influences the data collection and analysis. This resonates with Glaser and Strauss (1967), when emphasising the impact of the researcher during the study process; through their concept of theoretical sensitivity in grounded theory. However, Hall and Callery (2001) suggested incorporating reflexivity with theoretical sensitivity in enhancing the rigour in grounded theory study. Moreover, they mentioned that while theoretical sensitivity is self-reflexive in developing research questions, the reflexivity is directed at the interview and observation process (Hall and Callery 2001). Reflexivity could enrich the theoretical sensitivity since it provides assumptions from the participants and the researcher, which influenced the data generation (Silverman 2000; Hall and Callery 2001). The reflexivity issues should be clearly noted in order to explicate the researchers' views and provide a transparent data analysis process (Finlay 2003). In order to provide contextual detail on how the interpretation has been reached, the researcher should report on their reflection during the research process. This information enables the readers to determine the findings and conclusions of the research, through the researchers' perspectives (Chambliss and Schutt 2006).

3.6. Summary

Grounded theory is a strategy for the development of new theory grounded in the data. It is a method that enables researchers to discover what is going on from the participants' point of view. Moreover, it enables the participants' perspective to emerge in the data. It is an approach using concurrent data collection and the constant comparison method of analysis in order to allow the

exploration of new ideas. It highlights the theory being determined by participants' experiences rather than the researchers' preconceived ideas. This of course means that the researcher must be open and adaptable to the direction that she might take. Theoretical ideas can be traced back through writing and memoing and the development of the properties of categories.

Grounded theory also enabled an exploration of pregnancy and childbirth experiences from multiple perspectives in order to inform the data. It is also useful in exploring the role of the community in influencing maternity decision in the research setting. The data collection and analysis methods were valuable in providing different views of complex interpretations, thus enabling the discovery of the overall picture. In the next chapter, details about how grounded theory was employed in this research will be examined.

CHAPTER 4

THE RESEARCH METHOD

4.1.   Introduction

In this chapter, the researcher discusses how grounded theory method was employed within this research. The aim and objectives of the research are also presented at the outset. A consideration of study design and methods related to the research is undertaken. The data collection methods and procedures are also discussed along with the data analysis methods. Finally, a discussion of rigour and reflexivity of the research concludes this chapter.

4.2.   Research Aim and Objectives

Research Aim:

To gain understanding of pregnancy and childbirth experiences from multiple perspectives in relation to the use of maternal health services in Aceh, Indonesia.

Research Objectives:
- To explore the role of the community in influencing maternity practices/decisions.
- To explore factors which promote and hinder engagement with maternal health programme.

4.3.   Research Setting

Deciding on the location of the research setting is part of the decision-making in formulating the research design (Denzin and Lincoln 2000). Glaser (1992) points out that the initial selection of potential participants in the research is related to collecting the evidence from the research area. As this research aims to gain maternity experiences related to maternal death, it was decided that participants would be from the population who are experiencing the high incidences of maternal mortality. From the research design point of view, utilising the area of high incidents of maternal death would provide a variety of population and potentially a large amount of data. It is important to collect evidence from an appropriate settings in order to generate suitable data for the research (Glaser 1992). Therefore, this research was conducted in two villages in the Aceh Besar District of Aceh province, Indonesia which is still experiencing the high incidents

of maternal mortality (the map of Aceh is provided in chapter 1). For the reason of confidentiality, the name of the two villages is not given and only a brief description of the settings is provided. The code of ethics for professional and academic association insists on safeguarding to protect people's identity as well as the research location (Denzin and Lincoln 2000). Both villages were part of the rural areas in Aceh Besar District of Aceh Province, which is still experiencing a high incidence of maternal death in Aceh, Indonesia.

4.4. Symbolic Interactionism within this Research

This research is involved with the experiences of pregnant women and postpartum mothers, relevant community members and health professionals during pregnancy and childbirth. Exploring the views about pregnancy and childbirth and how the family members, community and health professionals interact during this period, plays an important role in this research. Pregnancy and childbirth are important experiences for women and they may face many 'new' things in these circumstances. During this period, there are a variety of views and beliefs that may impact on how the women redefine meanings, and deal with their society. These meanings could be modified based on the interaction either between individual selves, or interactions with other people and their surroundings, such as families, healthcare providers, health facilities and the community. Moreover pregnancy and childbirth are not only an individual experience but also are affected by social behaviour. The researcher used grounded theory in exploring the experience of participants during pregnancy and childbirth by utilising symbolic interactionism, in order to investigate the interaction among participants during this period.

4.5. Ethical Considerations

Conducting research with human participants involves the association between the researcher and the participants. These conditions may cause problems since it may lead to undesirable effects, especially to the participants as the research's object (Sarantakos 1998). Therefore, in order to avoid any physical and emotional harm to the participants, this research needs to follow certain codes of ethical approval (LoBiondo-Wood and Harber 2006; Polit and Beck 2006). The research was reviewed and given favourable opinion by the University of Manchester Research Ethics Committee (appendix 7). Prior to commencement of the research, ethical approval was gained from the Local Research Ethics Committee (LREC) (No: Peg.8000/5373) in Aceh, Indonesia (appendix 8). Permissions were sought and gained from the Director of District Health Office of

Aceh Besar, Indonesia to carry out the research in this area. Ethical consideration was gained in relation to the following considerations:

4.5.1 Informed Consent

Informed consent is the principle where the participants should not be persuaded or induced in terms of their involvement in the study. Their contributions should be based on volunteering to take part and being fully versed and understanding about their participation in the research (Green and Thorogood 2009).

Before starting the interview process, an information sheet translated into Indonesian was provided to participants to read (See appendix 9-12). All the participants in the research were literate; however, the participants were asked in advance whether they wanted the information explained verbally or already comfortable with the written form. Many participants in the village had only primary and secondary levels of education and required additional help. Therefore, most participants preferred to have the information sheet explained in detail by the researcher, prior to reading the information document. The participants had the opportunity to ask any questions and they were also provided with at least 72 hours in considering their decision to refuse or agree to take part in the research. It was explained that they could withdraw from the research at any time during the research process, without providing any reasons. All participants agreed to take part in the research and signed the consent form (See appendix 13).

4.5.2 Confidentiality and Anonymity

Confidentiality is the core ethical issue in conducting the research (Green and Thorogood 2009). All the data in this research were anonymised and kept strictly confidential to maintain privacy and respect for the participants; since maternal death is a sensitive issue to be discussed (Polit and Beck 2006).

For identification purposes, each participant was given a code number and pseudonyms were used when reporting the findings. The researcher is the only person who knew the participants' identity. All data are kept in an encrypted computer file and the code for this can only be accessed by the researcher. Once the Doctorate thesis and any publications arising from the work have been completed, the recordings will be confidentially erased. All the transcripts (which will have code numbers and pseudonym) will be kept for 5 years and all the files are stored in an encrypted computer, according to guidance on data storage of

The University of Manchester regulations. Any information gathered will be used for research purposes only.

4.5.3 Autonomy

During the interviews, it is possible that due to the nature of the topic being discussed, participants may have become upset, anxious or distressed. According to Alty and Rodham (1998), research that focuses on sensitive issues may raise the intensity of emotions which provides the opportunity of participants being unable to talk about their feelings, and could be perceived as irresponsible. It was expected during the interviews that the participants would talk about some problems which may cause some anxiety, discomfort or distress during or as a result from the interview. Several strategies were implemented to minimise the possibility of these issues being raised before and during the interview. Rosenblatt (1995) suggested using a consent process in order to give participants the opportunities to stop or withdraw from the interview without providing any reasons.

The participants were observed for any signs of discomfort, anxiety or distress during the interview. The researcher used techniques such as stopping the interview and also provided time and support. The information on the participants' right to stop from the interviews or audio recording at any time was also given to the participants. They had the right to withdraw from the research and retract their testimony and contribution if they no longer wished to proceed. They were also offered the choice to delete the interview from the transcription. None of the participants, either in individual or group interviews, asked to be withdrawn or removed their testimony from the research. Any participants who experienced further emotional distress would have been offered an opportunity to make contact with a counsellor, or other professionals at the local primary care unit. They would provide assistance to the participants in order to ensure 'no harm' in research. During the research process, none of the participants required further emotional support assistance.

4.5.4 Lone Working

Conducting sensitive fieldwork research may cause researchers to be vulnerable, since it involves visiting locations which are not known to the researcher. Moreover, the researcher may be susceptible to harm during the fieldwork research process (Punch 1994; Tisdale 1999). Access to supervision is suggested in the literature in order to deal with and to prevent the potential development

of emotional difficulties for the researcher (Dickson-Swift et al. 2008). Other scholars advised researchers to prepare themselves by anticipating and mediating danger (Hayes et al. 1996), and also to equip themselves with strategies to diffuse threats to their safety (Patterson et al. 1999).

In addition to carrying out this research, the safety matters of the researcher were considered. When the research fieldwork was conducted, the researcher informed an appropriate member of staff from the local University about the time and location of every interview. A phone call was made to her (the staff) before and after the interview to ensure the safety of the researcher. The researcher also did not divulge any personal information such as home address and telephone number as suggested by Patterson et al. (1999). The local research ethics board was informed about the research progress and regular research progress report were also provided to the supervisory team back in the University of Manchester. The interview location during the fieldwork was decided according to participants' preference. Most participants preferred to be interviewed in their home for individual interviews. They were contacted and asked in advance about the preferences and expectations in order to minimise the risks situations.

4.6. Sampling Principles and Procedures

This research comprised both purposive and theoretical sampling in its sampling procedures. Purposive sampling was used initially to recruit participants based on features or characteristics that were identified as being of interest that emerged during data analysis. In this research, both pregnant women and postpartum mothers were recruited initially as the sample of the research. The recruitment of relevant community members (such as husbands and mothers) and health professionals was conducted as the data were analysed; this process aided theoretical sampling.

4.6.1 Purposive Sampling

Purposive sampling aims to recruit respondents based on the features or characteristics that have been identified as being of interest (Cresswell 2007; Corbin and Strauss 2008). The initial main inclusion criteria were all pregnant women and postpartum mothers in the research area. All pregnant women and postpartum mothers in the research area were considered to be eligible and included in the research. Inclusion criteria for the research focused on the participants who were willing to take part and had the ability to give informed

consent to participate in the research. Moreover, the pregnant women who were identified to be in their first, second and third trimester during the research were also eligible. All pregnant women were included in the research without any consideration as to whether this was a normal or complicated pregnancy (i.e. twins or single baby) and first or subsequent pregnancy. There is also no consensus on the length of the postpartum period. Some authors consider it to be 8 to 32 weeks after delivery (Protonotariou et al. 2010). Other options defined the postpartum period either when the woman's menstruation reoccurs or towards the end of the lactation period which may be approximately 24 weeks after the birth (Milman 2011). The last definition was used in this research in order to identify the postpartum mothers in the village to participate in the research.

The women were approached and recruited initially with the help of the village midwives and the community health workers (kaders) in the research setting. The *snowballing technique* were also utilised in order to reach the pregnant women and postpartum mothers who did not have access to the health centre or the village midwives. This technique has the advantage of accessing participants through the extended families of participants in the research, who the researcher would have not known about (Heckathorn 2002). The second group of participants were the family members of the women who were taking part in the research. They were identified by the women in the research and involved in the care of the women during pregnancy and childbirth. One relevant community member for each pregnant woman who took part, either the women's husbands or female relatives (mothers and sisters) was individually interviewed.

4.6.2 Theoretical Sampling

Theoretical sampling in this research was based on the concept derived from data during concurrent data collection and analysis (Charmaz 2006; Corbin and Strauss 2008). Theoretical sampling is best used when some key concepts have been discovered as suggested by Charmaz (2000). The participants group of family members were identified and individually interviewed based on in-depth interview with the women as the initial sample. The other participant groups of midwives, student midwives, kaders and a village leader were also selected through a theoretical sampling process; in order to gain a comparison of maternity experiences in the research setting.

4.7.   Data Generation Methods

Within this research, in-depth face to face interviews were employed as the main method in generating the data. Following the utilisation of theoretical sampling in this research, observation and focus group discussions were used as additional data collection methods. These methods were utilised in order to generate in-depth data on these participants' perspectives and experiences of maternity care in the research setting.

4.7.1   In-depth Interview

Interviews in research are described as a conversation between the participants and the researcher, with the aim of deriving meaning through interpretation about a particular topic (Warren 2002). In-depth interviews were used in this research, since it enabled to explore the participants' beliefs and experiences (Cresswell 2007). Moreover, it provided the opportunity to explore the participant's own views about maternity care during pregnancy and childbirth. The interview topic guide (appendix 15) was initially used in order to cover all the relevant topics and to meet the aim and objectives in a logical structure. The structure of the interview was designed following the suggestion of Charmaz (2000) by using open ended questions. During the interview, participants were not restricted to the guide and were allowed to talk freely about any issues they thought relevant (Patton 2002).

Every interview was audio-recorded using a tape recorder and/or a mobile phone. Participants were informed about the importance of recording the interview in order to ensure the accuracy of their views (Loftland and Loftland 1971). Moreover, it enabled the researcher to focus on the interview questions and consequent responses, rather than taking notes during the interview. However, Warren (2002) also identifies where the discussion ensues more freely after the recorder has been switched off. It happens since either the participants do not want to talk and be recorded talking about particular issues; or they may discuss their concerns more spontaneously rather than be constrained by the interviewer's questions (Warren 2002). There were a number of occasions and interviews with participant within this research, where it was recorded by mobile phone instead of tape recorder. The researcher found that, in several interviews with participants, they were more relaxed and able to freely express their views without the presence of a tape recorder. Although all the participants were aware about being recorded, this strategy had contributed to in-depth discussion about the issues raised within the interview. It was such a powerful image, since

the participants were not distracted with the presence of a mobile phone; as they were more familiar with this technology than a tape recorder. Some interviews were conducted in Indonesian language and some with *Acehnese* local language. The analysis was conducted in English language.

This research was utilising in-depth and qualitative interviews as described by Charmaz (2000) and Warren (2002). Participants signed the consent form prior to the interview. Moreover, an introduction to the interview and explanation about the interview process were undertaken in order to create a comfortable environment, in which the participants could discuss their experiences in an informal manner. According to Cresswell (2007), the researcher needs to create a comfortable environment and develop a rapport with the participants, in order to disclose detailed perspectives as this reflected in the quality of data. The setting of the interview was based on the participants' preference and the researcher maintained professionalism in her manners and behaviours related to the cultural context as suggested by Chenitz and Swanson (1986). Most of the interviews were conducted in the participants' house according to their preference.

The structure of the interview started with using the initial open ended, intermediate and ending questions as suggested by Charmaz (2006). Open ended question such as '*Tell me how you feel about…?',* intermediate questions are more focused, such as '*Can you explain to me what you mean by…?'* and ending questions are more focus to summarising and allowed the participants to add some information which has not been covered during the interview process. This question, for example, '*Is there anything that you would like to add or to tell me about?'.* The ending question makes it easier for the interviewer to explore more depth from the participants. The initial in-depth interviews were conducted with the women and focused on their experiences during pregnancy and childbirth. From the interview, it also identified the relevant family and community members, as well as the health professionals whom involved in providing the women's care during pregnancy and childbirth. As part of the theoretical sampling, these participants were also either individually interviewed or participated in focus group discussion. At the end of the interview all participants were thanked for their time and contribution to the research.

4.7.2 Focus Group Discussion

Two focus group discussions (FGDs) were conducted during data collection process. One FGD consisted of three student midwives and another FGD

consisted of three senior midwives. Each FGD lasted around 70 to 90 minutes. Participants in FGDs were recruited based on the theoretical sampling method, where the emerging data required specific information regarding maternity experiences in the research area (Corbin and Strauss 2008). The group of student midwives were identified during the observation in health centre and requested to participate in the focus group. FGD enabled the participants to feel comfortable in sharing experiences of being a student midwife in the research setting. Moreover, it provided the students with the opportunity to share their opinions safely about maternity care experiences in the research setting among familiar colleagues (Kitzinger 1995). The senior midwives who participated in FGD were also identified and recruited using the theoretical sampling method. From the discussion with the supervisory team during data collection and analysis process, it was decided that some information about midwifery practices in the research setting from the senior midwives' viewpoint was required. The senior midwives were asked about their views and experiences of maternity care and the role of the midwives in providing the care. The FGD effectively provides insightful information into the views of maternal healthcare issues (Hyde et al. 2005). FGD also provided the opportunity to deliver more detail about the topic of interest from the participants. It also enables the interaction between each member of the group. Therefore, FGD was a very useful method to address the research questions (Stewart et al. 2007).

A time and suitable place for participants had been discussed and chosen prior to conducting each FGD. Each participant in the FGD was provided with informed consent and the discussions were digitally recorded. The group of student midwives chose the backyard of the community health centre after the working hours (at 6 pm), as the setting for the FGD. The group discussion went well and was conducted in a less formal way. All the student midwives in the FGD knew each other very well which made them felt less reluctant in discussion. They were able to discuss in a relaxed situation, but one of the three students seemed very quiet for the first five minute of discussion. The researcher managed to involve the quiet student to actively participate by allowing her to speak and share her views during the discussion. The focus group lasted for 70 minutes and all the student midwives were actively involved during the discussion. Meanwhile, all the participants in the senior midwives group discussion were already familiar with the researcher. They were identified as the colleagues of one of the senior midwives in Aceh, who happened to be the researcher's mother. Therefore, FGD with the senior midwives was undertaken in an informal

setting, which was in the hospital's cafeteria. However, the schedule for the FGD was adjusted to the after lunch time period in order to ensure the place was less crowded. The discussion was also held after or outside the working shifts of the three midwives in the hospital, at 4.30 pm. All the midwives who participated in group discussions were actively involved and shared their views and experiences of maternity care in Indonesia. Similar to the group of student midwives, all the senior midwives in group discussion were also known and familiar to each other; this appeared to make the participants relaxed, happier and more willing to share their viewpoints on the topic. The discussion lasted for approximately 90 minutes and was also audio tape recorded. Field notes were written after each FGD and the researcher thanked them for participating in the research. They were also respected for the points of view and experiences, which contributed to the research. Both FGDs went well and all participants participated during the whole session of FGD.

4.7.3 Non-Participant Observation

The decision to conduct observation was made as part of utilising theoretical sampling in this research. This method was conducted in order to generate and further explore the emerging categories during the data collection. This method also allowed the researcher to capture the interaction and observe the behaviours that were described by participants in their interviews (see appendix 16 for the observation guide). Non-participant observational methods were utilised in this research. It requires the researcher not to be interacting or participating in the scene during the observation (Green and Thorogood 2009). This method is really helpful in observing the actions and behaviours, that the participants would be unwilling or unable to talk about within the interview. Within this method, the opportunity to see things that may escape the participants' awareness are also provided (Patton 2002).

The participants who were involved in the observation signed a consent form prior to taking part in the research. The confidentiality and anonymity of the participants were also informed. This was maintained throughout the quotes used and the information within the research. There were four non-participant observations conducted in this research. These observations were undertaken based on the interaction between the women and the midwives in health centre as well as in one of the village midwife's private practice. Another two observations were conducted based on the interaction between the women and the kaders in the community setting. Prior to conducting the observation, the

participants who had already been interviewed were approached by the researcher to participate in observation, as a confirmation or elaborating on the interview data. Almost all women and some of the village midwives were willing to participate in the observation within this research.

The observation in health centre was conducted in order to observe the interaction between the village midwives and the women in health centre. The schedule for observation in the health centre was discussed with one of the village midwives who were willing to participate in the observation. The observation was arranged to be conducted in the maternity clinic of the health centre, where the village midwives would have the interaction with some women and some other colleagues in the room. Once the village midwife was contacted to confirm that she had some women and colleagues who were willing to participate, arrangements were made in order to visit and observe in the maternity clinic of the health centre. As the non-participant observer, the researcher was sitting in the corner of the room in order to provide less distraction during the observation. The observation lasted for approximately two and a half hours and each woman who presented in the clinic during the observation was informed and asked, whether they wished the researcher to be present or not during the observation. Similar observation procedures were also conducted in the village midwife's private practice. One of the village midwives who agreed to be observed in her private practice was contacted for the observation schedule. The non-participant observation was lasting for two hours and the researcher was also given permission to take some pictures of the village midwife's private practice as an additional documentation. Most of the women who came to village midwives both in health centre and private practice were willing to participate in the observation.

Another two observations were undertaken in the community in order to observe the interaction between the women and the kaders. Both observations were conducted when the kaders were delivering the health education to the women in the village. Each observation lasted between 2-3 hours and both of them were conducted in a *Balee* which is placed inside the courtyard of the mosque in the village. *Balee* is an Acehnese term describing an open small building belong to the village for gathering and at the time of consultation or meetings held in smaller groups. Most villages in Aceh do not have specific places for community gatherings; instead they use the village mosque as the place for meeting or consultation gathering in a large numbers. As the non-participant observer, the researcher was sitting with the other women and observed the interaction

between the kaders and the women during the health education session. The researcher took some notes during the observation and following the period of observations, field notes were also taken. During field notes writing, the reflective process was engaged. According to Charmaz (2006), recognising the reflexivity during the writing of field notes after the observation was important in grounded theory research. Writing the field notes by clarifying subsequent reflexivity right after the observation, enabled to probe the action within the observation (Charmaz 2006).

4.7.4 Transcribing Process

In this research, all the interviews were fully recorded and transcribed and preliminary thoughts about themes were noted. All the transcriptions were transcribed by the researcher as suggested by Easton et al. (2000). He suggests that ideally the interviewers should transcribe their own data in order to minimise the words and misinterpretation and losing the meaning during the interview. Moreover, some of the interviews were conducted in Acehnese language and the rest of them were in Indonesian language, which are familiar to and spoken by the researcher. Although this was a very time-consuming process as warned by Sandelowski (1994), since the researcher needed to translate and analyse both languages into English; it was valuable for the development of the analysis. The familiarity with the language and the interview content also enabled the researcher to write the memos during transcribing. The original local language transcripts and memos were then translated by the researcher. Each transcript took approximately six to seven hours to complete. As suggested by Streubert-Speziale and Carpenter (2003), the transcripts were read and re-read in order to get general sense of each participant's experiences as well as to become immersed in the data. The coding process was conducted with the English language. This was very helpful in order to start the analysis process as soon as possible, as advocated in grounded theory.

4.8. Data Analysis

In grounded theory practice, the process of data collection and data analysis often occur simultaneously (Glaser and Strauss 1967). The researcher utilised the theoretical sampling approach in order to inform the next data collection process. The process of data analysis commence during the process of data collection. At the beginning of the data analysis process, the researcher considered incorporating the data management system 'computer-aided qualitative data analysis' (CAQDAS) software of NVivo version 10 to support this

process. CAQDAS offers an effective way of conducting qualitative research undertaken within a defined time and where the resources are constrained (Dainty et al. 2000). It is very useful in data management as it assists the form of complex procedures and lengthy analytical techniques, combined with the need for rigorous and valid findings (Dainty et al. 2000). However, CAQDAS approach often restricts and can neither replace the intuition of the researcher nor the need to make judgements, which are the key characteristics of qualitative research and data analysis (Blismas and Dainty 2003). The researcher considered the strengths and limitations of CAQDAS and decided not to use it for this research. Therefore, the data analysis in this research was carried out manually by utilising Charmaz (2006)'s constructivist grounded theory suggestions. Line by line analysis and constant comparative processes were used to generate concepts and ideas during the data collection and analysis process (Glaser 1978).

4.8.1 Coding Process

Consistent with constructivist grounded theory research outlined by Charmaz (2006), this research employed 3 stages of coding: initial coding, focused coding and theoretical coding (final development) inherent with the reflexivity. These coding procedures were implemented as an effort to develop the theoretical concept or grounded theory from the voice of these participants (Charmaz 2006).

The first stage of initial coding was commenced to examine the data and label the individual experiences that emerged from data. This was done by examining each sentence in each transcript, line by line, to highlight and determine the relevant action or event (Fassinger 2005). These initial codes were simple and incorporated the participant's own words and meanings (Charmaz 2006). The second stage of focused coding was grouping the initial codes into categories using conceptualising processes, accounting for each concept within the category. The decision of grouping the codes involved constant comparison and was influenced through the use of memos which enabled the decision of which categories were appropriate for certain groups and needed to be reviewed and recorded. The final stage of coding processes took place where all the main categories and underpinning focus codes narrowed down into the development of the core category. This process was also assisted through the use of memoing during constant comparison process. Theoretical coding was then used to recognise the data and represent the participants' experiences from analytical

perspectives (Charmaz 2006). See appendix 17 for the illustrations of some of the coding development process.

4.8.2 Constant Comparative Analysis

Following the constant comparative analysis in this research, the initial codes were further reduced into focused codes. Together with the use of reflexive questions highlighted by Charmaz (2006), these focussed codes were then compared with one another. Field notes, theoretical memos and reflexivity in this process will be explained in the next section. These focused codes were then grouped into patterns by the similarities and their diversity within the data. The constant comparison analysis process was continued until the final stages of data collection and analysis to review the merging categories. The development of the codes through the concurrent analysis is as presented in appendix 17. The following memo extract, represents an example of the constant comparison process.

Constant Comparison Method

The constant comparative method is a process in which any newly collected data is compared with previous data, which was collected in one or more earlier studies. The constant comparative usually associated with the methodology of grounded theory, although it is also widely use with other research and evaluation framework. Theory that developed by using constant comparison is considered being grounded because it is derived and constituted by the data.

Decision Making/Mode of Care

The category of 'decision making' was derived during discussion and review of data analysis with one of my supervisors. Together, we went through the initial codes and categories and made some classifications, and then compared the codes which may have the same categories. From the initial codes, there were several items related to the rationale for choosing the place of maternal healthcare. Instead of making so many codes on the 'place of maternal healthcare', we merged these codes under the same category which became entitled 'decision making/mode of care' using conceptualisation. This category explained the decision-making process that the participants made, in order to choose between several available options on the place of maternal healthcare.

Under this category, we put several initial categories which had some commonalities in the physical context of the study. The initial category of 'maternal deaths background, the role of the health service provider in the community, the rationale for choosing the option of midwifery care and location/access for care' were placed under the same categories of 'physical context'.

Cultural Context

The category of 'cultural context' covered the initial categories of 'male domination, lack of awareness of maternal deaths and the ignorance of maternal deaths'. Moreover, the codes on 'value and respect for the man' were also considered as the cultural background categories.

Passage through Childbearing

Passage through childbearing is the term that encompasses the data from several categories. The initial 'cultural context / background' categories were considered to be placed under this new category. The initial categories of 'decision-making about option on seeking maternity care and the role of the health service provider' were also considered to be placed under this category. Similar to the cultural context, the code of '*male domination* and *respect for the men'* became one of the codes in passage through childbearing category. (Memo, November, 2012).

4.8.3 Field Notes and Memo Writing

Memos were kept as notes to the researcher and provided a means of documenting the emerging thoughts. These thoughts are related to the codes, emerging categories, as well as the interaction between the categories as the research progressed (Strauss and Corbin 1998). Within this research, memos were dated and linked to the interviews, observation or discussion that they were taken from. Both field notes and memos documented any situation and ideas that surfaced during the research progress. Charmaz (2006) indicates that memos may be free and flowing and suggests writing them in a flexible way related to the analysis undertaken. During data collection and analysis processes, field notes and memos were kept written by the researcher in order to examine pre-existing ideas and developing knowledge.

4.8.4   Data Saturation

In this research, saturation was reached when a concept could be explained by contrasting experiences of participants, and across different situations (Charmaz 2006). For example, the perception of attributes of a respected village midwife described by the women in the village, were contrasted with the perception from the students midwives. Saturation was reached when both groups of participants described the village midwives having positive personal characteristics, skill and knowledge. After several interviews, since no new concepts emerged and the categories were also not developing further; the interviews ceased at this point. Listening to the interview recording, writing theoretical memos and maintaining the discussion with the supervisory team were very valuable process. This process enables to ascertain to reach data saturation and deciding when to stop data collection.

4.8.5   Validating the Emergent Categories

In this grounded theory study, the data analysis is an iterative process where inter-related data were linked, merged and integrated to develop into themes /categories (Glaser and Strauss 1967). The generated ideas must be verified by the data and categories, which constantly in a continuous comparison process with the initial and new data, inherent with the field notes and memos which related to the data and the emerging ideas (Glaser 1978; Heath and Cowley 2004).

Within this research study, manual data analysis process was beneficial since it enabled the researcher to view the codes, field notes, memos and the context of all data simultaneously. This process facilitated the exploration of the early emerging categories. In order to verify the consistency of the emerging categories and codes, various methods such as, verification, peer-debriefing and constant comparison were made. After the interview and initial coding, the transcript was re-read in order to highlight and label the concept (Charmaz 2006). Thereafter, subsequent coding was undertaken by comparing the transcript with another transcript, in order to allow the emergence of the categories and their properties. By doing this process, the categories were emerged and allowed the researcher to validate the emerging concept. This process also added rigour of the data analysis process in this research.

4.9. Rigour of the Research

In this research, interviews, observations, focus groups and field notes were used to validate and increase knowledge, in relation to develop the emergence of data. Triangulation also ensured the capturing of different aspects of maternal death in the community, and any inconsistencies were then questioned (Patton 2002). Moreover, apart from interviewing the women as the main participant; their family members, the midwives, student midwives, kaders and the head of a village were also interviewed in order to present fair accounts. Therefore, quotations from different perspectives were presented in the data. In addition, several field notes and direct quotation were also presented in order to support sufficient information in the context of research. In evaluating the validity of the research quality, the researcher utilised Charmaz (2006)'s criteria of credibility, originality, resonance and usefulness. These criteria (appendix 18) were given consideration during the research process in order to ensure rigour and trustworthiness.

4.9.1 Credibility

The credibility or the research evaluation through *member checking* was not applied in this research. Glaser (1992) warns against the use of research participants to evaluate the analysis as a test of validity. Moreover, Guba and Lincoln (1981) also warn of the tendency to define verification through the research participants, since the response to the participants' concern may restrain the results to a descriptive level and invalidate the data. Therefore, participants' validation was not undertaken in this research. However, checking the emerging theory, as this was generated during data analysis, and verifying the codes from the previous interviews by asking direct questions to the next participants, enabled the researcher to validate the emerging codes as the study progressed. These measures added more credibility to the data. The in-depth nature of data generation using interviews, FGD and observations, fostered the emergence of theory from a wide range of informants in this research. The data generation processes thus enabled the researcher to gain a clear and in-depth understanding of the research setting and problems, related to maternal health and the childbearing process.

Peer-debriefing in this research was undertaken through regular meeting with the supervisory team during data collection and analysis processes. Suggestions provided from academic peers and critical review of ideas throughout the study design and study process at local seminars was taken into consideration. For

example, recruitment procedures were discussed together with the supervisory team to ensure confidentiality, free participation and no coercion. Moreover, the process of reviewing some of the transcriptions, coding and testing the emergence of hypothesises was conducted with the supervisory team. This process enabled the researcher to explain the study findings and subsequent analysis through the presentation of the participants' quotations(Lincoln and Guba 1985).

Being in the field for more than six months enabled the researcher to become familiar with the research setting, and immerse herself in the community's management of the childbearing process. The presentation of strong links between the data gathered, multiple data collection method and quotes from participants is presented in the findings.

An *audit trail* was developed by having the research proposal examined prior to conducting data collection in peer-review. This process is inherent in gaining favourable opinion from ethics committee. Consistent review with the supervisory team about the findings as well as presentation of the data in local seminars to peer PhD students and national conferences was helpful in order to receive feedback and critical comments. The presence of field notes and memos recorded the thoughts and ideas during data collection and analysis process. This enabled the researcher to determine the saturation process. The data analysis and the presentation of the quotes provide a coherent argument that explains how these participants deal with childbearing and maternal mortality.

4.9.2 Originality

This research builds and extends upon current knowledge about maternal death in Aceh, Indonesia. An increased understanding of maternity experiences and the high incidence of maternal death in Aceh is provided in this research. By utilising a grounded theory method, this research has explored the pregnancy and childbirth experiences from a wide range of perspectives, for the first time in this particular research setting. Moreover, the effectiveness and contributing factors which promote and hinder engagement with existing maternity care provision, in relation to maternal death incidents in the community have been presented and analysed. This research also provides an in-depth understanding on maternal death issues through the perceptions and views from the community in the research setting.

4.9.3 Resonance

According to Charmaz (2006) resonance is described as how well the emerging categories reflect the fullness of the studied experience. The resonance criterion is met in this research since it utilised a combination of in-depth interview, FGD and observation method within the data collection strategies. Utilising various data collection methods within data collection process, portrays the fullness of the pregnancy and childbirth experiences related to maternal mortality, from a wide range of participants. This procedure enabled the researcher to understand the data and reflects the experiences from the participants who share their circumstances. This process also offered deeper insights and revealed the full meaning of the studied experience in pregnancy and childbirth from multiple perspectives in the community.

4.9.4 Usefulness

Usefulness is one of the ways in order to measure the validity of grounded theory research study (Charmaz 2006). Usefulness portrays how well the analysis offer interpretations, and solutions to problems that people can use for their lives (Randall and Mello 2012). The analysis of the participants' view offers useful interpretations that lead to better understanding of the community's problems and interventions, that can be planned and focus on improving maternal health and the childbearing process within the community. The study analysis and the emergent categories represent maternal death problems and suggest the knowledge and practical implications in the community.

4.10. Reflexivity

In conducting this research, the researcher was aware of her responsibility as a nurse as well as a researcher, and need to be reflexive about what and how the research is carried out. Utilising the constant comparison process during data analysis enabled the researcher to maintain openness and sensitivity by questioning the data, looking for relationships and interactions between the data and other sources as suggested by Strauss and Corbin (1998). During data collection process, the researcher was challenged by her position as a researcher as well as a practising nurse in the community. Some of the participants were familiar and aware about the researcher's position as a nurse within public health and midwifery field. This might have had some effect on these participants' answers when providing their views and interpretations of the childbearing and maternal mortality. Moreover, the researcher's experiences in

dealing with maternal health problems in Aceh community; as well as her personal interest and in-depth discussions about maternal health with her mother who happened to be a midwife, might also have affected her reflection and interpretations of the research study. In this research, field notes and memo writing were used in order to provide an audit trail of the ideas about decision-making regarding theoretical sampling, data collection and analysis and how these may have been affected during the research process. Moreover, some information about the researcher is provided in order to report any personal and professional information that may have affected data collection, analysis and interpretation (Patton 2002).

Additionally, throughout the research process, the researcher was also challenged by the supervisory team and other PhD student colleagues, about the assumptions and judgements that were made in presenting this research. The supervisors' roles were significant in enhancing the credibility and dependently during the data analysis. Regular meeting and Skype calls with the supervisory team were held during data collection and analysis phases, in order to provide the opportunities for reflection in practice. Feedback from supervisory team was very helpful for the researcher to improve the skills and sensitivity in interviewing the participants and to build critical self-awareness during the data collection and analysis. This self-awareness was very helpful in order to be aware about the researcher's balance position between the insider and outsider role within the research

4.11. The Role of the Researcher

In the nature of qualitative research, the researcher is the important tool during the research process (Williams 2008). The social identity and background from the researcher have an impact on the research process (Lincoln and Guba 1985; Morse 1989). According to Morse (2001), the background of the researcher and whether they are an insider or outsider to the research setting, will be valuable in providing a variety of perspectives. As an insider, the researcher may find it easier in getting 'inside and be familiar with the research setting. However, the outsider will be able to become a 'fresh eye' and may not take for granted the environment and commonplace events in the research setting (Morse 2001). In grounded theory research, the data collection process becomes more focused as the categories are emerged (Stern and Coven 2001). It is important to ensure that the researcher does not take for granted any meanings, which may be problematic for the researcher who is already familiar with the research area.

In addition, the researcher's clinical background in community health nursing, and her interest in public health midwifery, prompted the development of this research. The maternity nursing course that she undertook during her Bachelorette Nursing education has made her develop knowledge on this topic. During the preparation of a proposal and work of the study design, the researcher had personal experiences of working with pregnant women in a maternal health development post-tsunami 2004 project; although she is not certificated as a midwife (see chapter 1 in the purpose of the study). Moreover the researcher's mother is also a senior practising midwife whom she shared experiences and knowledge with, and encouraged her interest in the area of the research. Previously, while working as a community nurse as well as an educator in the primary care, it was observed that there is the need of improving maternal health services especially in reducing the prevalence of maternal deaths in the country.

4.12. Summary

In this chapter, along with chapter 3, the data collection and analysis during the research process is illustrated. A variety of texts including memos and field notes were also utilised to enhance the data collection and analysis process. The rigour of the study and the reflexivity are provided in order to present the validity of the research study. Moreover, constructivist grounded theory provides a structure to assist the researcher in this research process. This method assists the researcher to develop and generate the categories which presented the maternity experiences related to maternal mortality incident in the community. The following chapters (chapter 5 to 9) will present the findings from the data that formed the four identified categories in this research.

CHAPTER 5

OVERVIEW OF THE EMERGENT THEORY

5.1 Introduction

In this chapter, an overview of the Grounded theory named "maternal deaths: the elephant in the room" is provided. The process of maternity practices that were experienced by the participants in this study is also explained. This process may demonstrate potential links to persistent maternal mortality rate in this community. This chapter begins with information about the characteristics of the participants who took part in this study.

5.2 Characteristic of the Participants

There were forty-nine participants from the two communities who participated in this study. Individual interviews were conducted with forty-three participants and the other six participants took part in focus group discussions. The participants groups were: the pregnant women and postpartum mothers, their family members, midwives, student midwives, community health workers (kaders) and a village leader in the community. Nineteen women (seventeen pregnant women and two postpartum mothers) and fifteen of their family members participated in this research. These family members were nine female relatives and six husbands. Seven midwives participated in this research; four village midwives were individually interviewed and the other three senior midwives participated in a group discussion. The village midwives were from two villages, while the senior midwives were the midwives who worked in the hospital. Three student midwives participated in another focus group discussion, while one student midwife participated in an individual interview. All the students were in their second year of midwifery education and undertaking their placement in the community when this study was conducted. The kaders were female and came from the two villages. In addition, a village leader from one of the villages was also interviewed. The table attached in (appendix 19) outlines the demographic data of the participants. Figure 5.1 below illustrates the overview of participants' participation:

Individual interview	Focus group discussion
The women (n=19) Pregnant women (n=17) Postpartum mothers (n=2)	
Family members (n=15) Husbands (n=6) Female relatives (n=9)	
Village Midwives (n=4)	**Senior midwives (n=3)**
Student midwife (n=1)	**Student midwives (n=3)**
Kaders (n=3)	
Village Leader (n=1)	
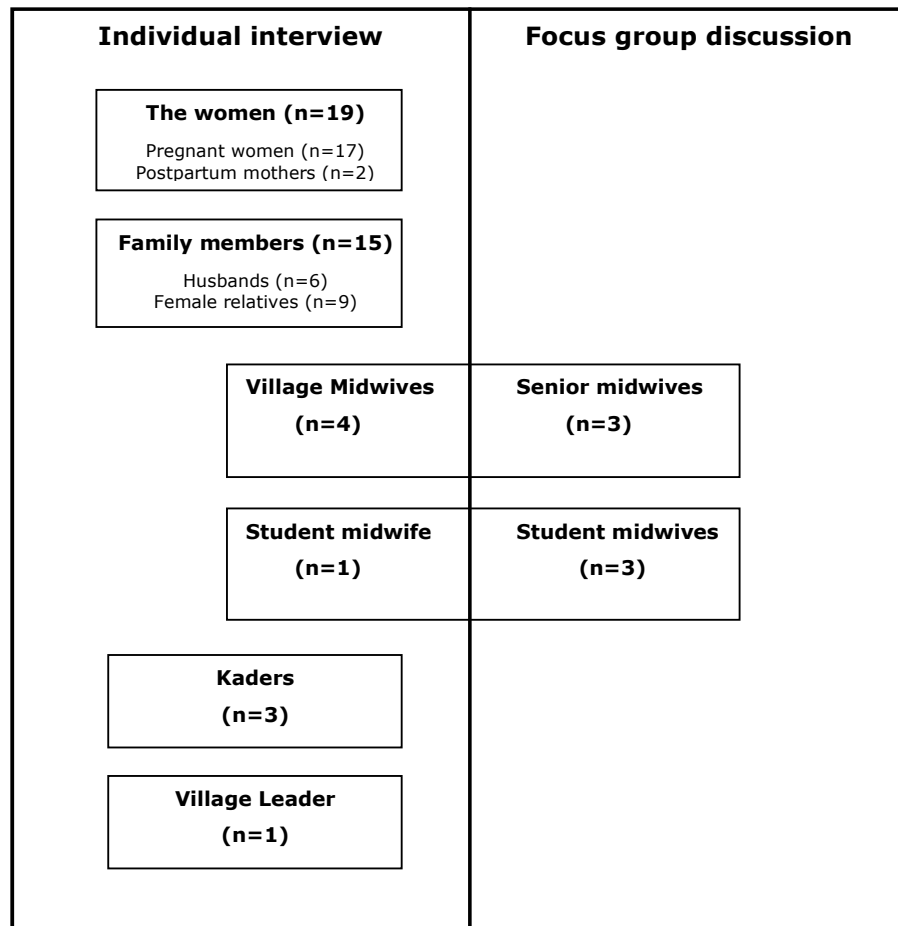
Figure 5.1: Participants' overview in this research

5.3   Maternal Death: the Elephant in the Room

The focus of this study was the high incidence of maternal mortality which still occurs in Aceh province, Indonesia. Despite the Indonesian Government's efforts in reducing maternal deaths through community-based maternal health programmes; the number of mothers who have died during pregnancy and childbirth has not significantly reduced. Community-based maternal health programmes have been effective in reducing maternal mortality in some other areas in Indonesia (Shefner-Rogers and Sood 2004). However, it is apparent that in Aceh province, particularly in the community where this research was conducted, there are wide variations in maternity experiences which may contribute to the continuous maternal death incidents.

This research was conducted by utilising grounded theory in order to understand the perceptions and ideas, within the people who experienced continuous

maternal death situation in Aceh. Grounded theory is very useful to understand the people's experiences and to discover new information; since it focuses on the social processes related to the issues and experiences of the subject (Glaser and Strauss 1967; Glaser 1998). The participants of this research were mainly focus on the population who experienced the high incidents of maternal mortality in Aceh. It was decided that the women who were pregnant and postpartum mothers as the main participants in this research, since they are the most influenced people who experienced and faced maternal death situation in the community. This research aimed to gain understanding of their pregnancy and childbirth experiences in the village. As part of the grounded theory process, theoretical sampling was utilised during the research process. This situation resulted in expanding the views and experiences of pregnancy and childbirth from the midwives as the health service provider in the community, the women's family members and the student midwives, as well as the village leader as part of the community member. Most participants provided their views in terms of maternal health experiences and their role and engagement within maternity practices in the community.

The Grounded theory of *maternal death: the elephant in the room* describes how the community were actually aware about the incident of maternal death in the village. However, it is apparent that maternal death was perceived as an ordinary situation which could and could not happen to any women in the community. All the community members, including the village midwives, considered that they provided their best efforts in order to save the life of the mothers in the village. When the case of maternal death still occurred in the village, most women and villagers would accept it as part of their life's destiny. Figure 5.2 is a diagram that provides an overview of *maternal deaths: the elephant in the room* with its four main categories and their integral fragments.

Maternal Death: The Elephant in the Room

A Grounded theory of community's perceptions and experiences of maternal death in Aceh, Indonesia

Distancing of maternal death

Responses to maternal death

Beliefs about maternal death

The value of midwifery in the community

The status of midwifery

Ineffective use of health resources

Decision-making in maternity care

The influence of the social and physical environment

Perceptions of value for money

The family's contribution

Social control of childbearing

Family involvement in maternity care

Interaction in the childbearing process
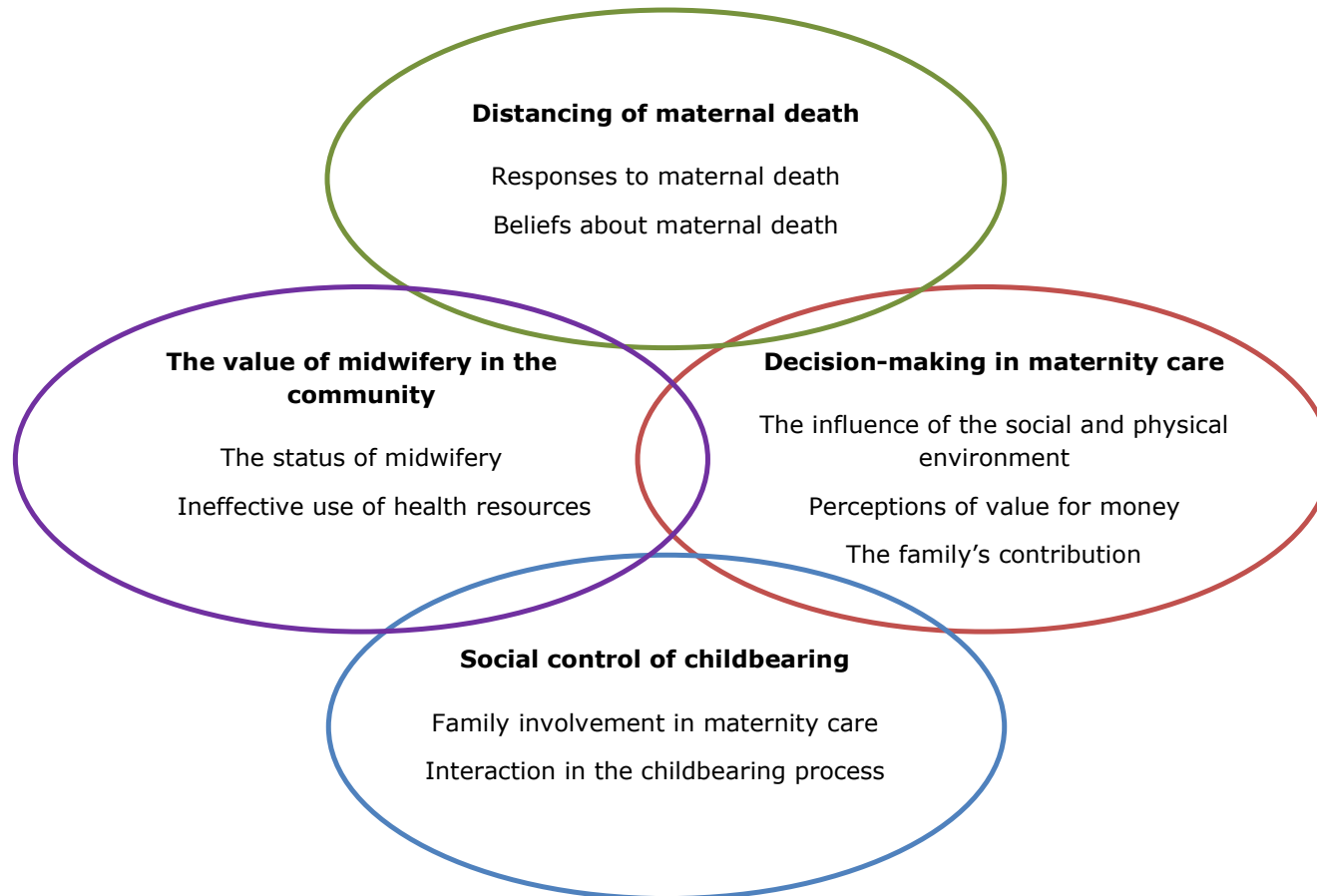
Figure 5.2: Maternal death: the elephant in the room

The Grounded theory of "maternal death: the elephant in the room" a community's perceptions and experiences of maternal death in Aceh, Indonesia has four main categories: *The value of midwifery in the community, decision-making in maternity care, social control of childbearing* and *distancing of maternal death.* These categories are overlapping and related to each other. The process of these categories illustrates the perceptions and experiences from the community on midwifery practices, which may be related to maternal death incidents in the village. The identified category related to maternal mortality is *distancing of maternal death*. However, the other three categories also have the potential to link with the incident of maternal mortality. Therefore, the categories of *the value of midwifery in the community, decision-making in maternity care* and *social control of the childbearing* are presented earlier, since they provide information on maternity practice in the community. These categories have the potential to contribute to maternal mortality in the research setting.

The value of midwifery in the community explains the context or the background of maternity services in the community. This includes *the status of midwifery,* where midwife in the village was considered as the key person in the community in delivering healthcare. The village midwife was also regarded as an important and respectful person in providing healthcare for the village. The participants especially the women valued the status of midwifery in the village based on the personal characteristics of the midwife. They also described *the ineffective use of health resources* which occurred in the village; since the available public health resources were described as inconvenient in delivering their services to the community. Although public health services provided free services in the village, most participants still described them as inconvenient places for both maternity care and general healthcare; with complicated procedures and few health education sessions delivered in the village. This category highlights how the participants depended on their village midwife in order to deliver maternity care in the village. Despite the inadequate continuing supervision and training from the village midwife, and the ineffective public health resources, the participants still valued their midwives in the community.

Decision-making in maternity care explains the rationale from the community, especially the women and their family members for the decision-making on care options. These data related the decision for maternity care with the value of midwifery practices in the community. Most women in the village made their decision to seek maternity care based on *the influence of the social*

and physical environment. The women described the social environment as their relationship with the midwife, and the physical environment as the available health service infrastructure's support. Despite the perception of unacceptable services from public health resources, there was a belief that the free service from public health resources has led to the sub-standard health services received by the community. The requirement of high quality of maternity care has made most women in the village seek midwifery care in private practices. Some midwives in the village had a private practice nearby to their community. The majority of women in the village described their preference for seeking maternity care with their midwife in her private practice, since it provided more privacy and continuity of care. Moreover, the women also described the contribution and influence of their family members on decision-making of maternity care during pregnancy and childbirth. Family members were one of the greatest supports during pregnancy and childbirth for the women in Aceh, Indonesia. Therefore, their opinion and advice were important as they indicated how the maternity care received by the women influenced their health status during the antenatal, intranatal and postnatal periods.

Social control of childbearing indicated the requirement for social support for the childbearing process from other people around them. Most women in the village mentioned that they needed the support from their female relatives particularly during the antenatal and postnatal care. Meanwhile, the women described their desire to include and have the support from their husbands during the labour process. This category also described how the women intended to include their husbands in the childbearing process; since most of them still considered the men as the main decision-maker in the family. Most women in the village were dependent on their husbands and believed that the men should be responsible for the women's lives. Therefore, their opinion was respected and they needed to include their decision-making during pregnancy and childbirth. This category also explains the role of other family members and the interaction between the women and the health professionals in the childbearing process. Most women in the village recognised the importance of village midwives and kaders as their carer during pregnancy and childbirth.

Distancing of maternal death is the category which describes the participant's reaction to maternal mortality in the community. It indicates how the participants viewed the incidence of maternal death in their village. It explains the *nature* and their *beliefs* as well as how they dealt with and their perception of maternal death in the community. Some women believed that maternal death

only occurred to the mother who had an illness before they conceived or during the pregnancy. Therefore, the women who were not suffering from an illness during pregnancy and childbirth were less concerned about maternal death. Moreover, the participants also accepted death as something uncontrollable and as a destiny from God. Their *acceptance* of maternal death has made maternal mortality less of a priority in the community. Some women in the village also described the issue of death as a painful and uncomfortable experience to be discussed. The women believed that having positive feelings towards their pregnancy and childbirth were important. Therefore, they preferred not to discuss maternal death issue within the community. Having the absence of illness and a reluctance to discuss maternal mortality had made the women believe that they were excluded from being exposed to maternal death. It was inevitable that maternal mortality still continuous to be occurred, since all the contributing issues above seemed to be distance from the villagers. This has made maternal death became "the elephant in the room" in the village, and may contribute to the high maternal death rate incidents in the community.

CHAPTER 6

THE VALUE OF MIDWIFERY IN THE COMMUNITY

6.1. Introduction

In this chapter and the following four chapters, each identified category in the findings is presented in detail. These categories were not mutually exclusive and the relationship between them is explored. Data that has emerged from the interviews, focus group discussions and non-participant observations are used to illustrate how the categories emerged. The data are also presented in relation to the relevant literature; where appropriate, memos, reflective diary entries, field notes and participants' quotations have been included to illustrate the process of constructing the category. As the interviews were undertaken in Aceh Province, Indonesia, most of the participants talked in a local language called *Acehnese;* the participants' quotations were, therefore, translated into and then analysed in English by the researcher. Each quotation from the participants has been presented using pseudonyms, ascribing a research number to each participant following the paragraph number in brackets. The words spoken between the researcher and the participants are preceded by the capital letters 'R' for the researcher and 'P' for the participants.

This chapter presents the findings of the first identified category: *the value of midwifery in the community.* From this, emerged two subcategories: *the status of midwifery* and *the ineffective use of health resources* (see Figure 6.1). These subcategories represented information about maternal health services in the community. They also highlighted the relationships between the women and the midwife within the community.
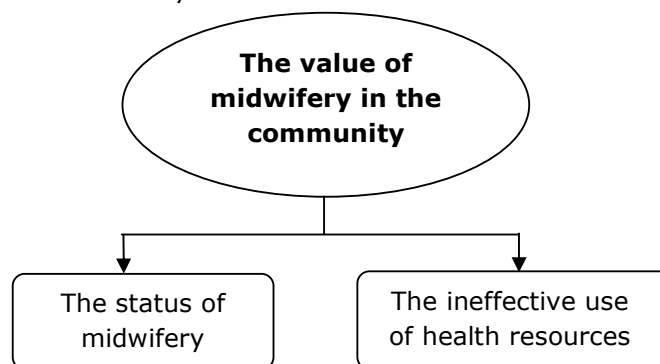
Figure 6.1: The value of midwifery in the community

6.2.   The Status of Midwifery

The first subcategory to emerge from the data is the status of midwifery. During the discussion about pregnancy and childbirth experiences, most of the responses from the community were related to maternal health services in the village. Moreover, the pregnant women and postpartum mothers tended to describe their pregnancies and childbirth experiences in terms of their relationships with the midwife. During the interviews with the women and community health workers (kaders), it became clear that they valued the midwife and respected her role in supporting maternity care in the village. Yuni, one of the pregnant women, expressed her views towards the midwife:

> *"[The midwife] has the knowledge about pregnancy and she also knows how to keep the pregnancy healthy and safe until the birth of the baby… so I will listen to her and try to follow her suggestions… because I want my pregnancy to be safe without having problems during this period"* (15: 112).

Yuni's quote illustrates the trust placed in the village midwife, whom Yuni believed was pivotal to a successful maternity outcome. Most of the women in the village considered the village midwife as the person who is most knowledgeable about maternity care in the community. Therefore, they respected her and developed a trusting relationship with the village midwife, as stated by Eka, another pregnant woman in the village:

> *"Of course I will follow her suggestions because she knows about healthy and safe pregnancy"* (16: 125).

Farah had a further reason for respecting the village midwife. As one of the kaders in the village, she described the village midwife as not only the person who has knowledge of maternity care, but also as a mentor who teaches her and provides her with an opportunity to learn about maternal health:

> *"The midwife teaches me everything about health… from her I know not only about mother and child healthcare, but also about all kinds of diseases and how to prevent them from occurring. From her, I also learnt how to deliver the health messages to the people, improving the health of pregnant women, mothers… and many, many things… The other kaders and I gain so much knowledge from her and we are so grateful to have her in this village"* (3: 122).

Farah's narrative provides a glimpse of the importance of the village midwife's presence in the community. The presence of the village midwife appears to have a great impact on the community's knowledge and perceptions of health, especially related to maternal and child healthcare. Frankenberg and Thomas

(2001) documented the positive impact of the village midwife in increasing the health of women during pregnancy and childbirth in Indonesia. They also found that the village midwife appeared to be the important link between community members and health services, particularly in environments with limited services or where health status is poor. These findings resonate with those found in this study, where most of the people in the village valued the midwife in their community as the primary source of health knowledge and as a connection to the wider health services in the village. Another kader in the village, Rahmi, had further opinions regarding how she valued the village midwife in the community:

> R: "Many people have described that they respect the midwife because she has knowledge about health, in particular maternal health. Do you agree with this?
>
> P: Well yes, of course… but for me… I think people respect her because she can work together and close to the people, especially the women...
>
> R: What do you mean by that?
>
> P: I think the midwife in our village is very keen to help the people in this community, especially the women. She likes to help us and is very happy to assist the women whenever they need her help… You know… having the knowledge is of course important, but if you are keen to use the knowledge to help others… that will make people respect you more" (2: 134).

Some positive personal values were identified in a village midwife in order to take on the role and be a valued midwife in the community. These values encouraged most of the community members, including the student midwives who were taking the placement in the community; in order to create a profile of what they believed to be a 'good' midwife. Linda, one of the student midwives, discussed her views about the reasons why she became interested in being a midwife and how she envisaged herself as a midwife in the future:

> "Well… because you will have a chance to meet the women in their houses… And I think this is the part where you can interact personally with them and their family… also provide them with so much health information during pregnancy and childbirth… I like to deliver health education and information to the women… it makes me feel important and they respect me as well" (1: 168).

Another student midwife, Dewi, gave a similar explanation:

> "I think it would be nice to become a midwife: you've got the chance of helping people, especially the women, and most people will love and respect you as well" (2: 36).

During the discussions with these student midwives, it was revealed that their personal interests and the sense of 'altruism' contributed to their desires to

support and develop relationships with the women during pregnancy and childbirth. Moreover, becoming a midwife was believed to give them a *'status'* and respect from others. Their views of becoming a midwife resonate with those of participants in a study by Williams (2000) in Bristol, England. Williams found that students intended to pursue a midwifery career in order to support women during pregnancy and childbirth, as well as to get respect for doing the job. The study revealed that the students expected status and respect through their ability to provide maternity care.

Other student midwives, Wati and Nanda, however, had a slightly different approach. Although they concurred with some of the above explanations, they also explained that midwifery work contributed to having certain employment, financial security and the opportunities to gain status in the community:

> *"I have the same reason… In addition, if you go to midwifery school, the chance of getting a job is higher… Well basically, if you go to a school with a health background…you also don't need to wait for a longer period after you graduate from the school to get a job. You can even work in the private clinics or hospitals… there is a lot of needs for midwives". (3: 77).*

> *"There is more needs from the government for midwives, and yes… you can get a proper job and salary as well" (4: 65).*

Apart from the sense of altruism and gaining respected status in the community, some students also highlighted the concept of secure employment in becoming a midwife. Despite the fulfilment of supporting women and their families during pregnancy and childbirth, the reward and the status of being respected professionally also contributed to a feeling of satisfaction in becoming a midwife in the community. These ideas were also discovered in some of the village midwives who shared their views of becoming a midwife. Lisa, one of the village midwives, described her views:

> *R:"Why did you decide to become a midwife then?"*

> *P: "Well…at that time, I decided to go to a midwifery school since it was a reputable school and I always wanted to get a job right after my studies… I always loved studying health and I thought studying midwifery was interesting since it focuses on women's health, which I also interested in… and the chance of employment is also high… that was my thought at that time… but then I discovered that I enjoy being a midwife, especially when I did my placement in the community. I realised that being a midwife was not just about getting the job but also the chance for you to interact with the women and supporting their health… so… yes, that's why I decided to be a midwife after I had finished my studies [(smiled)]" (2: 231).*

The village midwife was considered to be the person who provides not only maternity care but also general health services to the community in the village.

In most rural and remote areas in Indonesia, the community depends on the village midwife for health services (Shiffman 2003). This dependency and their role have made the people in the village respect the midwife and have made midwifery to be valued in the community. However, the status of midwifery in the community may be enhanced if the midwife has positive personal values also combined with knowledge and competent skills, which contribute to being perceived as a 'good' midwife. This combination could help to determine whether the midwife is perceived as a respected and important person in delivering health services, especially those related to maternal and child healthcare in the community.

6.2.1　Attributes of a Respected Midwife

The concept of *attributes of a respected midwife* emerged consistently throughout the interviews. This concept initially presented itself as open codes that were often labelled as *in vivo* coding. This coding expressed the community's description of a 'respected midwife' and her characteristics. After several interviews, it became apparent that most of the women and their families valued and selected a midwife based on 'positive characteristics' that they associated with her. This concept also relates to how people select their preferred midwives, as described by a woman and her sister below:

> *"Well… the fact that she is very patient… because I was really in pain at that time and I was crying a lot… I was also afraid because I never had any experience of giving birth before… but somehow she could made me feel comfortable…She was taking good care of me"* (8: 414).

> *"Yana is a very good midwife: she is smart and friendly and she helps lots of women in this village. So far…I haven't had any problems in having my maternity care with her and I also believe my sister will be alright seeing her as well"* (8: 140).

Most of the women described their 'respected' midwife based on her personal characteristics. Some personal attributes such as friendliness, being caring and being patient were considered to be important characteristics by most of the women in the village. These attributes described by the women provided a *comfortable* feeling for them in seeking maternity care from the midwives. Most of the women in the village used the term 'comfortable' to explain their close and positive relationships with the midwives in the village. Furthermore, they also mentioned that the effective communication skills were very important for the midwives in providing comfortable feeling to women during their maternity care:

"Well… she was always staying by my side and kept saying nice, encouraging words and 'dua' [(praying words)]… so it made me calm down a little bit and relax… She is very nice and kind… She took good care of me during pregnancy and childbirth… Besides, she is a very smart and experienced midwife…I wish that all village midwives were like her" (8: 422).

Generally, the women in the village stated their preferred midwife characteristics as having good attitudes and communication skills, as well as being knowledgeable and competent. Similar to this, Nicholls and Webb (2006) and Carolan (2011) mentioned that one of the greatest contributions of becoming a 'good' midwife is a combination of having effective communication skills and attitudes, coupled with knowledge of and competence in midwifery skills. These attributes are not only determinants of a good midwife but also of a good role model, and the attributes provide encouragement for student midwives to learn to become good midwives (Licqurish and Seibold 2008). This statement was supported within the interviews in the village. Linda, one of the placement student midwives in the community, described her views regarding a good midwife:

R: "What makes a midwife a good mentor, do you think?

P: Well… I like the midwives who are very supportive and guide you during your placement time.

R: What do you mean by supportive and being a guide?

P: Well… they teach you and show you the lesson and intervention… They don't just tell you what to do but also give you a good example of how to do it and why you have to do it… They're also there observing what we do, even though sometimes we may have done the intervention before… but I think we're still students and we need to know whether we've done the right thing or not" (1: 111).

It is apparent in the community that there is a tendency to value the midwives in relation to their positive personal attitudes and the perceived attributes of a good midwife. These characteristics are defined as the set of skills required by midwife in order to deliver maternity care and be professional in her duty. Yana, one of the village midwives, described her opinion of being a midwife:

"As a midwife, I need to be aware about the needs of the women in this village. I always try to think of myself not only as their midwife but also their friend, so I know exactly what they need and I could gain their trust… I always feel pleased to assist the births and take care of the women's health, and I think as a midwife, you must always increase your knowledge… both… midwifery skill and the community skill… because these two will help me as a midwife in order to provide good maternity care to the community" (1: 290).

Being competent in midwifery skills is important in order to deliver safe maternity services to the community (Smith et al. 2009). Along with a high level of maternity skill competence, the importance of having maternal health knowledge, understanding community profiles and having communication skills will also generate high-quality of maternity care (Lavender et al. 2002). It is apparent that the community respected and valued the village midwife based on her positive personal characteristics. This midwife is considered as the important person in providing maternity care and also gained respect from the community.

6.2.2 The Role of the Midwife in the Community

Midwives were regarded as important health professionals and were respected by the community for providing healthcare, especially maternal and child healthcare. Darmi, one of the senior midwives, described her views about the importance of being a midwife in the community:

> *"Being a midwife in the village mean you are connecting the people and the health services… because sometimes you are the only health professional in the community… especially in rural areas, there are not so many health staff and health services are found… So when the people want to access health services… they will come to see the village midwife"* (6: 454).

The importance of midwives in the village has made the community consider midwife's role as the main health resource in the village. The village midwives were also portrayed as the only health professional that the community had access to in the village. Another senior midwife, Rima, gave a similar explanation:

> *"In the village, you are [(as midwife)] the first gate for them to enter the health services. So… you are the health services for them… because you are the only person who has knowledge and skill about health in the village"* (5: 345).

These two extracts highlight the role of midwife in the community, particularly in the village, where health access is limited. Most rural areas in Indonesia have identified the village midwives as frontline healthcare providers, to serve and to link health service delivery with the community in reducing maternal and neonatal mortality and morbidity (Geefhuysen 2001). The village midwife is also considered as a valuable health resource, since she has the most knowledge of health in the community. Therefore, the villagers consider contacting the midwife when they seek health services, especially maternal and child healthcare in the community.

Rahmi, one of the kaders in the village who worked closely with the village midwife, described her view about the role of midwife in the community:

"I think the midwife in our village is an important person… because she is here in order to help the people to increase and maintain their health… ehm… She is also the health staff and the member from the government and she is here in order to educate people in the village about health… She teaches us… and informs us about health…She is here to help the women… to improve their health, especially during pregnancy and childbirth" (2: 235).

In general, Rahmi's opinion explains the role of the village midwife is to improve the health of the community; in addition to delivering maternity services to the women during pregnancy and childbirth. Hennessy et al. (2006) view is also consistent with this, as they stated that midwives in Indonesia play an important role in improving maternal and children's health, as well as in improving the health status of the community. As Indonesia is battling to reduce its high maternal mortality rate, the presence of the village midwife is very important, especially in reaching rural and remote areas, where health services are limited (Geefhuysen 1999; Makowiecka et al. 2008).

According to Battersby and Thomson (1997), in England, there are three main roles for the community midwife: clinical, supportive and educational. These aspects have been identified by the community as positive attributes within the midwife that enable her to perform her role in the community. During the discussions with the villagers, questions were raised about their views on the village midwife's performance and role in the community. Farah, one of the kaders who had worked with two village midwives, described her views about the midwives in her village:

"I worked with Yana [(the village midwife)] most of the time… I don't know… errm… maybe because she lives in this village… and… most women seek her assistance during pregnancy and childbirth… and she also performs the birth assistance in this village… so… you know… she is more likely to be active I guess… [If I can say that]… Whereas Lisa… ehm… she is a nice midwife… but she doesn't live in this village and she also doesn't perform the birth assistance… so that's why most women go to Yana, and this has made me work with Yana more than Lisa" (3: 332).

Maya, a pregnant woman in the same village, described a similar experience regarding the two village midwives:

"Well... I prefer Yana to be honest… because she is smart and friendly… I prefer to go to Yana for antenatal care, because I want to give birth with her and I think Yana has more experience too… because, you know… she assists the women giving birth more than Lisa… Lisa is also friendly but she does not provide the birth assistance… she just does antenatal care

and…ehm…she also doesn't stay in this village, so she wouldn't be available most of the time for us" (18: 376).

Both Farah and Maya described the performance of their village midwives in the community. Both of them shared the same experiences and expectations of the midwife being available and having a positive personal attitude, as well as being competent and knowledgeable in delivering maternity care. In many midwifery contexts, care provision and outcome are audited (Dimond 2000). Midwives' performance is examined and reviewed based on this evaluation. However, in this research, none of the participants emphasised that positive clinical outcomes were an indication of a good midwife. Instead, their views of successful midwives were based on the availability of providing the services and the midwives' positive personal values. According to Todd et al. (1998) and Homer et al. (2002), being available and providing continuity of care, combined with the desire to conduct the task, are considered aspects of good performance and provide job satisfaction for midwives in midwifery practice. The researcher found different views from one of the village midwives regarding her performance as a village midwife, as documented in this field note:

During the interview, I could see that Lisa loves her role as a midwife in this village. She is a friendly and chatty person and loves to discuss many things. However, when she described the condition of the village health post, she appeared to be disappointed. She described the village health post as an unsuitable place for a health post and as an unsuitable place for a midwife to stay in the village. This was due to the fact that the building was a little bit isolated from the residential area in the village, also the building only consisted of two bedrooms, which she described as not being a very convenient place to stay or deliver maternity services. I tried to understand her situation: she had a husband and two children who could not live with her in a small village health post. Therefore, she prefers to stay in her own house, which is only about 10 kilometres away from the village, and travel to the health post every day.

When Lisa told me about her reason for becoming a midwife, she appeared to describe carefully; without making her-self appeared to not have an interest in midwifery, but still maintaining the honesty. I could see that she did not want me to misinterpret her explanation, and think that she was not a good midwife. She explained to me about her role of becoming a midwife in the village without performing the birth assistance. She explained to me that she

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only focused on delivering maternal health education to the community. Her explanation has made me consider about the effect of this condition on her performance as a village midwife in the community (Field note 10: 42, April 2012).

6.2.3   Challenges in Midwifery

The discussions with the village midwives in the community revealed some challenges that were faced in delivering maternity care in the village. Some of these challenges were described by the midwives as a barrier to performing optimum maternity care in the community.

6.2.3.1. Equity in Provision of Care

It is important for the village midwives to gain the trust of and to meet the needs of the community to provide better midwifery care in the village. Some of the challenges that were faced in midwifery practice were related to midwife's equity in the provision of care in the village. One of them was described by a village midwife, Yana:

> *"As you can see, there are actually two midwives in this village. However, the other midwife doesn't actually stay in this village, although she comes to the health post… but it is just five days a week… She doesn't actually stand by in this village. Sometimes I feel that I carry out the responsibility of maternal health in this village by myself… it is too difficult to handle all of these maternal and health problems in this village by yourself really"* (1: 190).

Yana described the responsibility of providing maternity care in the village. The discussion revealed that not all the village midwives were performing the birth assistance in the community. This situation had created inequalities in the job responsibilities of the key players, who were delivering maternity services in the community; as only one particular midwife was responsible for supporting the births. Ratna, a midwife from a different village, gave a similar explanation regarding the job description and responsibility in the community:

> *"Not all the village midwives in this sub district can assist births… Although most villages have village midwives… sometimes the midwife doesn't perform the birth assistance… so the women in her village will have to travel to the neighbouring village when they want to give birth"* (3: 354).

Nearly half of the village midwives in the community were recognised as not performing the birth assistance in the village. Most of them were midwives who had several years of maternity experience and were based in the health centre.

The health centre in the community only provided the antenatal and postnatal care, without any intranatal services for women. This has resulted in some midwives in health centre becoming deskilled in supporting births:

> *"There are many midwives around this village… For example, the senior midwives who are based in health centre… they are supposed to be our supervisors… but even some of them do not support births… Maybe because they were no longer performed the birth assistance in health centre for such a long time, so… they don't feel confident enough to assist births" (3: 360).*

It is important to have the right number and a balanced distribution of village midwives in the community, in order to achieve optimum maternal health services (Makowiecka et al. 2008). However, midwifery practice in the village appears to be less effective, if there is no equity in performing job description in maternity care amongst the village midwives in the community.

6.2.3.2. Inadequacy of Midwifery Training and Supervision

Having an adequate number of qualified midwives is required in order to deliver optimum maternity services in the community. Geefhuysen (1999) reported that in order to support a safe motherhood programme in Indonesia, the government provided sufficient training to the village midwives, aiming to deliver high-quality of maternity care in the village. However, continuing professional development (CPD) regulations has not been completely established, especially in rural areas in Indonesia (Frankenberg et al. 2005). Updating midwifery skills regularly is needed for the midwives in order to enhance their maternity care provision (Hennessy et al. 2006). Mariam, one of the village midwives, also addressed this training issue during the interview:

> *P: "There are several midwifery training courses provided by the government for the midwives… especially for community midwives… However, I don't think all of the midwives, particularly those in this district, are interested in attending the programme…"*
>
> *R: "And why is that the case, do you think?"*
>
> *P: "Well… many reasons… Maybe some of them don't think it is quite useful for them… For example… the midwives in the health centre… they wouldn't think that the training regarding the birth assistance would be beneficial for them, since… mainly they don't assist births… Even if they attended the training… well… [since most midwifery training is obligatory]… they wouldn't actually apply it into practice" (4: 391).*

According to the midwives in the community, most courses for updating midwifery skills or CPD are compulsory for the village midwives, and monitored by the health department board. This training is important in order to improve and update their midwifery skill competence. However, it is important not only

to encourage village midwives' *enthusiasm* to attend the training but also encourage them to apply it in their clinical practice. Mariam also added to her explanation regarding this issue:

> "I think most midwives here have less interest in attending the training since they cannot apply it into their work… For example… the training about the latest skill competence in supporting the birth would be less useful for the midwives who do not perform the birth assistance in health centre, as it doesn't have a labour ward… Moreover, there is no pressure for the midwife to perform the birth assistance… You are still a midwife anyway… even though you are not supporting the birth" (4: 423).

Mariam's narratives emphasised the need for adequate supervision in order to increase the midwives' motivation to have highly skilled competency in maternity care. Another village midwife, Ratna, also reported that the midwives' lack of passion in the community to undertake the training also related to the lack of midwifery supervision. She and some others village midwives in the village were aware about the importance of supervision in midwifery practice. Despite the training availability, adequate supervision is important in order to maintain village midwives' competence in providing optimum maternity care as she stated below:

> "As you know… here… once you got the certificate as a midwife then you will be called as a midwife for the rest of your life… whether you do or do not practice as a midwife… When you do midwifery practice… you don't actually have the supervision… Well, of course by hierarchy you have the 'more' senior midwives in health centre or higher institution as your boss… but they don't actually supervise you in terms of your skill… So… there's no reason for you to upgrade your skill… Despite that you have to attend the training… but there is no enforcement for you to apply it into practice" (3: 435).

According to Högberg (2004), successful maternity care needs a supportive environment that consists of health services and on-going supervision for the health service provider. Some challenges described by the village midwives in this research, related to an unsupportive work infrastructure; which led to the barrier of applying adequate midwifery skills in practice, followed by continuous supervision. Thus, strengthening midwifery skill competence and supervision may contribute to adequate midwifery services. This may work towards the villagers valuing midwifery practices in their community (Högberg 2004).

6.3.   The Ineffective Use of Health Resources

The next subcategory to emerge from the data was *the ineffective use of health resources.* This subcategory was defined as the context of health access for care that was described by all the participants, based on observations in the

community. Most villagers recognised the importance of health facilities in order to seek healthcare in the community. Some health facilities in the village had been used by the villagers not only to seek healthcare, but also to gain health knowledge in order to improve the health status in the community.

6.3.1 The Role of the Health Centre (Puskesmas)

A health centre is the public health service in the community and is based in every sub district in Indonesia (MoH 2009). It provides free health services to the people in all villages inside the sub district. The health centre provides general public health services and is supported by adequate health professional staff.

Some of the villagers described their views of the malfunction of some health resources in the community. For example, the maternity care in health centre (Puskesmas) was described by some of the pregnant women in the village as follows:

> "I like to have my antenatal care at Puskesmas because it is free… and you can also meet various health staff members… However, the maternity room at Puskesmas is not very comfortable… It is quite 'open' and 'exposed'… Also, it is very crowded… I don't think it is really comfortable for the women. The maternity room should be quiet and private… without so many people inside… and unfortunately Puskesmas cannot provide that" (18: 443).

> "I didn't go to Puskesmas since it doesn't provide the labour service… Also, the place is not very comfortable for the antenatal care… Why should I go to a place where I already know that I cannot deliver my baby there?" (19: 323).

The absence of labour services is also one of the main concerns for the women in this research in seeking maternity care in the health centre. Although the health centre provides the antenatal and postnatal care, most of the women in the village were more concerned about the need for privacy and having antenatal care where they would be able to give birth. Apart from health centre's inconvenient setting and the absence of a labour ward, Imas (another pregnant woman) described her experiences in health centre:

> "Well… I don't really like having the antenatal care at Puskesmas, because you'll be placed with other women in the same room… Although they put a curtain near the examination bed… it still makes me feel uncomfortable to be there… Also, at Puskesmas… we have to go through some complicated procedures… for example the registration process… We have to bring our card every time we register… and if we forgot to bring it… they would again take our identity… and we have to register again from the beginning; it takes time… I think it's complicated and a little bit annoying" (8: 127).

During the discussions, some of the women also described the health service procedures provided by health centre. Some *bureaucratic* procedures in health centres have made their service performance unacceptable to the community. Most of the villagers wanted to have direct and clear procedures in accessing healthcare. According to Todd et al. (1998), the supporting healthcare environment is one of the factors of achieving better health services. Failures in providing convenience and basic health support influence the achievement of high-quality health services, as described by Zahra, one of the kaders:

> *"I think Puskesmas should be more active in delivering the health education… because people in the village deserve to know the health problems in their village… so they could be aware…I mean…they [(the health centre)] educated us [(the kaders)] about health… but giving the health education to the people is also important… not just relying on us to provide the health message… I would love to deliver the health education… but sometimes… the people in the village will be more convinced if it is from the health staff… because, unlike us, they [(the health staff)] are the health-educated people" (2: 417).*

The health education service provided by health centre is required by the community. It is important for the community to obtain health education from the health professionals in the health centre; so that the villagers receive clear messages regarding the current health issues and problems in their village. As some participants described the ineffective use of health resources, this implies a failure in providing health services in the community. Maternity care improvements require adequate health service resources that are available and delivered effectively in the community (Högberg 2004).

6.3.2 The Role of Posyandu

Posyandu is a national health programme in Indonesia with the main goal of improving the health status of women and children, by enhancing the participation of the community (Leimena 1989; Saito 2006). Posyandu stands for *Pos Pelayanan Terpadu* or integrated village health post. It was introduced by the Indonesian government in 1985 as part of a safe motherhood programme to support mothers' and children's healthcare (Saito 2006). Zahra, one of the kaders described Posyandu as following:

> *"Posyandu is an activity that is run in the village… It is organised by the village midwife and by us as kader… It provides services for mothers who have 'balita' [(children under five)]… and sometimes also for pregnant women… for example when they want to see the midwife for tetanus injections… or to discuss their pregnancies" (1: 40).*

There are five services in Posyandu: family planning, antenatal and postnatal care, child healthcare, immunisation and diarrhoeal disease control. Posyandu activities are supplied and supervised by the health centre staff (Leinbach 1988). The programme emphasises community involvement, since it is organised by the community in each village through the kaders, as the community health workers in the villages (Leimena 1989). These kaders receive training from health centres as the responsible community members in organising Posyandu activity. This was described by Farah, one of the kaders:

> *"We had training from Puskesmas about being Posyandu kaders. Usually, the training is about how to manage Posyandu and our roles in each activity. They [(the health centre]) also trained us about how to deliver health messages, especially to the women, and how to encourage them to participate in Posyandu… but basically about how to manage Posyandu" (3: 356).*

Posyandu is a maternal and child health programme that is integrated with the health centre services that are delivered in the villages (Saito 2006). With the assistance of the kaders, the village midwife is responsible for organising this activity in the village. As this programme enhances the involvement of the community, the kaders are responsible for managing this programme and encouraging the community to take part. The main idea of Posyandu is to raise awareness and educate the people in the village, as well as to contribute to maternal and child healthcare (Leimena 1989; Saito 2006). However, the involvement of the community in this activity was still limited, according to the interviews, as described by Rahmi, one of the kaders:

> *R:"How do people get involved in it? I mean… What is the contribution of the community, especially the women, to Posyandu?*
>
> *P: "Well… they attend the Posyandu really… I think their attendance is important… since it is a chance for them to see the midwife… or the health staffs from health centre… because sometimes not all of them have a chance to visit the midwife…So…yes, their contribution is important" (2: 243).*

From the discussions with some of the kaders and observations in the village, it was apparent that the involvement of the community in Posyandu activity is actually still limited and can be categorised as a *passive involvement*. The ideal Posyandu activity should have an active village community (Leimena 1989). However, in the village where this study was conducted, the active community members in Posyandu were still limited to the kaders who organised the Posyandu activity. They also acted as facilitators between the community and the village midwife or the health staff in the health centre.

6.3.3   The Role of the Village Health Post

The other available health resource in the village is the village health post. It is a small health post that is located in the village. It provides the village midwife with a place to stay in the village in order to deliver health services in the community. It is integrated with the work of health centre and also provides free health services. The researcher noted her description of village health post on the observation note below:

An Observation of the Village Health Post

The village health post is a small house away from the residential area. It is designed to be the place where the village midwife resided and delivered the maternity service in the village. From the outside, the village health post appeared to be like a normal residential house, only it is completed with the midwifery equipment inside the building. It has a big, open garden in a quiet area in the village. The building consists of one living room, a dining room (which is attached to the kitchen) and two bedrooms. One room is used as midwife's bedroom and the other one is used as the examination room. The examination room is approximately 6 metres x 5 metres with two single beds. One of the beds is used as an examination bed and there are two big cupboards where the midwives store some of their midwifery equipment. There is one table with two chairs facing each other for patient consultations. There is one small oxygen tube and an intravenous pole inside the room. There is a terrace with a long bench, which patients usually use whilst waiting (Observation note, April 2012).

The village health post is usually used by the community in order to seek healthcare in the village. Zakia, one of the pregnant women's sisters, explained about village health post:

> "The village health post is actually closer for us to go to and the service is also similar to Puskesmas… The midwife who provides the service in the post also works for Puskesmas… Moreover, we also don't need to pay when we seek services at the post…I usually take my mother there in order to get medication to cure her knee pain" (5: 231).

Some villagers use the village health post to seek general healthcare. However, it is appeared the pregnant women rarely seek maternity care at village health post. In this research, although maternity services at village health post were being performed by the village midwife, the women still did not consider to have

maternity services provided at the village health post. Ipah, one of the pregnant women, explained the services at village health post:

> *"Actually… I don't have any problem in accessing village health post… It is okay for me… although the place is not very comfortable… you know… the maternity room is small and has less privacy… but it is still fine with me… at least it is better than Puskesmas, which is very crowded sometimes… However, my only problem is… the midwife who stays in the post does not assist births… she only does the antenatal care… so I didn't see any point in seeking the antenatal care with her…I would rather go to the other midwife, who actually assists births" (6: 347).*

The absence of birth assistance skills in some of the village midwives at village health post had led to a barrier for the women in seeking maternity care. Despite the absence of this service, some village midwives were also rarely available in the village, since only a few of them actually resided at village health post. Although there were some village midwives who were offering the birth assistance, some of the women still preferred to visit the midwives in their private clinics, due to the physical context of village health post. This situation was related to the decision-making of the pregnant women in the village, which will be discussed in the next chapter.

6.4   Summary

This chapter has identified and examined a number of important findings for this study. Valuing midwifery in the community is a process whereby the villagers examined the status of midwifery in the village through the concept of attributes and the perceptions of being a respected midwife in the community. Intertwined with this process, the community also defined the access to care and the effectiveness of health services that are available in the community. Central to the process of the community valuing midwifery is the relationship between midwife and the community members in the village. The relationship between the village midwife and the community is important in order to learn how to provide optimal maternal health services through understanding pregnant women's needs. Whilst this chapter has provided insights into community perceptions of midwifery and how this relates to overall health services, the following chapter will explore more in-depth on how such perceptions influence decision-making in maternity care.

CHAPTER 7

DECISION-MAKING IN MATERNITY CARE

7.1   Introduction

In this chapter, several important features about maternity care experiences from the participants in the community are examined. This information emerged from the data as one of the categories in this research. As the participants discussed their decision-making in choosing maternity care, it became clear that there were certain values and actions that influenced the decisions made by the women and their family members when accessing maternity care. In the previous chapter, some positive attributes that led to respecting and valuing midwifery practices in the community were highlighted. An explanation about how the villagers appreciated the village midwife providing health services was also provided. Although some maternity resources were available in the community, most of the villagers had different experiences in accessing maternity care in the community. Some of the important views regarding making decisions about accessing maternity care in the village are provided in this chapter. The views discuss *the influence of the social and physical environment, perceptions of value for money* and *the family's contribution*. Figure 7.1 below provides an overview of decision-making in maternity care.
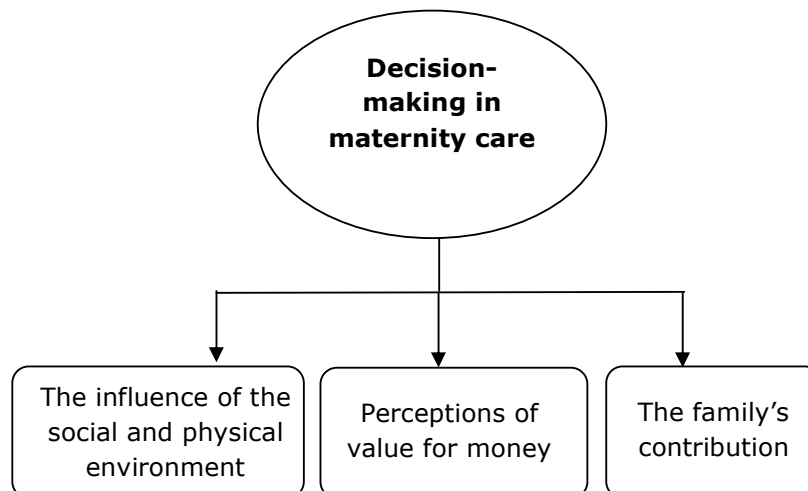
Figure 7.1: Decision-making in maternity care

7.2 The Influence of the Social and Physical Environment

The first sub category to emerge was *the influence of the social and physical environment.* The participants identified a number of rationales that indicated some important factors when choosing maternity care. These rationales were those considered to be influenced by the social and physical environment. The social environment was associated with the relationships within the community, particularly between women and their midwives. Meanwhile, the physical environment related to the physical context of the maternity resources in the community. This included the healthcare infrastructure and condition of the health resources.

7.2.1 The Social Environment

The concept of the social environment was discussed by some of the women and their families in their decision-making for maternity care. In the interviews with the women and their family members, they highlighted the importance of midwives who have good reputations and the importance of the trust given to maternity care provider. The extracts below highlight a number of important points raised by the participants, who described their intentions in choosing midwives who already had experience and were well known for their midwifery skills. Dila, one of the pregnant women, said:

> *"Well… firstly I chose her [(the midwife)] to be my midwife because she is one of the senior midwives with a good reputation"* (13: 165).

> *"…and she is also a qualified midwife, so I wouldn't feel very worried if I have problems during the birth… Well, of course… we don't want something bad to happen… so… hopefully, everything will be fine"* (13: 280).

Recognising midwives as health professionals who have maternity skills and experience was an important focus of the women in choosing their maternity carers. Most of the participants considered midwifery experience based on the number of years in practice, as well as the number of births that the midwife had assisted during her career. The participants believed that the more 'senior' the midwife, the more experience she had and the more *trust* they would put in midwife as their preferred health carer. They considered the midwife's experience in midwifery as one of the factors that indicated she has the skill to provide good maternity care. Ali, one of the pregnant women's husbands, described his view regarding this issue:

> *"I encouraged my wife to go to her [(the midwife's)] place for maternity care since she's been a midwife for quite some time… and she has also*

assisted most of the births in this village…It seems that most people in here are happy and didn't have any problems with her… so I want her to assist my wife's pregnancy and childbirth as well" (9: 345).

Ali's explanation regarding the midwife's reputation provided information about his rationale for selecting his wife's carer. He views a village midwife who provides high-quality midwifery practices, as one who has had many good experiences in the birth assistance in the community. Most of the participants also considered the midwife's reputation based on family or peer recommendations in selecting maternity care. The majority of the women considered their families' experiences when choosing their midwives. One of the pregnant women, Imas, described her view:

> *"I chose to go to her [(the village midwife's)] place this time based on my sister's suggestion and experiences also the experiences of most women in this village… I also find that she is a good midwife… My sister had a good experience during pregnancy and childbirth with her… Besides, she is a good midwife and I know her already… so I believe she will treat me well also" (8: 99).*

Most of the women in the village usually selected a *known* and familiar midwife as their maternity carer. Care provision by a familiar midwife and a midwife with a good reputation will increase trust and reduce concerns in women during pregnancy and childbirth (Coyle et al. 2001b). Moreover, the women in the village were more likely to trust and listen to a midwife who was already familiar to them. Many of the participants also described the development of trust and closeness in their relationships with familiar midwives in the community. These relationships had positive impacts on the women's pregnancy experiences, as described by Erika:

> *"I was thinking that I already knew her [(the midwife)] even before I got pregnant and she is also known as a good midwife… I was so relieved having a birth with somebody I was already familiar with and knew that she had good skills as well… It just makes you feel less worried and makes you believe that you can deliver your baby safely" (3: 280).*

In general, the women perceived many benefits of being supported by a trusted midwife. Reputation and trust were the convincing factors for the women when choosing their midwives, since these factors would reduce their concern during pregnancy and childbirth. Another pregnant woman, Wati, described her view regarding this issue:

> *"I have the chance to discuss my pregnancy and the problems that I have during this period… She (the village midwife) has given me some suggestions about what I should and should not do… and ehm… sometimes she also gives me some advice…She also listens to my*

concerns and what I need… that's why I like to go to her place" (14: 278).

In this research, midwives were selected on how well they were able to meet the women's perceptions of their own needs, rather than the ability to undertake midwifery-focused tasks. Most of the women in this study, considered midwife's ability to have a discussion and listen to their worries and problems as a requirement in their midwifery care. The importance of meeting the needs of the women became more apparent in incidents where they seemed unhappy about their care. Another pregnant woman, Rosa, had an experience in relation to this issue:

> *"I prefer to go to Yana [(a midwife)] rather than my previous midwife… because sometimes she [(the previous midwife)] doesn't provide the care… When I went to her clinic, instead of seeing and being cared by her, I was being cared by the student midwife in her clinic… Although she saw [(provided the care for)] me… it was just for a few minutes. After that, she left me with the student midwife… It was very disappointing: I went there in order to be cared by her and intended to have a midwifery consultation with her...on the other hand, Yana [(the current midwife)] is always available, and if I go to her place… she'll make sure that I'm being cared by her" (4: 487).*

Many of the women were dependent on their midwives as the core maternity carers in the community. They relied on midwives to carry out basic maternity care based on their needs and requirements. The relationships between the women and the midwives as maternity carers were an important aspect of choosing a midwife. Having a good reputation and being able to meet the women's needs would promote the women's trust and were also described as sources of comfort in seeking maternity care. Therefore, relationships between the midwife and the women should be maintained, in order to have positive experiences of maternity care (Edwards et al. 2004).

7.2.2 The Physical Environment

Some women described their 'comfortable feeling' in accessing maternity care based on their relationships with the midwives. During the discussions, being comfortable was also highlighted in the kinds of interactions that the participants had with health service infrastructures. Perceptions of 'good' or 'not so good' care (as the participants did not refer to 'bad' care) were connected to and based on their relationships with the health professionals, as well as the infrastructure of the health services. A positive view of care from the participants required the care providers' understanding of the need for a comfortable environment for maternity care.

Apart from having positive relationships with the village midwife, the women also talked about their feelings related to the setting of the maternity service infrastructure. As a service user, Dila (one of the pregnant women) explained her reason for not selecting a certain place for her labour:

> "However, I don't really like the place… I mean… it is not about the small size of her clinic, but the labour and the examination areas are placed in the same room… so I didn't feel very comfortable with it… When I had my antenatal care, there was a woman who had just given birth sharing the same room with me…I didn't feel comfortable with it… so I just went there once and after that I decided to go to my current midwife" (13: 186).

Maternity care settings were an important factor for the women in the provision of convenient maternity care. Most of the women in this research preferred having their care in a convenient and familiar setting, and knowing that they would be provided with satisfactory care by their midwives (Campbell and Macfarlane 1986; Lavender and Chapple 2008). Ipah and Lydia (both pregnant women) had further opinions about maternity care settings:

> "I like the fact that her place is closer to my house… I've been there before and I like the place… Also, I would like to give birth with her [the midwife's] assistance" (6: 328).

> "Well… because I'm planning to give birth with Ratna [(the village midwife)]… She is a good midwife and I would love to be taken care of by her… so that's why I have my antenatal care with her… Besides, she is also living here… in our village… and her place is also close to where I live… so it is easier for me" (12: 275).

These women provided an understanding of how access to maternity care contributes to a comfortable feeling in seeking maternity care. Moreover, the availability of healthcare services in the community also contributes to decision-making in accessing maternity care. Most of the women preferred their antenatal care to be available and easily accessible, since a long distance to travel in rural communities needs more effort, compared with care provision in urban areas. Most rural areas in Indonesia do not have adequate access to public transportation and sometimes convenient road access is limited (Frankenberg 1995). This has led to the majority of the women in the village preferring to seek closer places for maternity care in the community, due to the convenient access of healthcare.

7.2.3 Public Health Services vs. Private Midwives

The women and their families in this study discussed their views on the social and physical environment in terms of its contribution to their decision-making

for maternity care. During the discussions, the participants highlighted how they compared public and private health services when deciding upon their maternity care preferences. Both services were reviewed and selected based on the person's view of their social and physical environment. Makmur, one of the pregnant women's husbands, described his view:

"I think for people like me… Puskesmas is very useful… because I can't afford to pay every time I take my wife for the antenatal care, especially if there's any medication required… it's too much…Of course I want her pregnancy to be healthy…so that's why having the service at Puskesmas is very useful" (12: 234).

Although a number of the participants had a positive view towards the health centre, the majority of them did not consider the health centre as their preference in seeking healthcare. Yana, one of the village midwives, described how the women in the village do not use health centre (Puskesmas) as their main preference in accessing maternity care:

"People usually use Puskesmas for general health problems… very mild problems…However, for the specific ones… for example the women… most of them prefer to seek the antenatal care directly from a village midwife" (1: 124).

Most of the women in the village did not consider the health centre for their maternity care in the community. Even though the health centre provide free services, most of the participants found that certain rules and systems (as well as the physical environment) of health services, failed to meet their needs in maternity care. This was highlighted in some of the interviews as follows:

"I don't really like the queuing system at Puskesmas, as they are supposed to call your name to be examined based on your early presence. But, sometimes, if someone comes and she knows one of the health staff, then she will be prioritised to be examined first. It is very annoying… although it is not a big issue" (2: 251).

"Even if you see your preferred midwife at Puskesmas, it wouldn't be the same… because you wouldn't feel comfortable there… You'll be placed with other pregnant women in the same room… Although there is a curtain for the examination bed, sometimes you want to get information and you wouldn't feel comfortable if there are other people there… [(224)] and sometimes they are not just pregnant women, but also the student midwives… The most annoying thing is that there are also other staff members, not just the midwives… They were gathering and having a chat in the room… It is very annoying… [(255)] Also, in Puskesmas, sometimes the student midwives will take care of you instead of the senior midwife" (9: 299).

Similar to health centre, most of the pregnant women also mentioned their unwillingness to utilise village health post for maternity care. As a smaller scale

version of public health centre, village health post is expected to provide convenient and more easily and accessible health services in the village. One of the pregnant women, Ani, explained her views:

> "I would love to go to village health post for my antenatal care but it is usually open only in the morning… and it is difficult for me to go at that particular time, since I need to do all my housework in the morning… like cooking and other things… And I have small children that need to be taken care of as well… Moreover, the village midwife is rarely present at village health post… So, most of the time, I have found that it is closed" (7: 354).

To summarise, the settings and environments of both health centre and village health post have contributed to the dissatisfaction amongst the participants, especially the women who were wishing to access maternity care. This situation was also found by Turan et al. (2006) study in Turkey, which mentioned that the work settings and procedures in the antenatal, intranatal and postnatal environments have an impact on women's feelings towards using the care. Similar to Turan et al. (2006) study, in this research, complicated procedures and systems have failed some of the women and their families in the community in choosing health centre for the health services. Although the participants had benefitted from the free services at the health centre, the assurance of convenient procedures and environment settings were highly valued by the participants; these factors would positively affect their healthcare experiences.

Rejecting to seek the healthcare in health centre and village health post, most of the women in this research preferred to seek maternity care with the village midwife in her separate private practice. These women found that they had the opportunity to develop a rapport with the midwife when accessing maternity care in her private practice; as explained by the women below:

> "I will have the chance to discuss many things with her… because it is not very crowded like in the Puskesmas, so I can talk with her about all my problems without being ashamed… I can also ask her a lot of information related to my pregnancy" (19: 296).

> "Unlike at the Puskesmas… in her clinic, I will not be examined together with other women in the same room and I can get the treatment directly from her, not from other staff members or students. Also, I can ask questions and discuss my pregnancy problems with her, and I can spend more time with her as well" (19: 165).

A comfortable rapport was defined by the women as feeling at ease in obtaining maternal health information, and also having the opportunity to acquire convenient services where they felt that they were the focus of care. Although

having maternity care in private practices costs money, most of the participants described their need to obtain high-quality of health services as the main focus in accessing maternity care:

> "Fortunately, she [(the village midwife)] is a really understanding person; she knows our situation. So, in terms of financial matters, she really socially understands… Sometimes we don't have to pay immediately or she gives us a very cheap price, so my wife will still be able to have good and private antenatal care with her" (9: 213).

> "Although I knew that it was not free to have pregnancy care in her private clinic… I wanted to be examined by her privately and I wanted to get more information and discuss my pregnancy with her… It is okay for me to pay… Besides, she is a really understanding midwife. Sometimes I don't need to pay for her service immediately…I can pay her whenever I have the money…and I will still have a good quality of care in her private clinic" (14: 354).

Many women and their families stated that having maternity care in private practices would develop their rapport with the midwives, as their carers during pregnancy and childbirth period. According to Coyle et al. (2001a), developing a connection with the carer and having the opportunity to discuss concerns during maternity care, results in positive healthcare experiences. Most of the present study's participants intended to have this positive experience, by having 'women-focused' maternity care in the community. Private midwives' practices which are not free services in the community were considered to provide high-quality maternity care; since most of the participants had positive experiences in accessing such care.

7.3   Perceptions of Value for Money

The concept of *perceptions of value for money* was mentioned by a number of the participants. Most of the women and their families discussed the impact of having positive maternity care in private practices based on their perceptions and past experiences. According to the data, the participants saw the value in having satisfactory maternity care from private practices. It appeared that they engaged in a sequential process of observing, assessing and comparing their expectations with their own experiences of maternity care, both in public and private practices. Rosa, one of the pregnant women, explained her view:

> "I went to both Puskesmas and village midwife's private clinic for my antenatal care… I wanted to experience the care in both places… because people said this… and that… about having the care at a private clinic and also at Puskesmas… So I wanted to experience it for myself… and see which was suitable for me… And I can tell you that I'm more satisfied having maternity care from the midwife in her private clinic… although

you have to pay for it… But I think it's worth it…If you want to get good-quality of care, of course it would not be free" (4: 209).

Most of the women emphasised the importance of having positive maternity care experiences from the health service. Rosa's narrative revealed an approval for using financial support to obtain the care desired. The majority of the women experienced many positive benefits when they had the opportunity to be supported by their village midwives in a private practice throughout pregnancy and childbirth. Since they needed to provide some expenses for the care in a private practice, the perception of having good-quality care was related to payment support (Rosenthal et al. 2004). Some other participants also explained their views related to this issue:

> *"I don't want to complain about the maternity service at Puskesmas because we do not pay for the service… so you can't complain… If you don't want to pay then you have to accept the service…In a private clinic… of course you will get a better service… because you pay for it and you deserve to get their [(the midwives')] services"* (14: 297).

> *"I don't know… maybe because at Puskesmas the services are free… so that's why the quality of the medicine is also not very good… It is just standard medication from the government… In a private clinic, they provide good-quality of medication… but of course it's not free… Good quality should not be free… it is more costly"* (11: 243).

Most of the participants in this research compared their experiences in receiving care from both public and private practices. The majority of them experienced more satisfactory services in private practices rather than in public practices. They indicated that free health services from the government resulted in receiving a lesser quality of care. These experiences provide a glimpse of perceived importance in paying for the healthcare, in order to obtain a better quality of healthcare. As one of the village midwives in the community, Mariam also recognised the community's perceptions regarding this. In the interview with her, she explained:

> *"I've tried to explain to the community that the medication I've given to them has the same ingredients as the medications given at Puskesmas… but still they refuse to get the medication from Puskesmas and prefer the medication from the clinic…If I give them the medication from Puskesmas, they refuse to take it and prefer me to write a prescription, so they can buy it at a pharmacy"* (4: 487).

The participants' perceptions of the value of healthcare expenses for obtaining better health services, has been a challenge for the health service providers in the provision of care. The participants' disappointment in the experiences received from public health services has resulted in a mistrust of public

healthcare practices in the community. Therefore, they prefer to seek maternity care in private practices, which has resulted in the perception that value for money is important for having good-quality of care. Although most of the villagers have limited capabilities to pay for the healthcare, having good-quality health services with continuity of care was more important for these women, their families and the overall community in the village.

7.4   The Family's Contribution

One of the most important aspects in choosing the maternity services is the contribution of opinion and suggestions from the family in decision making. The relationships between family members in the community are very close, and it is important for the pregnant woman to include their family members in order to gain positive experiences during maternity care (Somers-Smith 1999; Carter 2002a). In terms of healthcare preferences, most of the women considered their family members' opinions in making decisions about their maternity care in the community.

7.4.1 The Partner/Husband's Contribution

Within the interviews, some of the women highlighted the importance of involving their husbands' opinion when making decision about their maternity services. According to McKellar et al. (2008), the contribution of husbands during pregnancy and childbirth in Australia emphasises the positive health benefits through social support. In Acehnese community, male involvement is important since most women are married and need support in the childbearing process. The majority of men in Indonesia are also considered to be the heads of their families and the decision-makers in their households. In general, both the women and their husbands reported that most of the women still considered their husbands' opinions and that all husbands gave advice during pregnancy and childbirth. The extracts below highlight a number of important points related to this issue:

> *"Well… I always discuss things with my husband, for example, where I want to give birth this time… My husband asked me whether I would like to give birth in Bidan Rania's [(the midwife's)] place again… because we have good experience with her… Well… most of the time, my husband leaves all the decisions to me regarding my pregnancy… He will basically agree… but I would love to include his advice because this pregnancy is also about our child" (12: 465).*

The views on male family members as the responsible people in the family made some of the women in the village respect their husbands' opinions regarding

pregnancy and childbirth. Many of the women in the village said that discussions with their husbands during this period revolved around wishes and preferences for maternity care. They identified a sense of mutual respect between themselves and their husbands in relation to care provision:

> *"My husband always asks me about everything that I need and checks on my health during pregnancy… He also accompanies me to the midwife and we discuss many things… like where am I going to give birth… and what else do I need for my pregnancy… And yes… we talk about it quite often" (18: 465).*

The discussions about maternity care during pregnancy and childbirth with their husbands were important for the women in the community. They respected and valued their husbands' advice as a support for their care, and the opinion from their husbands influencing the decision in maternity care. Some husbands in the community also preferred their opinion regarding maternity care to be considered by their wives. Below are some of the views from husbands regarding he decision making in maternity care:

> *"As the head of the family, I am the person who has responsibility for each of my family member, especially my wife. Therefore, I have to get involved in every decision made in this family. Regarding my wife pregnancy, it is up to her really…which midwife or place that she wants to give birth, she knows her midwife better than me…but she need to involve me when making decision" (6: 301).*

> *"I will let her decide where she wants to go for the antenatal care or where she wants to give birth of the baby…she is the one who is going through this pregnancy thing, she could discuss with her mother or sister, they are more experience, but of course, she need to informed me as well, because I am the person who is responsible for her" (10: 267).*

It is important to consider the husbands' opinion and suggestions in making decision about the women's maternity care during pregnancy and childbirth. Although the male family members are the decision-makers in the family, they still placed decisions about maternity care according to the women's preferences. The majority of the women in the village still considered their husbands' opinion and advice since most of them are still socially and financially dependent on their husband in the community (Mottram 2008).

7.4.2 The Female Family Members' Contribution

One of the most important supports for women in the community is their female family members. Based on the researcher's personal experience, traditional custom in Aceh demands that when a woman becomes pregnant and gives birth, the mother or female relatives will assist and look after her. The woman will go

to her parents' house when she is in the third trimester of her pregnancy and remain there until at least one month after the delivery (Vere 2008). Otherwise, the female relatives (either mothers or sisters) will accompany her during this period. Therefore, the relationships between and support from their female relatives were important for the women, and the advice and opinions from their female relatives were highly valued.

Most of the women in this research usually considered the opinions of their female relatives regarding the selection of maternity care, based on these relatives' experiences. They also discussed the support from female family members during the antenatal and postnatal period. Some of the women explained their views on this:

> *"My mother, of course, has been very supportive during my pregnancy so far… she's helping me a lot…so I will always consider her advice, including visiting the midwife and discussing with her about the place where I will be giving a birth" (2: 299).*

> *"I usually ask my sister's advice during my pregnancy… including the consideration on which midwife I should use to give birth… because she has the experience of being pregnant and use the maternity service" (5: 453).*

From the data, the women considered their female relatives' experiences in selecting and deciding upon their maternity care. Once selected, the women informed and discuss their decision on maternity care with their husbands, as the responsible person for them. Advice regarding the health service providers was more likely to be sought from the female relatives. Most of the women also indicated that they highly considered the female relatives' opinion and advice during pregnancy and childbirth. According to Madi et al. (1999) and Mullany et al. (2009), where women look after other women during the maternity period, this provides effective encouragement and positive social support. Most of the women in this research acknowledged that their female relatives share the same experiences of being pregnant and having the childbirth. Therefore, they valued female relatives' advice regarding their decisions on maternity care in the community, based on the relatives' experiences and support.

7.5   Summary

This chapter has illustrated how most of the women selected their maternity care. It provided insights into the participants' perceptions of the care they had received and they would like to receive, as part of their considerations in making decisions for maternity care. Due to the perceived uncomfortable use of public

health services, there was a perception that the free public services have led to substandard health services being received by the community. The need to have a good-quality of maternal healthcare made the women decide to seek private maternity care in the community.

The involvement of family members is one of the greatest supports during pregnancy and childbirth. Most of the women considered their female family members' support as valuable during the antenatal and postnatal care. By contrast, during the childbirth process, the involvement of their partners was considered to be the most important. In the next chapter, family support during pregnancy and childbirth will be explained in relation to the process of *social control of childbearing.*

CHAPTER 8

SOCIAL CONTROL OF CHILDBEARING

8.1   Introduction

In this chapter, the social context and support of maternity care in the community are explored. During the interviews with the participants, there were discussions about social interactions and relationships regarding the childbearing process in the community. The women shared their experiences of care during pregnancy and childbirth in relation to social interactions with family members and support from the community. During discussions with the women about maternity care, it emerged that support and involvement from the community became very important during pregnancy and childbirth. An interrelated set of concepts emerged that highlighted the role of the community and their involvement in supporting maternity care. The category of *social control of childbearing* comprised of two subcategories: *family involvement in maternity care* and *interaction in the childbearing process* (see Figure 8.1)*.* These subcategories signified the process of participants' relationships and interactions in maternity care and the childbearing process during pregnancy and childbirth.
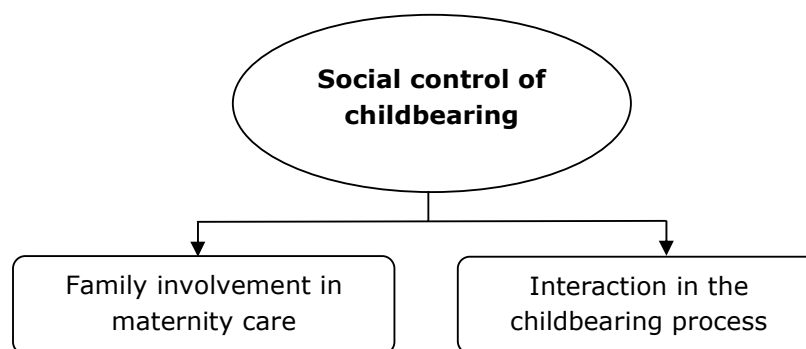
Figure 8.1: Social control of childbearing

8.2   Family Involvement in Maternity Care

The first subcategory to emerge from the data was *family involvement in maternity care.* It was defined as women's perceptions of the type of involvement and the sharing of responsibilities with their family members in the childbearing process. The women identified that the involvement of their family

members varied from equality with their husbands to female relatives being the primary carers in the childbearing process.

8.2.1 Equality with Husbands

The feature of equality with partners was defined as an equal relationship and responsibility between the women and their partners in terms of maternity care. The responsibility in maternity care was perceived by the women to be one of equal status:

> *"He was very supportive… He helped me with the children and sometimes with the housework as well… Because I only had my husband with me and my mother was not staying with us, so… he was such a valuable support during my pregnancy…He was there when I gave birth and he also checked my health condition regularly by accompanying me when I had the check-ups with the midwife" (19: 509).*

Several women reported that their husbands had provided assistance and shared responsibility in the childbearing process. Many men had helped with the housework and had assisted the women in caring for their other children. This is similar to findings from Carter (2002a), who found that most of the husbands in rural areas in Guatemala were also involved in housework and helped with other children during pregnancy and childbirth. Most women in rural areas in Indonesia depend on their families' assistance during pregnancy and childbirth. Although the majority of the women who took part in this research referred to female relatives' assistance during this period, they believed that husbands should also share responsibility in the childbearing process as part of their life as a couple:

> *"Because I'm pregnant with his child… so, yes… This is our child… and I want him to get involved and help me during this period… and he has also realised that this is also part of his responsibility as a husband… and yes… he helps me a lot" (15: 521).*

It is suggested in the data that the majority of the women would like to involve their partners in all three aspects of maternal health: pregnancy, birth and the postpartum period. However, the most common forms of husband involvement seemed to be providing financial support during pregnancy and childbirth, as explained by these two husbands:

> *"Well… actually, I would be very happy to get involved during my wife's pregnancy and childbirth… but I guess the female family members (like her mother) know best about pregnancy… I think all I can do to help is to assist my wife by accompanying her to the midwife and preparing for the birth process, such as providing the money for the labour and hospital or anything required for her care" (6: 223).*

> *"My support? Well… I support her during pregnancy for sure, such as preparing everything she needs during pregnancy and I have to prepare the money for the birth process as well" (7: 302).*

It is interesting to note that the universal form of participation during pregnancy and childbirth reported by the husbands in this research was mainly providing financial support; especially when their wives visited the midwives in private practices. Similar to the provision of advice, accompanying their wives on antenatal care visits was also common, although participation was still limited to travelling with their wives, instead of participating in the antenatal care itself. Carter (2002b) also found similar findings in her research in Guatemala, which revealed that the involvement of most husbands during pregnancy and childbirth was still very limited to financial support and accompanying their wives during antenatal visits and the birth process.

Some of the women in the village defined their husbands as having little experience in maternity care and the childbearing process, compared to female relatives. Therefore, some of the women prefer to include their husbands and require their presence during the birth process, more than during the antenatal and postnatal period:

> *"I would also like my husband to get involved during my pregnancy and childbirth… especially during the labour process… because I also want him to be there when we meet our baby… And since men are less experienced in dealing with babies, I think that would be the best time for him to get involved" (3: 457).*

According to Greene and Biddlecom (2000), the promotion of male involvement in maternity care has become an important part of developing reproductive health policies. The effectiveness of involving husbands during pregnancy and childbirth has been associated with positive maternity health outcomes, and it has also been found to improve social support for mothers (Mullany 2006; Mullany et al. 2009). In West Java Province, another part of Indonesia, involving husbands in maternal health education resulted in the decrease of maternal mortality rate in the region (Shefner-Rogers and Sood 2004). Although sharing responsibilities in maternity care appeared to exist in the study's data, the husbands' roles and involvement, further than performing housework and providing financial support need to be considered. The active participation from the husbands in obtaining maternity education and their involvement in the antenatal, intranatal and postnatal period with their wives would be considered as a support in the childbearing process, and would result in positive maternity care outcomes.

8.2.2 Female Relatives as Primary Carers

Female relatives appeared to have primary involvement in maternity care. Most of the women in this research considered their female relatives as their companions and support during pregnancy and childbirth. Traditional customs in Aceh require female relatives to provide support during this period, since they are considered as having experience of the childbearing process. Below is an interview with one of the pregnant women and her husband:

> *"Both my mum and my husband are very supportive… I need my mum's support the most, since she is also a woman [(she smiled)] and she knows and has experience of being pregnant and giving birth… so I could depend on her… She knows what to do… and I could ask and learn from her experience… And mothers are the best carers for the children and I need her support during this period" (7: 508).*

> *"I support her [(his wife)], of course… I help her with the housework and I try to provide anything that she needs during pregnancy and childbirth… but then again I should let her mother get involved as well, because pregnancy is about 'women's things'… and her mother knows more than me about being pregnant and handling a baby, so… I prefer to support her in providing the things that she needs for her pregnancy… Things like preparing the finance and… basically, more related to providing everything that my wife needs during pregnancy and childbirth" (7: 289).*

Both of these interviews present the perception in the community that pregnancy and childbirth are 'unique female experiences' and refer to the area of womanhood and female solidarity. Therefore, this period is considered as part of women's responsibility in providing the care. According to Ny et al. (2007), most women wish to have their mothers' support during pregnancy and childbirth, since mothers are considered to have experience and normally provide support during their daughters' childbearing process. According to research by Madi et al. (1999) and Maimbolwa et al. (2001), involving female relatives during labour improved emotional support and resulted in fewer interventions, as well as higher frequencies of normal labour in Botswana and Zambia. Although the female relatives make major contributions during the childbearing process, unlike in those two countries, only a few women in this study considered including their mothers in the labour process:

> *"I think I would prefer my husband to be with me during the labour… because during my pregnancy period and after the childbirth… my mother will be more involved and she will be taking care of me most of the time for sure… and I will need her support more during those times… So I consider the support from my husband during labour" (17: 521).*

> *"I want my mother's support during the pregnancy and childbirth period, but during the labour process, I think I would prefer my husband to be with me… because labour is such an exhaustive process and my mother*

<div align="center">134</div>

better not to be there… She is already tired from taking care of me during my pregnancy period and she will be involved again after I have my baby…So I will consider the labour process with my husband's support, so he will also see and get involved in the childbearing process" (16: 496).

Nearly all of the women in this research stated that they needed their female relatives' support during the antenatal and postnatal period. Most of them felt comfortable and satisfied in having interactions with their mothers or sisters in terms of their maternity care during this period. The women mentioned that giving their husbands, instead of female relatives, the chance to take part in the intranatal period would give the men the opportunity to be involved in the childbearing process (Ny et al. 2007):

"I want him to be with me during the labour time because I think he is stronger and could cope with seeing me in pain more, rather than my mother…Also, he needs to be there when his baby arrives, so he can also develop feelings for the baby, and he is the father anyway" (16: 496).

The women considered their female relatives' support during the pregnancy and after the childbirth, since female relatives would usually assist the women throughout this period. Most Acehnese women, especially in rural areas, traditionally live surrounded by their extended families (Basri 2010). Even though some of them live apart, when it comes to the pregnancy and childbirth period, the presence of female relatives is part of traditional customs in order to provide social support. Based on the researcher's personal experiences, most women either go to their parents' house, or their mothers and/or sisters accompany them during the pregnancy and childbirth period. Most of them stay from the third trimester until one month after the delivery, and some of them sometimes stay throughout the breast-feeding period, until about three to six months after the birth of the baby.

8.3   Interaction in the Childbearing Process

The category of *interaction in the childbearing process* was defined as the opportunities that the women have, to develop a rapport with their carers during pregnancy and childbirth. Interactions in the childbearing process were determined as: *men as primary decision-makers* and *women's relationships with health professionals.*

8.3.1 Men as Primary Decision-Makers

The feature of men as primary decision-makers was defined as husbands taking responsibility for decisions related to maternity care. In this study, men were

considered as the heads of families and the main decision-makers in the community. Although it was a relatively common perception in the community that men were marginal decision-makers in terms of maternal health, the women still valued their opinions and decisions in maternity care. There is a belief that women should discuss and seek their husbands' advice and opinions including in relation to the childbearing process; as the husbands are the heads of their families. Ani, one of the pregnant women, described her view:

> *"Yes, of course… Being pregnant and raising the children are the area of women… We are born with it and it comes naturally to us… so basically it becomes our responsibility and we know how to do it better than our husbands… But still, your husband is the leader in the house… so you should respect him and ask for his opinion… Because although you are the one who became pregnant, the child belongs to both of you… so you need his approval in everything related to your pregnancy and your child"* (7: 479).

The women acknowledged that mothers were the central carers for their children and pregnancy. The role of the mother is to be responsible for the children's upbringing and she has more patience in dealing with children and is more committed than men (Ny et al. 2007). However, the women in this study still considered their husbands' opinions in order to support their decision-making in terms of the childbearing process. Ani's husband, Hasan, believed that his wife knows the best actions in the childbearing process and the best options for maternity care during pregnancy and childbirth. However, as the head of the family and the person who is responsible for his wife, he would appreciate if his wife asked for his advice:

> *"I'm not experienced and don't have enough knowledge about these 'pregnancy' things… this is the area of the women… And in terms of the children… my wife has also spent more time with them than me… so I believe my wife knows what she wants and what's best for the children and her pregnancy… Especially since this is not our first child… so she knows already what to do… Basically, she could decide for her own preferences, as long as they are still related to her pregnancy… but if she could discuss things with me and ask for my opinion, that would be appreciated"* (7: 304).

Although there were perceptions that men were considered as being marginal in terms of maternal health and upbringing their children, they would still like to be appreciated and considered as the heads of the families, and the responsible people in their households. The majority of the women in the community also respected their husbands' opinions and sought their approval in childbearing and maternity care. Therefore, the prevailing concept that emerged from these data

was that the men were still considered as the primary decision-makers in the community, as explained in one of the researcher's memos:

The interview that I had with Hasan has made me wonder about the position of men in the community related to maternal health issues. Some of the literature that I read mentioned that maternity decisions amongst women (especially in traditional rural areas) are affected by gender issues, where most male partners will control their wives' decisions, including maternal health decisions. The majority of the women that I interviewed mentioned that their husbands do not control their decisions regarding maternity care. Moreover, within the interviews, most of the husbands mentioned that they leave the decisions on maternity care to their wives. When I interviewed Hasan, I could see that he was not the type of husband who would like to take control over his wife. He seemed a very caring husband and considered the needs of his family. When I interviewed him, he was helping his wife in looking after the couple's other children. Although he said to me that he had limited knowledge about pregnancy and childbirth, I could see that he was very experienced and gentle in handling his children. He explained to me that he considered his wife as the person who knows best about pregnancy and the upbringing of the children compared to him. Therefore, he would not control this 'authority', which he considered belonged to his wife. However, he also mentioned that he appreciated his wife whenever she asked his opinions about maternity care, since he considered his wife is part of his responsibility. I could see that he still considered himself as the responsible person or 'the man' in the family. He wanted to be considered as decision-maker and involved in the decision-making, including in his wife maternity care (Memo, April 2012).

These data provide information about the men as primary decision-makers in the community. This is due to the fact that the socio-economic status of the couple inside the household plays a major role in decision-making (Beegle et al. 2001). In a study conducted by Beegle et al. (2001) in Indonesia, both economic and social dimensional distributions between couples, influenced the decision-making power. Women who are better educated or from families with higher social status than their husbands, tend to have more power in deciding their maternity care. Moreover, women who work and are not dependent on their husbands' income are also more independent in making decisions related to their maternity care. The majority of the women in this study were dependent on their husbands' economic status. Therefore, they need to consider their husbands' advice and capability in choosing maternity care during the

childbearing process. Although there were equal responsibilities in the childbearing process, men's advices and opinions were still highly appreciated in this research community.

8.3.2 Women's Relationships with Healthcare Providers

This feature was defined as women feeling comfortable with their interactions with the village midwives and community health workers (kaders), during pregnancy and childbirth. During maternity care and the childbearing process in the community, women in this research intended to have multiple exposures to the village midwives and kaders. These interactions enabled the women to develop rapport with them as their carers, since the village midwives and kaders were considered to be trusted people in providing maternity care in the village. The majority of the women felt that the degree of comfort that they perceived in the interactions was directly linked to the communication that they had with the village midwives and kaders. The communication process was facilitated further by being cared for by the village midwives and kaders, with whom they were familiar. Moreover, they were more likely to disclose information and discuss concerns with a familiar carer, especially about maternity care and the childbearing process:

> *"I feel more relaxed every time I have discussions with her [(the village midwife)]… because I know that I can discuss many things about my pregnancy… I often meet her and I was already familiar with her, so I feel more comfortable with her, rather than meeting a stranger"* (18: 390).

Care provision by a 'familiar' village midwife also resulted in the women being able to achieve positive maternity care, since they were more likely to trust and listen to familiar midwives. Many of the women in the community described the development of closeness in their relationships with the village midwives during the childbearing process:

> *"I've had so much support from her [(the midwife)]… and I'm also felt glad to have her support, apart from your family… you know… such as your mum and husband… And I also have a midwife as my close friend and as a support… I don't know what to say really…I think it should be like that… You are supposed to be close and have a bond with your midwife… It really helped me…and it also reduced my worries"* (15: 505).

Mainly, the women considered the village midwife as their friend and had strong connections with her, especially during pregnancy and childbirth. As the main source of maternity care in the village, the village midwife is a valuable person for the women in the community as she has the most knowledge about maternal health. It was also discovered that the women developed closer relationships

with the village midwife through the opportunity of having continuous contact, especially with a midwife who already resided in the village. The community, particularly the women, would not consider the village midwife as a stranger; instead, they would regard her as part of the 'big family' in the village. Therefore, the childbearing support from the village midwife would also be considered as family support during pregnancy and childbirth.

According to Sandall (1997), the development of closer relationships amongst women and midwives in Australia would enhance the positive continuity of maternity care. This was also the case in Aceh Province, where most of the women (especially in the village) were reported to have strong connections with the village midwives and had developed positive perceptions about maternity care with them. However, positive maternity care perceptions amongst the women in the village should also be associated with the high-quality of maternity skills of the village midwife. Since the village midwife is considered to be a trusted person in the village and knowledgeable about maternity care, her performances and skills in midwifery should be developed and updated regularly in order to provide a good quality of care.

Several women in the village also reported their interactions and good relationships with the community health workers (kaders). As the members of the community chosen to provide basic healthcare in the village (Morrell et al. 2000), most kaders are women who work closely with the village midwife in the community. Most of the women usually felt comfortable in asking for the kaders' support during the childbearing process. Some kaders in the village were also relatives and had family relationships with the women in the village:

> "I've had so much support, especially about maternal health information, from Rahmi [(a kader)]… Apart from being a kader, she is also my cousin… so… it is great, actually… having someone from your family and also capable enough to teach me about maternal health… She suggested contraception methods to me… but I haven't decided yet…She told me to discuss it with the village midwife as well" (10: 486).

The majority of the women perceived many positive benefits when they had the opportunity to be cared for throughout the pregnancy and childbirth by familiar village midwives and kaders. They found it beneficial to be cared for by someone who knew their history and experiences. Although Green et al. (1998) argued in their UK research that positive maternal health outcomes were more likely to be linked to professional support instead of familiar caregivers. In some rural areas in Indonesia, the presence of familiar maternity carers during pregnancy and

childbirth would be more beneficial for most women in the community. The presence of kaders and highly skilled village midwives could provide positive social support for the women during pregnancy and childbirth.

8.4 Summary

This chapter has discussed the requirement of social support during pregnancy and childbirth in the community. Most of the women in the village addressed the importance of having support from both their male partners and female relatives in terms of care during pregnancy and childbirth. Furthermore, the women also acknowledged that there was equal responsibility with their partners in the childbearing process and that their partners supported their maternity care. However, the women wanted to have more support from female relatives during the antenatal and postnatal period and required their husbands' presence during labour. In terms of the interaction in the childbearing process, the women still considered their husbands' advice and opinions. This situation happened since most of the women in the research setting still depended on their husband both socially and economically. Therefore, although there was an equal responsibility in the childbearing process, the husbands' opinions were respected, since the men were still considered as the decision-maker in the community.

Most of the women also mentioned the important presence of both village midwives and kaders in supporting their maternity care in the village. They also required assistance from the village midwives and kaders in terms of maternity care during pregnancy and childbirth. Therefore, maintaining effective relationships with village midwives and kaders in the village is needed in order to obtain positive social support during the childbearing process.

CHAPTER 9

DISTANCING OF MATERNAL DEATH

9.1   Introduction

The maternal mortality context is discussed in this chapter under the heading of *distancing of maternal death.* The participants' responses regarding maternal death in the village are also provided in this chapter. All of the participants interviewed in this research shared their experiences and perceptions about maternal deaths that had occurred in the village. During the discussions with the participants in the village, it emerged that there were some aspects and beliefs about maternal mortality that were still apparent in the community. The category of *distancing of maternal death* comprised of two subcategories: *responses to maternal death* and *beliefs about maternal death* (see Figure 9.1)*.* Each of these subcategories describes the reactions of all the participants, especially the women in the community to maternal death.
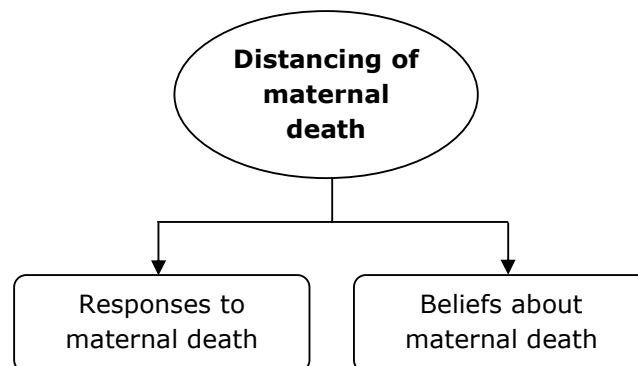
Figure 9.1: Distancing of maternal death

9.2   Response to Maternal Death

The first subcategory that emerged from the data was *responses to maternal death*, defined as the participants' responses to maternal deaths in the community. Most of the villagers were aware of the deaths of some mothers during pregnancy and childbirth. However, they perceived the deaths as a 'fate' and accepted them as part of life destiny. Moreover, maternal mortality was also considered as an unmentionable topic in the community and most of the participants were unwilling to discuss this issue further.

9.2.1 Acceptance of Maternal Death

The phrase *acceptance of maternal death* is used to describe the participants' reactions to maternal deaths in the community. Most of the villagers perceived death as part of life and as a fate decided by God. This concept of fate led the villagers to accept the situation, as described by one of the pregnant women:

> *"Well… yes, of course I'm worried… but as long as I am healthy during the pregnancy period, I don't think it will become a problem… I always pray to God that my pregnancy will be okay and I trust Him [(God)]… and I take care of my pregnancy very well. If death still happens…what can I do? It is our destiny from God… We're all going to die anyway… and only God knows when and how… so… It is not a nice thing of course… as nobody wants to die… but if it is meant to be like that, it will be like that… We have to accept it…God knows best" (18: 602).*

Most of the participants believed that the incident of death (including maternal mortality) was part of life's experiences, whether or not the death happened by accident. The majority of Acehnese (especially in rural areas) are devoted Muslims and strongly believe in God's will and fate in all aspects of their lives (Basri 2010); including the outcomes related to the pregnancy and childbirth. A study conducted by Rööst et al. (2004) in rural Guatemala also identified a common idea about maternal death during pregnancy and childbirth. The local women shared the same belief that the outcomes of pregnancy and childbirth are predestined by God. Therefore, maternal mortality is seen as part of destiny, and people tend to accept this, as they have positive beliefs in God's plan:

> *"Of course, we do our best in order to prevent the mothers from dying during pregnancy and childbirth. I [(a kader)] always encourage the women to have good antenatal care, so they don't get sick during pregnancy and childbirth… Strong support from the family is important, and the midwife also does her best to help the women... But if death still happens, we should accept that God may have another better plan for us" (2: 598)*

Furthermore, most of the villagers also described their expectations of the village midwives in terms of minimising problems during pregnancy and childbirth. Many of the women in the village were already familiar with and put their trust in the village midwife, and considered her as their friend. They believed that the village midwives would provide the best maternity care and would maximise their efforts to help them during pregnancy and childbirth:

> *"I believe the midwife wouldn't put us [(the women)] into trouble… She is already part of our community… Most women in the village and I have already known her for quite some time… We consider her as our family, so I believe she will do her best in order to help the mothers in this*

village… In sha Allah [(by God's will)], mothers won't die in this village"
(14: 497)

Most of the women believed and accepted the maternity services provided by the village midwife, as they considered the village midwife as their friend who would do her best in providing maternity care. They would not consider maternal death in the community as part of the village midwife's negligence in delivering maternity services. They accepted death as God's will and still had faith in the village midwife's efforts to deliver optimum maternity care in order to help the women in the village.

9.2.2 Unmentionable Maternal Death

The phrase *unmentionable maternal death* emerged as the reluctance from the community to discuss maternal deaths that had occurred in the village. Most of the participants in this study seemed to feel uncomfortable discussing this issue during the data collection process, as the researcher documented in her field note:

The maternal death or maternal mortality issue is the background to the research that I have been conducting in this village. However, during my data collection activities, this point did not arise directly in the interview processes with most of the villagers. Moreover, the women in the village also didn't raise this issue within the discussions on their experiences during pregnancy and childbirth. I had to bring up this issue directly by myself, by questioning the participants at the end of the interviews about their views on maternal deaths that had occurred in the community. Generally, the people in the village felt uncomfortable when they were asked about maternal death. In the interviews, most of the participants (especially the women) appeared to be uneasy and a little bit nervous every time the maternal death issue was raised. I could see that most of them didn't like to talk about such death, since it was not a joyful and pleasant topic to discuss, especially during pregnancy and childbirth. Some of the women went silent or lowered their voices in explaining their views. Although they knew the incidents had happened, they didn't like to discuss them and still considered maternal death as part of life's experiences. The reluctance in discussing the topic of maternal death usually made this topic difficult to raise during the interviews. I was carefully raised this topic by considering the ethical procedure (Field note, June 2012).

The field note above describes the situation, whenever maternal death was discussed during the interviews. The women considered it as an uncomfortable topic and this would increase their concern during pregnancy and childbirth.

> *"Well… I don't know what to say… Of course, sometimes you feel worried… afraid… [You know]… what if that happened to you? Because you're also pregnant…I don't know… I hope that my pregnancy will be alright… I just pray to God that my pregnancy will be fine… and nothing serious will happen with my pregnancy and when I give birth… [(Her voice became lower)] I just don't like to talk about death… it is sad and painful" (8: 331).*

During the interviews, questions about maternal death needed to be raised sensitively in order to prevent the women from being in a stressful situation. The researcher ensured that if the women felt uncomfortable with the questions they were asked, they were provided with the chance to discontinue or terminate the discussion about maternal death. Most of the women in this research appeared to answer the questions and provided their views on maternal death. However, they appeared reluctant to engage in further in-depth discussion on this issue; since they considered the topic of maternal death during pregnancy and childbirth may provoke stressful and negative feelings throughout this period:

> *"I have a positive feeling about my pregnancy… and speaking about mothers who have died during pregnancy and childbirth will just make me worried and not happy about my pregnancy [(she looked upset)]… All mothers are different, and I just want to focus on being aware of how to keep my pregnancy healthy, instead of to discuss about mothers who have died" (5: 499).*

> *"Sometimes, I [(a midwife)] mention and discuss maternal death with the women during antenatal care… However, I have to say it carefully… because most of the women and the people in this village don't like to talk about death… you know… it is miserable…So, instead of discussing the incidents of mothers who have died during pregnancy and childbirth…I will focus on how to keep the pregnancy healthy" (4: 396).*

The unwillingness of the women to discuss maternal deaths in the community made this topic difficult to discuss. It appears that most of the people in the village knew about the occurrences of maternal death in the village. However, they refused to raise this issue as an important feature in relation to pregnancy and childbirth. This may have contributed to the inattention from the community about maternal death issue, and may have contributed to this being a continuous problem in the community. According to AbouZahr (2003), inadequate information about maternal mortality contribute to one of the major reasons for continuous problems with maternal death. It is essential to have knowledge and information about maternal death, in relation to the pregnancy

status of the women and the causes of the deaths. This information may be important for 'lesson learning' in order to prevent the incident from reoccurring. Although maternal death is a painful issue to rise, obtaining information about maternal death may be valuable in prohibiting similar incidents from happening in the community.

9.3   Beliefs about Maternal Death

The second subcategory to emerge from the data was *beliefs about maternal death.* This subcategory referred to participants' attitudes and beliefs about maternal mortality. These beliefs were identified within the data, whereby maternal death was viewed as an *illness ideology* and perceived as a *psychological effect*.

9.3.1   Maternal Death as an Illness Ideology

This feature was defined as the belief amongst the women that maternal death was more likely to happen to mothers who had been identified as being ill prior to and during pregnancy and childbirth.

> *"Well… of course I'm afraid… but I don't need to worry too much… because… I haven't been exposed or experienced any illnesses or diseases so far… even since the beginning of my pregnancy… and hopefully I will stay healthy until the birth of my baby… I will try to keep eating healthy food and visiting the midwife… The first time I got pregnant I was also in a healthy condition… that's why I didn't worry too much… If I had a disease when I got pregnant, maybe I would be worried, because you may get problems during pregnancy and childbirth… Hopefully I will be fine and I always pray that nothing bad will happen to me"* (4: 434).

Many of the women believed that maternal death was an outcome of being ill during pregnancy and childbirth. They had the assumption that maternal death would not occur to a woman whom they considered to be healthy during her pregnancy and childbirth. Most of the women in the village regarded being healthy as the absence of illnesses during the pregnancy and birth period. Similar to this, McKague and Verhoef (2003) also mentioned this health concept in their study about clients and healthcare providers' perceptions regarding health in urban community health centres in the USA. They found that most laypeople in the community assumed that the absence of illnesses would determine them as being healthy. Moreover, this assumption is also perceived in the research community, as most healthcare providers often advise their clients to prevent illnesses in order to stay healthy.

Many of the women, who had contact with the village midwives and kaders during the antenatal care, were advised to avoid illnesses in order to have safe pregnancies and childbirth. Some of the village midwives also suggested to the women that they should prevent themselves from being ill during the pregnancy period in order to avoid the maternal death incident. This was explained in interviews with a midwife and a pregnant woman:

> "Most maternal deaths in this village have occurred to mothers who already had risks when getting pregnant, but they still wanted to become pregnant. So they didn't want to listen and wanted to continue their pregnancies… Or, in another case, for example, a woman had just had an abortion. We [(the midwives)] had already advised her to wait for a certain period before she started for the next pregnancy. However, she didn't want to listen and prefer to get pregnant straight away" (2: 47).

> "The first time I went to the midwife she talked about the diseases that I should prevent, and said that I should try to avoid becoming ill during pregnancy… also about the drugs that I should be taking in order not to get sick… I was a little bit terrified… you know… because I had a miscarriage experience before… and she told me not to do this… and that… and take this pill and so on… based on my miscarriage experience… she asked me to make sure that I don't have any diseases before I got pregnant again, in order not to have any problems during my pregnancy and childbirth" (7: 468).

Several women in the village believed that by avoiding becoming ill and listening to medical advice, would prevent them from experiencing or being exposed to maternal death. This belief has become an ideology regarding how to avoid maternal death incidents. This belief has resulted in women seeking the antenatal care only if they have problems or any diseases during pregnancy and childbirth. When illnesses are absent during this period, the women considered themselves as not having the risk of maternal death:

> "So far, thank God, my pregnancy has been fine… I haven't had any problems or any kinds of illnesses before or during my pregnancy… So I don't think it is necessary to go to the midwife quite often … especially I don't have that much money…So I only go to health centre to take the pill and maybe to just check my blood pressure during my pregnancy" (6: 286).

According to Allen (2000) and McCarthy and Maine (1992), the health status of a woman prior to and during pregnancy and childbirth could influence the survival of the pregnancy and the potential for childbirth complications. The consequences of having illnesses during pregnancy and childbirth will increase the potential for complications, which could lead to maternal death (Ronsmans and Graham 2006). This 'illness ideology' triggered the belief amongst most of

the participants in the village that maternal death only happens to women who have illnesses during pregnancy and childbirth.

However, some of the women also misinterpreted the idea that the absence of illnesses during pregnancy and childbirth means that they would have no risk of developing complications or being exposed to maternal death. Having no illnesses during pregnancy and childbirth resulted in an unwillingness from the women to attend regular antenatal care. Attending regular antenatal care is important to have a good health status during pregnancy and childbirth. Nevertheless, the risk of developing complications may occur at any time during pregnancy and childbirth. It is apparent in the community that most of the women were still unaware that the absence of illnesses is more effective, if it is combined with adequate antenatal and postnatal care as well as a safe childbirth. This combination is important in reducing the chance of developing complications and the risk of maternal death.

9.3.2 Maternal Death as a Psychological Effect

This feature was defined as a belief that the psychological status of women during pregnancy and childbirth, will determine their pregnancy and childbirth outcomes. Many of the participants expressed the beliefs that maternal death was also a result of poor mental health status, as described by Yuni (one of the pregnant women):

> *"Yes, of course… we have to make sure that we are healthy during pregnancy and childbirth… and that is not just physically but also mentally… Here… we believe that if you are distressed or get depressed during pregnancy and childbirth, it wouldn't be great for your baby's development inside the womb… You may have difficulties during pregnancy as well as during the childbirth… So I have to make sure that I'm staying happy and have the support from my family… because most mothers who died usually had the stress or depression during their pregnancy and childbirth" (15: 378).*

Generally, the women in the village acknowledged the importance of having optimum psychological health in order to prevent the risk of complications during pregnancy and childbirth (Patel et al. 2004). Therefore, the women believed that having "positive feelings" during pregnancy and childbirth would prevent the risk of maternal death:

> *"I understand that if you are not happy with your pregnancy then something bad will happen… either during your pregnancy or during the childbirth… because having stress or depression is almost similar to having diseases… you know… Your body is also sick… That's why I want to make sure that I am always positive towards my pregnancy… I will*

avoid unhappy feelings or stress… That's why I don't like to talk about maternal death because it is just miserable and you will feel threatened as well… and it is not good for your pregnancy" (12: 504).

Mainly, the women in this research were happy and had positive feelings towards their pregnancies. Most of them described their pregnancy experiences as wonderful occasions and expressed the views that having the chance to become a mother is a very exciting moment. Therefore, they believed that they should be treated and encouraged to have strong positive feelings towards their pregnancies and childbirth. Some women considered that the discussion of maternal death would lead to their unease and an uncomfortable feeling that would lead to fear and stressful feelings. Although maternal death incidents had occurred in the community, most pregnant women believed that they had to stay 'positive' towards their pregnancies and childbirth. They had the faith that maternal death would not happen to them, as long as they maintained both their physical and mental health during pregnancy and childbirth.

Patel et al. (2004) and Austin et al. (2007) identified that maternal psychological illnesses lead to poor maternal health conditions, which may lead to one of the main causes of maternal death in India and Australia. However, their studies mentioned that severe mental illnesses (such as evidenced by the past and current contact with psychiatric services) were more likely to lead pregnant women to commit suicide. Nevertheless, the effects of the mild symptoms of mental health problems (such as stress and depression) that the women in this research referred to cannot be excluded. The fact that 'positive feelings' towards their pregnancies and childbirth from most of the pregnant women in the village was an optimistic point in preventing complications in maternal death. However, they may also need to consider having discussions about maternal death incidents in order to obtain knowledge about maternal death and to prevent them from happening in the future.

9.4   Summary

This chapter has discussed the context of maternal mortality in the village. It has explained the perceptions amongst the community about maternal deaths. These perceptions were found to be related to the beliefs of the participants. Most of the participants acknowledged the nature of acceptance and the unmentionable issues related to maternal deaths in the village. They considered the issue as part of their life's events and they accepted it as a fate handed down by God. This chapter has also revealed that maternal death was described

as a painful and miserable topic in the community. Therefore, it was rarely discussed and mentioned by the people in the village.

The women also addressed their beliefs about maternal death as a result of diseases and mental health problems. Most of the women considered themselves as having no risk of maternal death as long as they maintained their physical and mental health during their pregnancies. Nevertheless, some of the women felt it was less necessary to have regular antenatal visits with a midwife. This was a result of the belief that the absence of diseases during pregnancy and childbirth would exclude them from the risk of to be exposed with maternal death.

CHAPTER 10

DISCUSSIONS AND CONCLUSIONS

10.1.   Introduction

In this chapter, a review of the whole thesis is briefly presented. A discussion of the main findings and the theoretical propositions with reference to the theory is also argued. The strengths and the limitations of the research are debated and its contribution to knowledge is assessed. In addition, the recommendations for policy, practice and education for further research are also provided.

10.2.   Review of the Thesis

This thesis consists of ten chapters. An outline of each chapter that comprises the whole thesis is briefly reviewed in the following section:

Chapter 1: The context of the research study is presented in this chapter. The background of Indonesia, particularly Aceh Province where this research was conducted is outlined. Information on maternal mortality as the main subject of the thesis is introduced. The justification of conducting the research is discussed, and the purpose of conducting the research is also defined.

Chapter 2: An overview of the comprehensive literature search is presented in this chapter. A detailed description of the literature searching process, which includes electronic databases and keywords used are discussed in detail. The inclusion and exclusion criteria employed for identifying initial literature sources are also provided.

Chapter 3: The research paradigm and the principles of grounded theory method are described in this chapter. The theoretical framework and intermediate conflicts between the adopted methodologies are discussed in detail. In addition, the rationale for deciding the methodology used is also presented in this chapter.

Chapter 4: The methodology that was employed in this research study is explained in this chapter. The discussion includes how data collection, theoretical sampling and analysis were conducted. The ethical considerations and rigour of

the research study, which were associated with the researcher's reflexivity is also explored in detail.

The findings of this research are presented in five chapters (chapter 5-9). Within **Chapter 5**, the overview of the emergent theories as well as the core category of the grounded theory is highlighted. The core category of "Maternal death: the elephant in the room" is described and the relationship between the four emergent categories is explored. It is this relationship that brings meaningful understanding to the concepts developed and is the original contribution to existing knowledge in this research.

Chapter 6: The first emerging category named "The value of midwifery in the community" is presented. The context of maternity services in the research setting and the relationship between the village midwives and the community is discussed in detail.

Chapter 7: The second emerging category named "Decision-making in maternity care" is presented in this chapter. The rationale from the community especially the women and their family members in making decisions about maternity care is discussed. Some contextual factors and environmental situations affecting the women's decision-making in maternity care are explained in detail.

Chapter 8: The third emerging category named "Social control of childbearing" is highlighted in this chapter. The requirement of social support from the community during pregnancy and childbirth is analysed. The involvement of family members and their interaction with the women in the childbearing process in the research setting are also presented.

Chapter 9: The fourth emerging category named "Distancing of maternal death" is described. The description of the community's views and reaction towards maternal death in the research setting are explained in this chapter. The contextual background, responses and beliefs from the community which may contribute to the incidence of maternal mortality are highlighted and discussed in detail.

Chapter 10: The issues that arise from the findings are discussed in this chapter. The links are also made with a range of theoretical and substantive literature. The original contribution of this thesis is discussed and suggestions for further research in this area are also identified. Finally, the strengths and

weakness of the research are highlighted. The implications and recommendations for policy and practice are also addressed in this chapter.

10.3. Theoretical Propositions

The primary aim of the research study was to gain an understanding of pregnancy and childbirth experiences from multiple perspectives, in relation to the use of maternal health service in Aceh, Indonesia. The research study also explored the role of the community in influencing maternity practices / decisions as well as factors which promote and hinder the engagement with maternal health programmes as the research study objectives. The research aim and objectives were developed based on the on-going situation of maternal death in Aceh, Indonesia; despite the government's efforts in reducing the maternal mortality rate in the country. The research study revealed that the maternal death situation in Aceh, especially in the research setting is a multifaceted phenomenon that obviously occurs in the community. However, this is not acknowledged by the local community. The emerging finding from the data generation during the research study is named *maternal death: the elephant in the room.* The data analysis process revealed different dimensions of the phenomenon, which have indicated the contribution of the various individuals involved in maternal deaths in the community. In this discussion chapter, the different dimensions that were exposed from the analysis and findings are addressed and discussed.

10.4. Maternal Death: the Elephant in the Room

The core category of *maternal death: the elephant in the room* emphasises the experience of maternity practices from multiple perspectives, in relation to the incidence of maternal death in Aceh community. The term "elephant in the room" is a collection of words which provide a metaphor for something that is very obvious but people choose to ignore. Despite the maternal mortality rate in the region still being high, maternal death was not a focus of discussion in the community during the interview process. The community appeared to be reluctant to discuss the maternal death issue in the discourse during pregnancy and childbirth. Addressing maternal death emerged as a taboo topic in the discussions among the women in the community, during the pregnancy and childbirth period. Moreover, most villagers appeared to accept the incidence of death as part of life's destiny which contributed to the 'distance' of maternal death issues in the community. Furthermore, the midwifery practices were inadequate in the community; where the village midwives who are considered as

the key important person in providing maternity care in the village were not all qualified in providing the services. The health centre, as the main public health facility in the community, also appeared to be ineffective in the delivery of its maternity care, with the absence of birth support and the inconvenience of maternity clinics for the women in the village who utilised these resources. Additionally, the women in the village had limited decision-making about maternity care related to the limitation of the available maternity services, also the women's economic and social dependency on their husband and family member.

The grounded theory of "*Maternal death: the elephant in the room"* revealed that the issue of maternal deaths was a hidden problem in the community and this was related to the inadequate maternity practices in the village. These practices appeared to have a significant impact on the contribution of maternal death. The wider community may be aware of the maternal death incidence. However, some of the maternity practices suggested in this grounded theory may have contributed to the incidence.

10.4.1. The Value of Midwifery in the Community

The first category that emerged in the findings was the "value of midwifery in the community". The value of midwifery in the community revealed the views from the community about the utilisation of maternal health services in the village. The value of midwifery in the community covered both the hierarchy of the village midwives in the community as the main maternity care providers and the utilisation of maternal health facilities in the village. The dominance of the village midwives in providing maternity care in the village occurred, since the midwives were the main maternal health resource in the community. They were positioned as an important community member in the village and the community depended on their village midwives not only for maternity care, but also the general healthcare provision in the community.

Despite the ineffective maternity practices provided by the village midwives in the community, due to their lack of midwifery supervision and the absence of birth attendance skill from some of the village midwives; most women still utilised their services based on their personal relationship with the midwives. The majority of the women utilised the maternity service within their village midwife's private practice. Most women in the research community found the health centre to be an inconvenient public health service in delivering maternity care. This situation meant the community, especially the women valued

midwife's private health practices, more than the public service in the village. Although the village midwives' private practice were still affordable for most women in the village, it was still an obstacle for the women who were seeking maternity care in the community. It resulted in less motivation from the women for having regular antenatal care provided by the village midwives in this research setting.

10.4.1.1. The Village Midwife in the Community

The midwives in this research community play an important role in promoting health and wellbeing, not only for the women but also for the whole community. According to Van Wagner et al. (2007) the health professionals in most rural areas are considered to be the lead healthcare givers and the community depend on their services in the village. During their research project about midwifery practices in one of the villages in Canada, Van Wagner et al. (2007) discovered that most of the community were really dependent on their midwives in the village when seeking maternity care. This situation also occurred in this research setting, where most villagers considered the village midwives as the main support, not only for maternity but also for the general healthcare in the village. They considered and positioned the village midwives as the top hierarchy in the community in terms of providing healthcare. Most villagers, especially the women, depend on their village midwives' support, as they put trust in and consider the midwives to be part of the community members in the village.

Most villagers valued their village midwife mainly based on her personal character, followed by her midwifery skill competence. The villagers, especially the women tended to choose their midwife based on her positive characteristics and good relationships with the community. Some women also aimed to focus on the midwives' midwifery skills and competence. However, the midwives' characteristics were emphasised as being most important when seeking maternity care in the village. The majority of the women preferred being cared for by the village midwife who has good personal characteristics and whom they have good relationships with. Lundgren and Berg (2007) also supported this finding with their research about women and their midwife relationships in Scandinavian countries. The research found that most pregnant women intend to have a positive experience in pregnancy and childbirth based on their relationship with the midwife; whom they can expect to rely on and be available for them. Since the village midwife is the most available and knowledgeable health service provider in this research setting; most villagers, especially the

women, relied on the midwife's services and believed in her skills and capabilities in providing healthcare.

The important role of the village midwives in the community positioned them at the top of the hierarchy in the healthcare system. The village midwives held the key role in determining the health performance of the community in this research setting. Most of maternal healthcare activities in the community such as Posyandu and providing the health education were delivered and organised by the village midwives. They were also involved in some of the decisions in the village regarding healthcare, such as the selection of the village health workers (kaders) in the village. The dominant roles of the village midwives were considered to contribute to the outcome of the health performance in the community. A study conducted by Scott et al. (2003), revealed some evidence about the organisational cultures influencing the healthcare performance in the UK. Scott et al. (2003) noted that the hierarchical culture is one of the significant ways in influencing healthcare outcomes. The role of the village midwives in coordinating the care and the bureaucratic rules around maternity care in the village, positioned the village midwife as the key person in the village in determining the maternal health performance and outcome in the community.

Despite the village midwives' important roles in the community, this research study found that only a few village midwives in the research setting performed birth assistance in the community. Though, some village midwives appeared to be responsible to assist more than one village in order to provide the local birth assistance. A small number of village midwives also did not reside in the village where they worked and instead, visited the village on a regular basis. This situation leads to maternity services in the village to be less effectively delivered in the community. Whilst the women relied on their village midwives' services, the availability of midwives in the village was limited and their skill and competence in performing birth assistance was also inadequate. Chatterjee's (2005) study also found this situation occurred in the maternity care setting in rural village in Cambodia. Chatterjee (2005) revealed that most government's health workers who were placed in rural areas preferred to live in the city or the nearest place to the urban areas. This made the village midwives who resided and who performed the birth assistance in this research setting, criticise their workload and service provision in the community. They were aggrieved by the lack of supervision in midwifery practice by the higher health institution in the community. Although there was a medical doctor in the health centre who was positioned as the village midwives' manager, it appeared that there was no

direct supervision or responsible person for the performance of the village midwives in the community to discuss their role and work load with.

Furthermore, when this research was conducted, most of midwifery licenses to practice in Indonesia were not regularly evaluated. Once the midwives obtained their midwifery licences, they would become a midwife indefinitely with limited supervision and this included when they were not practising as a midwife. This situation has resulted in some midwives being less interested in performing their holistic practices in providing midwifery services, including birth assistance. The midwives who participated in this research study were deskilled by the situation, yet still practising as a midwife in the community. In addition, it is also evident that there was not enough midwifery skill training and development provided in the health centres either in the district or provincial levels. Nevertheless, when the midwifery skill training was provided by the government, only a few midwives in the community actually participated and enrolled in the training; since there was a lack of midwifery supervision in the community. Based on these findings, some of the midwives in the community only joined the training for the purpose of the ticking the attendance list and acquiring the certificate.

10.4.1.2. Maternal Health Services in the Community

Throughout the period of the health services' observation in the village, it appeared that the community had several maternal health facilities and activities related to childbearing in the village. The health centre (Puskesmas) functioned as the main health service resource for the community in the village. The health centre has been used by the community not only for seeking healthcare but also for providing the health education in the village. Most of the community recognised the importance of health centre as the main health service which can assist in improving their healthcare situation. However, the majority of the villagers criticised the inadequate services from the health centre. The bureaucratic procedures within the health centre were observed and perceived as complicated procedures by the community. Moreover, the maternity clinic in the health centre appeared to be less private and was perceived by the women as an inconvenient place to receive antenatal and postnatal care. It is evident that the health centre also did not have adequate facilities for the women for giving a birth. This situation has made the health service fail in delivering effective health support within the community.

According to Graham et al. (2008) adequate health services and facilities support the best outcome in delivering healthcare practices. As the main

healthcare services in the community, the health centre should reinforce and substantiate its facilities and services to the community, in order to improve the health status in the village. The community, especially the women, need supportive healthcare environments in order to improve the quality of maternal healthcare. Furthermore, the absence of the birth support facilities in the health centre had made some of the midwives in the community become deskilled in supporting the birth. Some of them were less encouraged to perform birth assistance, and this resulted in their being less motivated to enrol in further midwifery skill trainings, especially related to supporting the birth. Clinical supervision is really important in order to enable both the health services and the health practitioners to deliver fully potential of healthcare (Lyth 2000). Adequate supervision is needed in order to supervise midwifery practice in the community. The implementation and evaluation of midwifery skill competence is really important in order to maintain and monitor the quality of midwives in performing midwifery practise in the community. Moreover, it is also important to have supporting maternal health facilities in order to assist the performance of the midwives in delivering the maternity services to the community.

10.4.2. Decision-Making in Maternity Care

The evidence in this research study indicates that there were certain values and actions from the community especially the women, when they made decisions about maternity care. According to Goldberg (2009), it is important for the women to be provided with all the information related to maternity services in order to make the right decision in maternity care. Most women in this research study had flexibility in deciding their maternity services during pregnancy and childbirth. Although there was no indication found in this research study that the women were being controlled in their maternal healthcare; several situations and conditions in the village influenced the women in making decision about maternity care.

Women in Acehnese society have significant roles in the community as mothers, carers and workers (Basri 2010). They are the responsible person for the household including the childbearing process in the society. However, most Acehnese women in the village still hold on to the traditional social norms; where extended family support is important in women's lives (Holland and Hogg 2010). On the one hand, this is a positive behaviour for the women in order to get support in performing their tasks in the society. On the other hand, this has made the women more socially attached to their extended family in decision-

making including healthcare. Moreover, most Acehnese women in the village are usually housewives and responsible for the household; whilst the men tend to stay out of the domestic affairs, and are responsible for the economic support and income for the family (Basri 2010). This situation has made the majority of Acehnese women in the village economically attached to their men and considered the males' views on the women's decision-making. Furthermore, most member of Acehnese society are devoted Muslims (Basri 2010), the men are considered as the centre of the family and responsible for the welfare of the family (Henley and Britain 1982). Therefore, most women in this research study considered the views of the men in the family before making any decision in the society.

10.4.2.1. Social Contributions

From the evidence in this research study, the social environment appeared to have an influence on the women in their decision-making of maternity care. Their social environments consist of the women's family members and the village midwives in the community. Beside the family members, the village midwives also influenced the women in their maternity care. The women's relationship with the village midwives contributed to their knowledge and experiences in choosing their midwifery support. The village midwives were considered to have an important position and hierarchy in terms of healthcare in the community. Therefore, when it came to the decision of maternity care, the women considered the midwives' views in making the decision of maternal healthcare.

Most women highlighted that their relationship and their trust in certain midwives, resulted in the selection of their preferred midwives for maternity care during pregnancy and childbirth. The women usually chose the village midwife who had the reputation on midwifery skills, as well as the one with whom they were already familiar and had a good relationship. The village midwives who had a good reputation and relationship with the women in providing maternity services in the village, appeared to be selected by the women (Edwards et al. 2004). However, it also appeared that there were only certain village midwives in this research setting who actually could perform birth assistance. Therefore, most women did not have many options regarding midwifery proficiency from the village midwives and intended to be supported by familiar midwives.

Being cared for by the familiar midwives in order to have a safe childbirth is considered as part of the decision-making in having the continuum of care

(Kerber et al. 2007). Every pregnant women needs to have the antenatal care which is linked to a safe childbirth, and access to the postnatal care after giving a birth as the whole process in her maternity care (Kerber et al. 2007). In order to have a comprehensive maternity care, the women need to consider their social support which includes the village midwives and their family members. Therefore, the selection of their preferred midwives is important apart from their family contribution in supporting the care. Women in many rural areas in the developing countries are socially dependent on their society and have less personal autonomy, and are economically dependent on their male partners (Filippi et al. 2006; Holland and Hogg 2010). Consequently, most women in this research setting considered their male partners' suggestions and according to their economical context in choosing their maternity care. Although the women were not restricted or were controlled by their family members in deciding maternity care; however, their family's suggestions and advices were prioritised.

The men were usually marginalised in deciding upon the maternity services in the community. This is related to the traditional cultural norms in most villages in Indonesia, where men are believed to stay out of the household activities including maternity care (Holland and Hogg 2010). However, most women generally still considered their husband's advice and suggestions on maternity care, since they are still economically dependent on their husband. Therefore, the advice and suggestions from the men influenced the women's decision on maternity care. In addition, most women in the research setting also usually put trust in their female relatives' (mothers and sisters) experiences in utilising certain midwifery practices. It is considered to be a 'normal' behaviour in Acehnese society that the women received support from their extended family in performing their tasks in the society (Holland and Hogg 2010). Therefore, the female relatives' support and experiences are highly valued during pregnancy and childbirth (Holland and Hogg 2010).

10.4.2.2. Public vs. Private Health Services

The decisions made about maternity care in the research community were also influenced by the maternity services provided in the community. Apart from the health centre in the village, there were also the private practices from the village midwives in providing maternity services to the community. Although a health centre is the main health service in the community, most women in the village preferred to utilise the village midwives' private practices in accessing the maternal healthcare. Most women expressed their positive experiences in having

maternity care with the village midwives in their private practices. With the fact that health centre did not have the birth support facilities and the inconvenient infrastructure of its maternity clinic; the women selected the midwives' private practices as their main maternity services in the village. Moreover, the women also identified that maternity services from the village midwives in their private practice was based on the rapport they had, convenient location, as well as providing more maternal health education; compared to maternity clinic in health centre. This situation is also supported by Turan et al. (2006)'s research on the quality of antenatal care in Turkey; where the environment and the working procedures of maternal health facilities determined the women's decision in maternity care. Most women in Turan et al. (2006)'s research study intended to have a convenient maternal health supporter in order to experience the positive outcome in antenatal care, which lead to a safe childbirth and postnatal care.

Most women in this research study experienced positive maternity services from the private practice. Although the same village midwives provided the maternity services in both health centre and private practices; most women would rather decide to have the village midwives' services in their private practices. It appeared that the women needed to pay for the services and most of them did not object to do this. The women experienced the private practice with a more comfortable environment, and more developed in the provision of maternal health information. This has resulted in women in this research study, believing that better healthcare requires more expensive expenditure. According to the study of Bhatia and Cleland (2001) about young Indian mothers seeking healthcare in public and private practice in India, indicated that most mothers believed that private practice provides better health services, since it delivers the continuum of care and is served in a more confidential way. However, another research study conducted by Siddiqi et al. (2002) about the prescription used in a public and private practice in one of the districts in Pakistan indicated that, although most communities in Pakistan also preferred private practices for seeking healthcare and medical prescriptions; it was evident that most prescriptions in private practices in the research setting in Pakistan prescribed in higher number of drugs with highly inappropriate doses. A similar situation also occurred in this research community, where most villagers preferred to seek healthcare with the village midwives in their private practice; since the medication provided in the private practices was perceived to be more effective than the ones prescribed in the health centre. Despite the prescription provided

in private practices containing the same substances with the one in the health centre; the community were not convinced with the prescriptions provided in health centre. Most women and the general community were not convinced with the services from public health centre, where there was no expense required to access the services. The community especially the women valued private practice for their maternity services and resulted in the village midwives not performing their best practices in public health centre.

It is important for the women to have access to information when deciding their maternity practices (Goldberg 2009). Regardless of any influences from the women in selecting their maternity care, the information and the available maternal health services should be effectively delivered for the women, as the service users in maternity care. A literature study conducted by Dowswell et al. (2001) about women's views and satisfaction on their maternity care in the community in the UK; identified that most of the women expressed their high levels of satisfaction with their maternity care. There was some evidence from the reviewed papers that the majority of the women felt satisfied with maternity care in the community which provides high quality information on maternal health, shorter waiting time in receiving the care and the continuity of care. Furthermore, according to Redshaw (2008)'s UK study about the important of measuring the satisfaction and dissatisfaction of the women in their maternity care. It revealed that it is important for the women to be listened to their need in order to provide positive maternity care as part of the continuity of care.

The majority of the women in this community research setting also identified the same satisfactions of maternity care from the village midwives in their private practices. It is important for the women in the village to have their familiar midwives in order to have positive experience of maternity services. However, the attention on midwifery skill competence from the village midwives should always be prioritised in seeking maternity care. This means, the village midwives should maintain and improve their midwifery skill competence in order to deliver a high quality of maternity care. Moreover, the services from public health centre need to be improved and need to be focused on the privacy of the women in delivering maternity services in the community. This would make maternal health services more affordable to the community, especially the women in selecting their maternity care.

10.4.3. Social Control of Childbearing

The evidence in this research study emphasises the involvement and relationships from the women, their family and the community regarding the childbearing process in the research setting. Family is believed to hold a central role when considering the health and wellbeing of the children. Different families have different ways and ideas about the family norms that are applied based on different classes and cultures within the family (Swanwick 1996). A study by Mares et al. (1994) emphasised that in nuclear families, parents intend to share responsibilities in the childbearing processes. Whilst the extended family which usually belong to a large family network; raise their children by a number of extended female relatives such as mothers, grandmothers and sisters.

Rural Acehnese families' culture, like many rural Indonesian families are mainly extended family types; where the parents, grandparents, children and sometimes the cousins are living in the same house (Chodorow 1995). Most female relatives intend to support the women in the childbearing process. Although most families in the research setting were categorised as the extended family type, many young couples in this research community were now living in their separate houses, though still surrounded by their extended families. Therefore, it was indicated that many young couple in the research setting were adopting the nuclear family style in terms of raising their children; where the parents were still the main responsible for their children with extra support from their relatives.

10.4.3.1. The Family Involvement in Maternity Care

This research study indicated the strong relationship between the women and their family regarding the childbearing process. It was indicated that the women in this research study shared the responsibility with most husbands involved and assisting their wives in the childbearing process. Moreover, the women had flexibility in assessing the care related to their health and wellbeing. A study conducted by Mullany (2006) about husband's involvement in Nepal, indicated that although most husbands were now playing a significant role in assisting their wives in maternal healthcare; the stigma still remained that women should undertake the housework, and most husbands were still seen as uncommon in performing the housework including the childbearing process. Furthermore, most husbands considered them-selves as being marginalised in terms of maternity care and the childbearing process, and therefore provided the flexibility to the women in their maternity care preferences. Another study conducted by Hoga et

al. (2001) about male involvement in reproductive health in Brazil indicated that some men considered their involvement in reproductive health as part of their loving relationship instead of sharing responsibilities, as they still considered it to be the women's role. In this research study, most husbands involved in the childbearing process with their wives, as part of the responsibility as the head of the family. They were also wanted to be considered as a responsible husband by being involved in their wives' maternity care.

This research study also noted that the women still considered their husbands' advice in every decision, especially those related to the childbearing process. Most women were socially and economically dependent on their husband and therefore, they considered their husbands' advice regarding their wellbeing including maternity care. This situation is also supported with the research study by Carter (2002b) about the involvement of male partner in maternity care in rural Guatemala; which indicated that most involvement from the husbands during maternity care was still limited in providing financial support. The majority of husbands in this research setting may need their opinion to be considered as part of their contribution and responsibility on their women's maternity care. Moreover, Acehnese society is also utilising a patriarchy system where the male family members are usually positioned as the head of the family (Basri 2010). The advice, suggestions and approval from their male family members were also considered as a form of respect and responsibility from the male in the society.

In terms of maternity care, the women focused on their interaction with the female family members (mothers and sisters); as the female relatives were likely to have had experiences in maternal healthcare. Whilst the women required their female relatives support during pregnancy and childbirth, the involvement of husbands was more likely needed during the childbirth. Most women expressed their need to involve their husbands during the childbearing process in order to create the bond and their responsibilities to their children. During the pregnancy and postpartum period, the women appeared to involve their female relatives as they have more experiences during this period. It is important to have family support and their involvement during pregnancy and childbirth. However, equal involvement and responsibilities are needed within the family in every period of pregnancy and childbirth, in order to develop the rapport with the women during pregnancy and childbirth.

10.4.3.2. The Community Involvement in Maternity Care

It appeared in this research study that the women also had strong relationships with their carer during pregnancy and childbirth. The village midwives and kaders were indicated as the people whom the women required support from and would like to develop a rapport and relationship with in accessing maternity care. According to Kirkham (2000) the relationship between the mothers and their midwife are really important in order to determine maternal healthcare outcome. Furthermore, Kirkham (2000) also noted that the women intend to engage with their midwife during their pregnancy and childbirth, both physically and emotionally in order to have a positive maternity care impact and experience on all element of their life. Most women in this research community were dependent on their village midwives in seeking maternity care during pregnancy and childbirth. Therefore, it is important for the women to be taking care of by their preferred midwives in order to have positive experiences during this period. As the main healthcare provider in the village, the role of the village midwives were not only supporting the women's pregnancy and childbirth, but also to develop a rapport with the women; as the maternity care outcome in the research setting are also measured based on the physical, intellectual, social and spiritual support during pregnancy and childbirth (Kirkham 2000).

In small communal areas in Indonesia, the community play an important part in keeping up each other's wellbeing in the village (Basri 2010). According to Rifkin (1990) and Rosato et al. (2008) the support from the community is very important in accessing maternal healthcare, especially in the area where the presence of health professionals and health services are inadequate. During the research study process, there were some maternal health activities in the community. Through the community health workers (kaders), the community run the Posyandu activities which focus on maternal and child healthcare with emphasising the involvement from the community. Although the Posyandu activity in the research setting was still implemented in a passive involvement, thus, this activity was regularly held in the village and appeared to provide significant contribution to the health of the women and the children in the community. According to a research study by Rahman et al. (2008) about the intervention of the community health workers for mothers with depression in rural Pakistan discovered that the involvement and the health intervention from community health workers has the potential to be integrated in the low research setting's health system. In this research community, the role of community health workers (kaders) is really important in order to engage the community in

maternal health programmes. Since the kaders were from and part of the village community, their contribution and involvement would benefit in the sustainability of maternal health programme in the village.

According to Laverack and Labonte (2000), there are different levels of community participation where the community could participate in the activities. In the past, most community participation activities consist of communities responding to directions given by professionals to improve their health (Laverack 2001; Rosato et al. 2008). This process usually includes the activities where the communities were passively involved as the setting of implementation or the target of specific intervention (e. g campaign and education on immunisation or maternal health) (Rifkin and Pridmore 2001). Recently, the health development workers in Indonesia have begun to act as facilitators focusing on the improvement as well as the outcomes (Rosato et al. 2008). In this approach, the facilitators support the local communities to be actively involved and participated in both activities and decision that affect their own health. These activities included to provide the resources in order to address the health problems, or as an active agent that uses its own development capacities to address its needs (Rosato et al. 2008). This is the highest level in community participation where the community has built its own capacities and capabilities in order to sustaining the implemented programmes (Laverack and Wallerstein 2001).

Since the first time it was established in 1998, Siaga campaign in Indonesia emphasised on the active level of participation in improving maternal health in Indonesia. It addressed the involvement of the husbands, the midwives and the community member to address maternal health problems in the community. Together with the funding bodies, the government work towards maternal health improvement. However, the implementation of the programme seems to be inadequate in recent years in Indonesia, since there is no adequate monitoring and evaluation on its outcome from the government. Furthermore, Posyandu activity was also appeared in this research setting, which implemented by the kaders with the help of some community members with a minor assistance. However, Posyandu was still considered in the passive level towards the active participation in maternal health; since this activity is still directed by the health professionals (in this case the village midwives).

Regardless of the level of community participation in the village, the community appeared to have an assertive contribution to maternity care in the village through the Posyandu activity. However, more efforts need to be made in order

to encourage the community to be more involved in improving maternal healthcare in their village. In the small communal area such as the village in Indonesia, the role of the community in improving their health status need to be more emphasised and encouraged; since the strong rapport within the community in the village would be benefit in assisting each other's wellbeing and improving the health status of the community.

10.4.4. Distancing of Maternal Death

In this research study, it was revealed that maternal death was viewed as an inevitable burden within this research setting. However, the community also appeared to be reluctant to discuss maternal death during the research process. The discussion about death is always becoming as unpleasant issues and appeared to be sensitive to be discussed (Luper 2009). Therefore, this issue was carefully carried out during the research process by considering the involvement of the ethical dilemmas. Although the issue of maternal death was acknowledged within the community, nevertheless, this issue was avoided in discussions especially by the pregnant women in the village. The researcher noted that discussing maternal death is one of the taboo topics during pregnancy and childbirth for the wellbeing of the pregnant women and the unborn child. A research study conducted by Goodburn et al. (1995) and Mboho et al. (2013) in Bangladesh and Nigeria also indicated some taboos and beliefs about the evil spirit influences as the cause of maternal mortality. Although there was no indication that the belief on the influence of the evil spirits has caused maternal mortality in this research community; discussion on maternal death topic seemed to have the same impact in terms of the beliefs that influence maternal death.

Most of the pregnant women in the community believed that their wellbeing both physically and emotionally during pregnancy and childbirth is very important to be maintained. The discourse about maternal death is believed to have negatively impacted on their psychological health. Therefore, they prefer not to mention about maternal death during pregnancy and childbirth. Most women believed that they must have a positive feeling and behaviour towards their pregnancy, which would make them having a healthy pregnancy and a safe childbirth. According to Patel et al. (2004) and Austin et al. (2007), physiological wellbeing among pregnant women is important during pregnancy and childbirth. Their research identified that maternal physiological illness would lead to poor maternal health condition and in some cases would induce mental

illness in pregnancy. Moreover, it appeared in the research study that the reluctance to discuss about maternal death is actually one of the coping mechanisms used by the women to deal with maternal death incident in the community. This statement is also supported by Furber et al. (2009) in their research about psychological distress in pregnancy in England. The study found that some of the pregnant women used negative coping strategies by restricting their access to related maternal health information in order to reduce more distress. Although there has not been any evidence yet that physiological illness will contribute directly to maternal death, maintaining physiological wellbeing is inevitably important during pregnancy and childbirth.

The reluctance from the community to discourse about maternal mortality also supported the belief that, maternal death only occurs to the women who have had illness prior to or during pregnancy and childbirth. Maternal death was regarded as an outcome of being ill or having the illness, and this would lead to the higher chance of being exposed to maternal death. Thus, the women who are considered to be healthy were less worried about maternal death. Being healthy is identified as the absence of the illness prior to and during pregnancy and childbirth, as supported by Papadopoulos (2000) and McKague and Verhoef (2003)'s definition about health. In this research community, this illness ideology was also reinforced by the practice from the village midwives who encouraged the women to maintain their wellbeing during pregnancy and childbirth; by only focusing on the avoiding of being exposed from any illness and diseases. This however, has made some women in the village to have the antenatal care, only if they had the illness during pregnancy and childbirth. The women did not consider of having the chance of being associated to maternal death when the illness is absence during their pregnancy and childbirth. Therefore, the women became less worried about maternal death incident in the community.

Furthermore, most of the villagers also believed that the incident of death, regardless at the cause of the death is part of the life's destiny and is the will of God. Consequently, the incident of maternal death is accepted by the community as part of their fate and considered to be one of the outcomes of being pregnant and having childbirth. This belief also identified in Rööst et al. (2004)'s research in rural Guatemala, which considered the pregnancy and childbirth outcome as predestined by God. The majority of Acehnese especially in rural areas are devoted Muslims and strongly believe in God's will and fate in all aspects of their lives (Basri 2010). This identification is also supported by Koenig et al. (2012)

which noted that the religious practices provides the ability to transcend and to cope with overwhelmingly negative experiences to their current situation in order to remain safe. Most villagers appeared to accept the maternal death situation in their community and less complains about the quality of care or healthcare services that they have received in the community; in order to cope with the maternal death incidents.

The underlying knowledge and belief systems from the individual are essential in their worldview and social identity (Chit 2007). In this research setting, the women's views about maternal death may identify their ideas of what is 'good' in maternal healthcare. Conversely, each individual is a product of socialisation where the cognitive process that control the people's act and behaviour are controlled by the environment (Blumer 1969; Chit 2007). A meaning and beliefs from the individual are the keys to understanding human behaviour (Holborn et al. 2009); thus, maternal health issues should addressed the misunderstanding in maternal health beliefs. The implication of the illness ideology and the belief of acceptance in maternal health should be provided with the support that must be sought from various systems, not only professional health but also social network in order to have an effective partnership between health facilities and community based institutions. It is important to be addressed by the health professionals, in this case the midwives in the village that maintaining the wellbeing during pregnancy and childbirth is not only by avoiding of being exposed to the illness, but also having regular antenatal and postnatal care, and performs complete procedures in maternity care.

The education about maternal death incident should be taken placed carefully with the respect of the women's psychological wellbeing, by being focus on the knowledge of the danger signs in pregnancy and how to prevent maternal death occur in the community. The supports also need to be emphasised by the religious leaders in order to encourage the community to accept the incident of maternal deaths in a positive way. The understanding of maternal death situation would not only require the acceptance but also the prevention efforts in order not to be exposed to the negative experiences in maternal death. From the religious approach, the supporting statement could also be emphasised with the religious leader by following the verse from the Qur'an (As most Acehnese were devoted Muslims and taken into account on the religious leader's statement) which is "*Indeed, Allah (God) will not change the condition of a people until they change what is in them-selves" (Qur'an verse 13:11).* Certainly,

coping with the distancing of maternal death problems should not be seen as a matter only for the women but also for the whole community.

10.5. Critique of Research

In this section, the limitations and strengths from the research are considered. The impact of the chosen research strategy is also provided based on the limitations and strengths of the research.

10.5.1. Limitations

Some limitations are acknowledged during the research process, although the aim of the study has been met. Qualitative studies assist in providing a detailed account of experiences from the participants (Streubert-Speziale and Carpenter 2003). However, they are relatively small in scale and only focus on limited participants in a particular setting, context and time. This research was limited by its size which focused only on two neighbouring villages which have maternal mortality cases in the suburb areas of Aceh, Indonesia. A larger study could have explored the wider community services and practices across different villages especially in remote areas. However, this limitation is inevitable in a qualitative study, in which quality as opposed to quantity is prioritised. Moreover, this research study was also conducted for this academic qualification, where it has some restrictions in the matter of time and only a single researcher conducting the research.

Collecting the data through individual and group discussions is really suitable in obtaining participants' experiences. However, these techniques also have the potential to be distorted by the participants. According to Stewart et al. (2007) during the individual and group interview, participants may feel embarrassed to talk about or have problems in remembering their experiences. Moreover, only few opportunities in collecting observational data in this research were identified. Some observations were not observed due to several factors such as: the reluctance of some participants to be observed and some meetings or events were cancelled. Despite only a few observations being conducted, during the individual and group interviews, there was a chance where the participants' answered might be influenced by the researcher's professional background. The participants might conceive to provide the desirable answers by the researcher, despite attempts being made to ensure that the data collection process was rigorous. Combining multiple sources of data collection (individual interviews, FGD and observation method), the presence of an audit trail and conducting the

research under the supervision of academic supervisors, had contributed to the rigour of this study. Member checking did not take place in this research; therefore, resonance (Charmaz 2006) with the research participants cannot be claimed at this stage. However, a report and/ or presentation will be disseminated on return to Indonesia.

A further limitation of this research is that the findings of this research are temporally situated and based on a particular setting. The field work of this research was conducted based on a particular time, place and particular influences at the time the data were collected. However, the developed theory in this research was made specific to the research sample and setting from which it was developed. The presented theory can also be developed in other context in order to allow the transferability and further enhancement.

Another limitation is that the analysis in this research is inevitably a personal analysis by the researcher. According to Charmaz (2000), it is difficult for the researcher to completely objective in conducting qualitative research, as the researcher is also part of the study. Despite the efforts in making the analysis and interpretation of data being transparent and as rigorous as possible, the background of the researcher as a community nurse and working within maternal healthcare settings could not be ignored. Most participants were also aware about the researcher's background, and this may have affected the way they provided the information. Throughout the research process, the utilisation of reflexivity, self-awareness and constant comparative method was made during the discussion with the academic supervisors and in presenting the data. This process was conducted in order to minimise the research methodology limitations.

10.5.2. Strengths

One of the strengths of this research is utilising a grounded theory method for achieving the research aim and objectives. Grounded theory is also very useful in discovering new findings and contributed significantly in the existing knowledge and the literatures of the study area (Corbin and Strauss 2008). By utilising grounded theory, theoretical insights which accounted for the participants' experiences in the occurrence of maternal death in the community could be generated. The experience of maternity services from multiple perspectives in the research settings and the role of community in maternity care were suggested to enrich information about persistent maternal death in the village.

Symbolic interactionism as a philosophical underpinning of a grounded theory was a helpful framework to this research. Symbolic interactionism enables the exploration of participants' experiences in accordance with the meanings and understanding which have developed through interaction (both social and physical) with their environment (Blumer 1969). The interpersonal relationship between the women with the village midwives as well as with the community has been acknowledged within this research. The theoretical sampling in grounded theory enables the identification of appropriate informants for generating the theoretical elements of the study.

This research adopted a constructivist grounded theory as suggested by Charmaz (2006). This approach acknowledges seeing the data from different perspectives (Charmaz 2000; 2006). Different researchers may develop a different viewpoints on the theoretical persepective of the study, with their own theoretical sensitivity. Constructivist grounded theory enriched the research findings as Charmaz (2006) emphasises that it is not the answer instead the response of the research questions provided, which stimulate the further debates and exploration in the research area.

The data collection in this research is from a wide range of sources which is considered to be the strength of this work. Conducting data collection by utilising various data collection techniques could provides different perspectives. Pursuing a wide range of perspectives allowed the complexities in the incident of maternal death in the community to be revealed,and enriched the findings that have not been comprehensively explored by the previous studies.

In summary, in accordance with the limitations of the research, this study was also a learning process with the choices that have been made, which could have been improved. A larger study could incorporate the research settings which have the highest number of maternal mortality rate, particularly in the remote areas. Different choices could be made which would further strengthen the research. However, this research was also conducted in a rigorous way with particular attention in all stages to achieve the best result. All procedures outlined in chapter four were followed with pay attention to the best practices. A particular strength of the design is grounded theory approach which provided the fundamental analysis and responses based on the research aim and objectives. The study design and the rigour allowed to induce the data and were sufficient to produce justifiable findings which resonance and have the utility with the policy makers, practitioners and fellow researcher.

10.6. Reflection of the Research Study

Being reflexive has enabled the researcher to challenge prior assumptions held before the study commenced. During the research process, the researcher has focussed on the experiences of pregnancy and childbirth, from a wide range of perspectives in relation to maternal mortality in the community.

As this was the first qualitative research that the researcher conducted; it was assumed that it would be a challenge and that she needed to learn more on conducting qualitative methods, especially using grounded theory. Furthermore, during the collection of qualitative data, the researcher found that it was quite challenging to conduct the in-depth interviews. Some participants were open and willing to talk freely, but some were surprisingly unwilling to talk. The researcher developed her skills especially in conducting the in-depth interview and encouraging the participants to talk during the interviews. The use of field notes and memos enabled a meaningful reflection on the researcher's contribution to the data generation phase.

In addition, the researcher found that there were still few women whom their husbands were present during the interviews; were less likely to talk and able to take time to discuss their views with the researcher. The researcher expected the women to be more open, because of the usual openness she experienced between women in her culture, as well as with some women in the community. She now realises that most women in the rural areas, where they still depended on their husbands either socially and economically, carefully mentioned their views and needs when their husbands were present. This had not been experienced before, when conversing with women in less isolated communities and urban areas. The researcher also realised that it was also related to the view that she was considered as an outsider, in her role as a researcher in the community.

The researcher also learnt from the research findings about the usual midwifery practices in the community that were not thoroughly understood. The use of kaders was already familiar in assisting the village midwives in the community. However, the researcher did not realise that the kaders were the active members in the community in delivering maternal health education, with limited health information provided. Moreover, the researcher was also surprised with the fact that some midwives in the community did not perform the birth assistance. The main health centre in the community also delivered maternity services that were considered to be inadequate by the community. Moreover,

most women also consequently preferred to pay for private care in the community. The researcher's prior assumptions about the role of kaders, midwives' role in performing the birth assistance, and perception of the service quality delivered by the local maternity service were challenged during the research process.

Furthermore, the researcher's position during the research process could be described both as an insider and an outsider. As an insider and a native Acehnese, the researcher is considered as part of the community. She was also already familiar with the research setting from her previous work experiences. However, as a researcher as well as a nurse, she was aware about her position where the participants especially the health professionals (the midwives) considered her to be in a management position. This created a different set of relationship in the community, in which the researcher was considered as an outsider and faced greater resistance to the research. For example, some of the village midwives appeared to be reluctant to participate in the observation method. The in-depth interview with the village leader was also conducted in a formal and less communicative way. Some of these participants considered the researcher as a person who would like to evaluate their performance and explore the weaknesses of maternity services in the community.

The researcher also learnt to maintain reflexivity during the research process. She needed to ensure self-awareness at all times and how this may have an impact during the research process. The researcher found it was quite interesting when she conducted the FGD with the senior midwives who happened to be her mother's midwife colleagues and friends. She had already met them previously and therefore, needed to maintain a professional role as a researcher during the discussion process.

10.7. The Contribution of the Thesis

There are two important unique contributions identified in this thesis. The study methodology is considered to provide a unique contribution, since for the first time maternal mortality has been explored in this particular setting by utilising grounded theory approach. The methodology of grounded theory enables the researcher to understand the perception and ideas within the people's experiences (Heath and Cowley 2004). Grounded theory also focuses on social processes in terms of how people think and behave, related to the issues and experiences of the subject (Glaser and Strauss 1967; Glaser 1998). In this particular research setting, the views on pregnancy and childbirth's experiences

from the women, community and health professionals provided in-depth understanding on maternal death issues in this community. The social process within the community was identified as the interaction between the women, families, midwives and kaders in their management of childbearing and maternal healthcare. This process was captured by utilising grounded theory which enabled the researcher to explore maternity practices and decisions within the research setting.

The main unique contribution to knowledge of this thesis is the research findings. The findings of the research are displayed as a core category "*maternal death: the elephant in the room*", which emphasises the relevance of the midwives' role in terms of maternal death issues in the research setting. The village midwives as the main maternity care providers in the community had a perpetual role and a central contribution to the persistent maternal mortality rate in the region. Although maternal mortality cannot be directly attributed to the midwives, their pivotal role within a dysfunctional system and disenabling environment is likely to impact on the care provided and outcomes of the women that they support. The inadequate maternity practices in the community related to maternal healthcare facilities, also the role and hierarchy of the midwives in the community may have contributed to maternal death incident in the research setting. The research findings revealed information about the inadequate maternity practices from the midwives in the community related to the lack of training and supervision in the village. Moreover, the absence of the birth assistance skill from some of the village midwives also contributed to the ineffective maternity care provision by the midwives in the community. The fact that most of the women also considered their midwives' preference based on personal instead of professional relationships, might also affect the midwives' responsibilities in delivering maternity care. The dominance of the midwives in the context of maternal mortality as an unspoken and hidden problem in the community, may contribute to the persistent maternal mortality rate in the country.

This thesis also adds to the literature that highlights the community involvement in maternal healthcare; and provides an original account of childbearing in the research setting. It supports the importance of community in reducing maternal mortality rates by highlighting the awareness of maternal healthcare situation and recognising the importance of maternal health programmes. Whilst most prior research on community participation and maternal health emphasises the role of maternal health programmes; this research extends the literature on

community participation in maternal health, by bringing attention to the role and experiences of the community and health professionals in providing maternity services to the women during pregnancy and childbirth. It also helps to create an understanding of pregnancy and childbirth experiences and what the respondents value on their maternity care. The research findings of "maternal death: the elephant in the room" provide a useful explanation and in-depth understanding of how maternal mortality and the childbearing process are managed by the women, families and healthcare professionals in these communities. This knowledge will provide the potential to develop meaningful interventions, based on evidence that is relevant for these communities; in order to improve maternal health status and reduce the maternal mortality rate in the country. Whilst this research does not emphasise on maternal health policy, the thesis findings may enlighten decision-makers and politicians about the need to address and take account in decreasing maternal mortality rate. Additionally, the new information from the thesis may also contribute to the available information for fellow academic researchers and those who are interested in researching maternal mortality and improving maternal healthcare.

10.8. Recommendations for Policy, Practice and Education

Recommendations of this research can also be identified for policy, practice and education. Some of these recommendations are provided below:

10.8.1. Recommendations for Policy

The observations and studies about maternity practices, the role of the community as well as decision-making in maternity care, and the belief of maternal death in the community have been made during the research process. Based on this research study, it was revealed the suggestions for the need of change also improvement in strategies and intervention for maternal healthcare in Aceh, Indonesia.

Community involvement is historically strong in Indonesia (Shefner-Rogers and Sood 2004). Therefore, some of the community based maternal health programmes that have been established in Indonesia, such as Siaga campaign, Village midwife programme and Posyandu as explained in chapter 1 (see section 1.7 of maternal health and community participation) need to be strengthened in the implementation. The users' involvement and the evaluation of healthcare programme is a significant aspect of health service policy. Since the first time the Siaga campaign was launched by the Indonesian government during 1998 – 2002, it was shown positive significant impact on maternity care in Indonesia

(Shefner-Rogers and Sood 2004). There was decreasing numbers towards maternal mortality rate (Shefner-Rogers and Sood 2004) and the increasing of community involvement in maternal health programme (Palmer and Sood 2004). However, the establishment of the programme seemed to be inadequate in recent years and did not show any progressing in work and implementation in most of Indonesian regions, especially in Aceh province. There is a need for the continuation of the Siaga campaign programme and its evaluation in order to maintain and focus on the quality of the programme.

The implementation of the village midwife programme needs to be strengthened across Indonesia. Currently, the Indonesian government has been working towards the establishment of a strong monitoring health committee, in order to set standards for regulate maternity supervision and performance. The findings of this research study could be used to influence the regulatory board to set standards and regulate maternity supervision. The midwifery skill and competence of all the midwives, especially the village midwives in the community need to be assessed gradually; in order to increase the quality of their provision of maternity, care to ensure the compliance of maternity care set of goals.

10.8.2. Recommendations for Practice

This research study also highlights some recommendations for midwifery practices in Aceh, Indonesia. This research strengthens the knowledge development about maternity care and also the experience from the women and the community on maternity practices. It is evident that most women who participated in this research having the antenatal care with their village midwives in their private practices instead of in health centre. The women acknowledged that the private practice provided better maternity services with more maternal health information provided. Moreover, they could also seek the midwives' services in a more convenient environment. Constructing the maternity clinic design in health centre into a more comfortable environment; such as providing enclosed room and more private space for the women to have the antenatal care, would facilitated the women to seek maternity care in health centre. Furthermore, there is a need for the supervision and evaluation on the village midwives' performance in health centre, in providing maternity service. When the midwives' performance in health centre is assessed and supervised, it will boost their best performance in providing the care and would encourage the women to utilise maternity services in public health centre.

Furthermore, it was found that the decision-making of maternity care from most of the women in this research study were trusted and depended on their family members (husbands, mothers and sisters). Although most family members (especially the husbands) provided the flexibility for the women to choose their maternity services; nevertheless, most women still sought for their husbands' approval in maternity care. Most of the women in the village depended on their husbands both socially and economically. Therefore, they still considered for their husbands' approval in most decision made for their lives. This situation may limit the women's decision-making powers either in maternal healthcare or other issues related to their wellbeing. Priority should be made in order to encourage the women in the village to acquire higher education, as most women in the village only have the average of secondary level of education. Women with higher education level intend to have better understanding not only on maternal healthcare, but also other general issues concerning their health. With education, the women also encouraged to be economically independent or even earned and assisted their family in terms of the economic income. With this situation, the women are able to take appropriate decisions on issues that could affect their lives and wellbeing.

This research study also found the perception of maternal death from the community in this research setting. Maternal deaths are considered by most villagers as part of their life and intend to accept the maternal death as the destiny from God. Furthermore, it was indicated that the community especially the women were reluctant to discuss maternal death incident. Although maternal death is not a pleasant experience to be discussed; however, raising this issue is also required as awareness about the incident in the community. It is important for the health professionals in the village to be carefully raised this issue in order to deliver maternal healthcare education especially in obstetric emergency; instead of threatening the community with the unpleasant issues in their village. There is also the need for collaboration with the community stakeholders such as *geuchik* (the head of the village) and the imam (religious leader); in order to deliver the message of the importance of maternal healthcare and the awareness of the danger signs in pregnancy. Such collaboration from the community element in the village is important in order to provide the understanding, as well as improving the knowledge of avoiding and reducing maternal deaths in the community.

10.8.3. Recommendations for Education

The women and the community members valued the exclusivity of their midwives' performance and technical skills. This could suggest that the educationalist should proceed with caution on the assessment of midwifery students' competence. Education providers should ensure the quality of the students before they graduate from midwifery schools and could actually perform as a midwife in the community. The assessment of skill competence should be performed before the students graduate and their midwifery performance license needs to be monitored gradually in the future practice. Close supervision is also needed to the establishment of midwifery schools and education in order to maintain the quality of the midwives in the future.

There is also the need for strengthening the Kaders' training in the health centre either in provincial or the district level. Kaders are at the frontline and the main assistance for the village midwives in order to reach the community. Since kaders are from and form part of the community, their role is important in engaging the community in participating in maternal health programmes in the village. Therefore, their knowledge is based on both general healthcare and specific maternal healthcare needs to be developed in order to deliver the maternity care effectively in the village.

10.9. Recommendations for Further Research

A number of interesting questions arose from this research study and it would be valuable to continue and address these with future research. Some of these are explored below:

Research is needed to explore further about the role of the community especially family members in maternal health services. Further research on the community not only as passive but also active stakeholders in maternal health programme; especially the role of the women's family members in maternal health and in the reduction of maternal mortality in Indonesia should be conducted. Their participation and contribution is important for achieving the maternal health desired goal.

The relationship between the women and their carers (midwives, kaders etc.) could be explored more fully in the way that the different needs and expectations could provide more insight into the impact on both utilisation and satisfaction of maternity services. Furthermore, an exploration on how decisions are made about how the maternity services are planned and managed could also

contribute to more efficient and better maternal health services in the community.

Further research is also needed to examine the views of the women and community members about private and public maternity services; and how these services could be facilitated and could be improved from this research study. This would increase the understanding of decision-making from the service users' perspectives about the quality of maternal health services.

In addition, research about service provision from the health facilities and health service providers within the community needs further exploration. The complexity of care provision and the outcome of maternity services need to be recognised in order to enable the government in assessing how the health facilities and healthcare providers contribute best to their services.

10.10. Summary

In this chapter, the research findings are discussed. The research findings are integrated within existing literature and the contribution of the thesis is explained. The limitations and strengths of the research were outlined, with the recommendation for policy, practice and further research.

This research examined the understanding of maternity experiences from multiple perspectives, in the context of high maternal mortality rates within the community. This research study adopted constructivist grounded theory in order to assist with a better understanding of experiences of the women and the villagers in the community. This research highlighted the maternity practices and the experiences from the community in utilising maternal health services in the village. It also emphasised the relationship between the women and the community with their village midwives, as they valued the midwives in providing not only the maternity but also the general healthcare in the village.

This research study also focused on the role of the community in maternity practices and decisions. The maternity care in the village was decided based on the influence of the family members as well as the performance of the village midwives in both private and public services. Maternal death incident in the village was rarely to be discussed and stressed out in the village, either with the community as well as the health professionals in the community. Recommendations for policy, practice and education have been identified and how this research may be developed further.

10.11. Final Remark

The researcher has gained immensely from the experiences of completing this PhD research. Not only has this journey changed her, both as a researcher and as a person; but it has enabled her to illuminate her own understandings and prejudices. She can now see the various strands of research through the complete process of conducting research; from the background reading, planning the study proposal, its implementation and practical application, analysing the data, and presenting the findings. The study was both interesting and challenging for the researcher and she has endeavoured to legitimate the rich data from the participants. She also has a greater appreciation of the problems that could be encountered, in carrying out research involving the women and the community, in the context of improving maternal health. In conclusion, she believes that this research study could contribute to the vital knowledge and understandings of social processes related to maternal health. Moreover, it also could assist in strategies to improve the quality of maternal healthcare in Aceh, Indonesia.

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Organisational Structure of Health System in Indonesia

MoH level from central to peripheral level

Kementrian Kesehatan (KEMENKES)

(Ministry of Health)

Central Level

⇩

Dinas Kesehatan Provinsi (DINKES)

(Provincial Health Office)

Provincial level

⇩

Dinas Kesehatan tingkat Kabupaten/Kota

(District Health Office)

District Level

⇩

Pusat Kesehatan Masyarakat (PUSKESMAS) tingkat kecamatan

(Sub-district Health Centre)

Sub-district and Village level

⇩

PUSKESMAS Pembantu (PUSTU) Pondok Bersalin Desa (POLINDES) Pos Pelayanan Terpadu
(POSYANDU)

Sub Health Centre   Village Midwife Clinic   Integrated Health Post

Terms Search Strategy   **Appendix 2**

Research Question Area	Keyword	Combined with	Combined with
"Community participation"	Community involvement	OR	AND
	Community engagement		
	Community development		
	Community contribution		
	Community members		
	Family members		
	Family involvement		
	Husband involvement		
	Mother involvement		
	People involvement		
	Health Staff		
	Health professionals		
"Community participation model"	Community engagement model	OR	
	Community development model		
"Maternal mortality"	Maternal death	OR	
"Maternal health"	Maternal healthcare	OR	
	Maternal health services		
	Maternal health mortality		
	Maternal morbidity		
	Maternal health behaviour		
"Maternity campaign"	Maternal health programme	OR	
	Maternal health campaign		
	Maternal campaign		
	Safer motherhood		
"Developing countries"	Developed countries	OR	
	Asia		
	Southeast Asia		
	Indonesia		

Literature Review Flowchart

```
                    ┌─────────────┐
                    │  Data base  │
                    │   Search    │
                    └─────────────┘
                           │
                           ▼                          ⇦ Reading title
```

Medline No=279	Cinahl No=86	PubMed No=78	Global Health No=429	Scopus No=40	ASSIA No=23	Maternity & Infant Care= 57	Google Scholar No=1235

⇦ Reading abstract

Medline No=118	Global Health No=225	Scopus No=11	ASSIA No=8	Google Scholar No=355

```
                    ┌─────────────────┐
                    │ Total of all=100│          ⇦ Reading full text
                    └─────────────────┘
                           │
                           ▼
                    ┌─────────────────┐
                    │  28 for review  │
                    └─────────────────┘
```
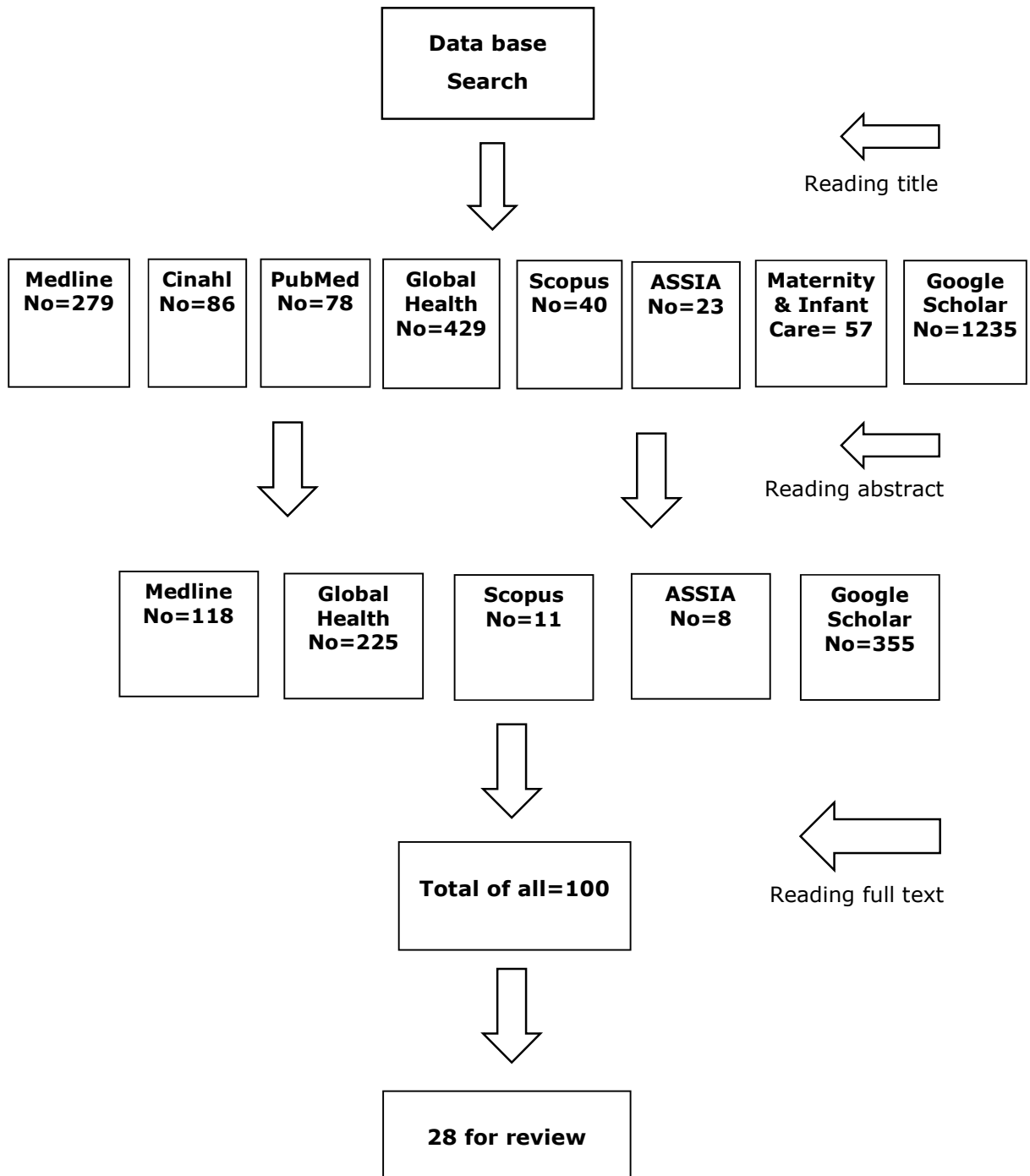
Hawker's Assessment Tool

Author and title: _____

Date: _____

	Good	Fair	Poor	Very Poor	Comment
1. Abstract and title					
2. Introduction and aims					
3. Method and data					
4. Sampling					
5. Data analysis					
6. Ethics and bias					
7. Findings/results					
8.Transferability/generalisability					
9. Implications and usefulness					

Assessment Criteria

1. **Abstract and title: Did they provide a clear description of the study?**

   Good : Structured abstract with full information and clear title.

   Fair : Abstract with most of the information.

   Poor : Inadequate abstract.

   Very Poor: No abstract.

2. **Introduction and aims: Was there a good background and clear statement of the aims of the research?**

   Good : Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge.

   Clear statement of aim and objectives, including the research questions.

   Fair : Some background and literature review. Research questions outlined.

   Poor : Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background.

   Very Poor: No mention of aims/objectives. No background or literature review.

3. **Method and data: Is the method appropriate and clearly explained?**

   Good :   Method is appropriate and described clearly (e.g., questionnaires included).

   Clear details on data collection and the recording process.

   Fair : Method appropriate, description could be better. Data described.

   Poor : Questionable whether method is appropriate.

   Method described inadequately. Little description is given on data.

   Very Poor: No mention of method, AND/OR Method inappropriate, AND/OR No details of data.

4. **Sampling: Was the sampling strategy appropriate to address the aims?**

   Good : Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates is shown and explained.

   Fair : Sample size justified. Most information given, but some is missing.

   Poor : Sampling mentioned but few descriptive details.

   Very Poor: No details of sample.

5. **Data analysis: Was the description of the data analysis sufficiently rigorous?**

Good : Clear description of how analysis was done.

Qualitative studies: Description of how themes derived/respondent validation or triangulation.

Quantitative studies: Reasons for tests selected hypothesis driven/numbers add up/statistical significance discussed.

Fair :

Qualitative: Descriptive discussion of analysis.

Quantitative: The process of data analysis

Poor : Minimal details about analysis.

Very Poor: No discussion of analysis.

6. **Ethics and bias: Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?**

Good : Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed.

Bias : Researcher was reflexive and/or aware of own bias.

Fair : Lip service was paid to above (i.e., these issues were acknowledged).

Poor : Brief mention of issues.

Very Poor: No mention of issues.

7. **Results: Is there a clear statement of the findings?**

Good : Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.

Fair : Findings mentioned but more explanation could be given. Data presented relate directly to results.

Poor : Findings presented haphazardly, not explained, and do not progress logically from results.

Very Poor: Findings not mentioned or do not relate to aims.

8. **Transferability or generalisability: Are the findings of this study transferable (generalisability) to a wider population?**

Good : Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).

Fair   : Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.

Poor : Minimal description of context/setting.

Very Poor: No description of context/setting.

9. **Implications and usefulness: How important are these findings to policy and practice?**

Good :   Contributes   something   new   and/or   different   in   terms   of understanding/insight or perspective.

Suggests some ideas for further research.

Suggests the implications for policy and/or practice.

Fair   : Two of the above (state what is missing in comments).

Poor : Only one of the above.

Very Poor: None of the above.

Synthesis Table

Author / Protocol	Abstract & Title	Method & Data	Introduction & aims	Sampling	Data Analysis	Ethics & Bias	Findings / Results	Transferability/ Generalizability	Implications & Usefulness	Total
Abdulkarim et al. (2008)	3	4	3	3	2	3	4	3	4	29
Ahluwalia et al. (2003)	4	4	4	3	3	3	3	3	3	30
Azad et al. (2010)	4	4	3	4	4	3	3	2	3	30
Emond et al. (2002)	4	3	4	2	4	3	3	3	4	30
Kazi et al. (2006)	3	3	4	2	3	2	4	3	4	28
Kidney et al. (2009)	4	3	3	4	4	3	3	2	3	29
Lassi et al. (2010)	4	3	3	3	3	4	3	2	3	28
Lee et al. (2009)	4	4	3	3	4	3	3	3	3	29

Maimbolwa et al. (2001)	4	3	3	3	2	3	3	3	4	28
Makowiecka et al. (2008)	4	3	3	3	3	2	3	4	3	28
Manandhar (2004)	4	3	3	4	4	3	3	2	4	30
Martin et al. (2007)	3	4	4	2	3	3	3	2	3	27
Mullany et al. (2009)	4	3	4	4	3	2	3	2	3	28
Mushi et al. (2010)	4	3	4	3	2	3	3	2	4	28
Ny et al. (2007)	3	4	4	4	4	3	2	2	3	29
Ogwang et al. (2012)	4	3	4	3	3	3	3	4	3	30
Orr (2004)	2	2	3	2	3	2	4	2	4	24
Perreira (2002)	4	3	4	3	3	2	3	2	3	27
Prata et al. (2012)	4	4	4	3	4	2	4	2	3	30
Rath et al. (2010)	4	2	3	4	3	3	4	2	3	28

Ronsmans et al. (2009)	4	2	4	3	3	2	2	3	3	26
Rosato et al. (2008)	4	3	3	4	4	2	3	3	3	29
Shefner-Rogers and Sood (2004)	3	4	4	3	3	3	2	3	4	29
Shehu (1999)	3	3	4	3	3	3	3	3	4	29
Steen et al. (2012)	4	4	3	3	4	2	3	4	3	30
Teela et al. (2009)	3	4	3	4	3	2	4	3	4	30
Teitler (2001)	3	2	3	3	3	3	3	3	3	26
Titaley et al. (2010)	4	3	3	4	3	2	3	4	4	30

Data Extraction Table

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
1.	Abdulkarim et al. (2008) Community Perception of Maternal Mortality in North-eastern Nigeria.	To find out community's knowledge and perceived implications of maternal mortality and morbidity.	168 community members in Borno state Nigeria.	Qualitative design Focus Group Discussion (FGD) and in-depth interviews.	Respondents identified two of the main five direct causes of maternal mortality. The knowledge and implications of maternal mortality was good in the areas & therefore intervention programmes should exploit & the linkages between the perceived implications & the causes of maternal deaths.	The data collection process was clearly explained. However, there was minimum discussion on how the theme emerged and minimum discussion of sampling.	29
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
2.	Ahluwalia et al. (2003) An evaluation of community based approach to safe motherhood in Northwestern Tanzania.	To evaluate the community capacity building and empowerment initiative To address high maternal morbidity and mortality.	Community members & health staff in 52 villages Northwestern Tanzania.	Qualitative design Group interview Review of programme data.	Project activities increased community participation in MH. Increase in: knowledge danger sign in pregnancy, birth planning, time referral and transport of pregnant women to hospitals.	The study evaluates just short time after the programme established. Using multiple data collection (group interview) and program data review has strengthening the evaluation programme.	30

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
3.	Azad et al. (2010) Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial.	To assess the effectiveness of a scaled-up development programme with women's groups in order to address maternal and neonatal healthcare in three rural districts of Bangladesh.	Groups of women aged 15-49 years, assigned for both control and intervention in participatory action in order to develop and implement strategies to address maternal and neonatal health problems in three rural districts Bangladesh.	Cluster Randomised Control Trial	The participatory women's groups to have a significant effect on the increasing of the enrolment of newly pregnant women, detailed attention to the maternal health programme, which contributed to the decreasing of neonatal mortality in Bangladesh.	Although the study did not significantly reduce the incident of maternal and neonatal mortality, the trial provide significant outcome in better maternal and neonatal health. The study also provides in-depth and thorough analysis of the research process.	30
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
4.	Emond et al. (2002) The effectiveness of community based interventions to improve maternal and infant health in Northeast Brazil.	To evaluate the effectiveness of community based intervention project aimed at reducing maternal and infant mortality in a poor urban district.	200 representatives' families in the city of Natal Brazil which exposed to maternal and infant project.	Survey Mixed-method	There was reduction in maternal deaths after the project implemented. The increasing of participation in antenatal care also reported after the project implemented.	Each intervention was clearly evaluated and the analysis process was provided. The project was evaluated just after the short time after it was being implemented.	30

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
5.	Kazi et al. (2006) Social environment and depression among pregnant women in urban areas of Pakistan: Importance of social relations.	To evaluate the relative power of social relations and social condition in predicting depression among pregnant women.	79 pregnant women (hospital and 2 communities) in Pakistan	Mix method with qualitative study in phase one and quantitative study in phase 2.	Themes identified: Social relation (involving husband, in-law and children), social condition (economy, illness, life events, household work) and pregnancy related concern (symptom, changes etc.) Among these themes social relations were significantly associated with depression in pregnant women.	One of the strengths of the study was using mix-method which provides more comprehensive understanding of the factors that contribute to particular incidents. However, limited explanation on the participants (pregnant women condition) selected which may affect the information provided related to the topic.	28
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
6.	Kidney et al. (2009) Systematic review of effect of community-level interventions to reduce maternal mortality.	To provide the systematic review of the effectiveness of community level interventions to reduce maternal mortality.	Papers related to community level intervention and maternal death as an outcome	Systematic review	Community level intervention in perinatal care could bring a reduction in maternal mortality	Although the inclusion and exclusion criteria of the review papers are not mentioned clearly; the description of the analysis and methodology of the retrieved papers are all mentioned. The strengths and the weaknesses of the reviewed papers are provided.	29

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
7.	Lassi (2010) Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes.	To assess the effectiveness of community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes.	Randomised or quasi-randomised control trial papers related to maternal health community-based studies; by using several databases.	Systematic review	Evidence showed the value of integrating maternal and newborn care in the community through the intervention that can be packaged effectively for delivery through health promotion groups. The study also highlighted the importance of skilled delivery and facility based service for maternal and neonatal health.	Although the review papers limited to the randomised control trial studies, the assessment of the papers are clearly provided which is necessary to examine the reliability of data extraction and focus in minimising potential bias and selection error.	28
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
8.	Lee et. al (2009) Linking families and facilities for care at birth: What works to avert intrapartum-related death.	To describe the evidence for interventions to link mothers with skilled care during pregnancy and childbirth	Papers that focused on reduction of related deaths	Systematic review Meta-analysis	There is quality evidence that community mobilization with high levels of community engagement can increase institutional births and significantly reduce perinatal and early neonatal mortality.	The review papers are presented in rigorous way with the description of the quality of the review papers. The description of the methodology and the analysis process of the study are also provided.	29

210

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
9.	Maimbolwa et al. (2001) Views on involving a social support person during labour in Zambian maternities.	To explore the views of mothers and health staff about allowing women to be attended by supportive companion during labour.	84 mothers (primipara& multipara) and 40 health staffs divided to 2 groups: Group 1: in Zambian urban & rural maternities (54) and Group 2: in teaching hospital (30).	Qualitative •Observation •Interview: Pregnant women (8-12 hours post-partum)	63 % group 1 and 59 % in group 2 wanted supportive companion during labour Observation: Most of women were accompanied by somebody in maternity unit. However they did not present during the labour.	Women in labour and health staffs both have positive and negative views of involving social support in Zambian maternities. Most of negative views from health staffs are related to insecurity about accepting traditional medicine. Social supports in this study refer to female family member. None of mothers mentioned husbands as the support.	28
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
10	Makowiecka et. al (2008) Midwifery provision in two district in Indonesia; how well are rural areas served.	To provide the distribution of midwifery provision in 2 rural areas Indonesia.	Practitioners who register to provide midwifery care in two district Of west Java Indonesia in July 2005.	Quantitative Case control study	10% of villages do not have midwife but a nurse as a midwifery provider. There is deficit number of midwife density in remote villages compared with urban areas.	Using case control provide more comprehensive understanding of the contribution factors to particular incidents. Focus on selected informants which may affect the representativeness of the study to the entire population.	28

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
11	Manandhar et. al (2004) Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster randomised controlled trial.	To find out whether community based participatory intervention could significantly reduce neonatal mortality rates.	42 geopolitical clusters in Makwanpur district Nepal 12 pairs randomly assigned 1 to another to be intervention and control cluster Each cluster consists of 7000 average population.	Randomised control Trial (RCT)	From 2001-2003 • The Neonatal and mortality rates was reduce in intervention cluster compared with the control cluster • Still birth rates remain the same between 2 clusters Women in intervention cluster more likely to attend antenatal care, institutional delivery, skill birth attendance and hygienic care than were controls.	Birth outcomes in a poor rural population improved greatly through a low cost, potentially sustainable and scalable and participatory intervention with women's' group. The evaluation did just after the intervention and the author did not mention how to keep the behaviour remain sustainable.	30
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
12	Martin et al. (2007) The Effects of Father Involvement during Pregnancy on Receipt of Prenatal Care and Maternal Smoking.	To examine the influence of father involvement during pregnancy and maternal behaviours during pregnancy.	5,404 women and their partners from the first wave of early childhood longitudinal study from 46 states in the district of Columbia.	Quantitative: Cohort study	Women whose partners were involved in their pregnancy were likely to have antenatal care. The involvement of father may have important contribution to the health of mother during pregnancy and childbirth.	The study did not provide clear description of the participants' characteristic as age and demographic data. However, the data collection process was explained clearly for the purpose of follow-up check.	27

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
13	Mullany et al. (2009) The impact of including husbands in antenatal health education services on MH practices in urban Nepal.	To test the impact of involving male partners in antenatal health education on maternal healthcare.	442 second trimester pregnant women seeking antenatal care. • Group 1: Women + husbands + education • Group 2: Women without husbands + education • Group 3: women without education (control).	Randomised control Trial (RCT) Women given education 2 x 35 minutes of MH education and followed until delivery	• Group 1 are more likely to attend post-partum period compare with other group. • Group 1 and 2 also reported making birth preparedness in the community. Women who were educated with their partner could identify more pregnancy complication	Strong and thorough analysis in each step of the study method and analysis. The challenge in this study was having proper intervention is not easy. It needs a lot of efforts in transferring the knowledge into action.	28
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
14	Mushi et al. (2010) Effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care. The case of Mtwara, Rural District in Tanzania.	To develop, test and assess a community based safe motherhood intervention in Mtwara, rural district Tanzania.	A total of 8,300 population in 4 rural districts Tanzania	Mixed-method: Comparative study Community based intervention	The study demonstrated the effectiveness of community based safe motherhood intervention in promoting the utilisation of obstetric care and skilled attendant at delivery.	Strong comparative study with the methodology explained clearly. There is little discussion of how the study conducted in each village as a comparison. The data analysis provided was not really strong although the data collection was presented in detail.	28

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
15	Ny et al. (2007) Middle Eastern mothers in Sweden, their experiences of the maternal health service and their partner involvement.	To describe Middle eastern immigrants mothers' experiences of maternal healthcare services in Sweden and the involvement of their male partner.	13 immigrants' mothers from middle east who had used the maternal health services in Sweden.	Qualitative studies FGD and in depth interview.	Four main categories developed; access to professional midwives, useful counselling, stable motherhood in transition, being a family living in different cultures. There was a greater need for involvement and support by the father during the perinatal period.	Most respondents said that understanding the women native language is not vital to develop a good relationship with the midwives. Instead developed trust by empathy from the midwives. The researchers didn't put the criteria of the duration of immigrants mothers stayed. This might be affected on their views.	29
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
16	Ogwang et al. (2012) Community involvement in obstetric emergency management in rural areas: a case of Rukungiri district, Western Uganda.	To identify types of community involvement and examine factors influencing the level of community involvement in the management of obstetric emergencies.	A total of 448 heads of households randomly selected from sub-counties, parishes and villages in Uganda.	Descriptive Study (interview)	Community pre-emergency support interventions available included community awareness creation (sensitization) while interventions undertaken when emergency had occur included transportation and referring women to health facility.	This study provide clear explanation about the community context which beneficial for the sustainability of the programme Types of community involvement in obstetric emergency management include practices and support programmes. Community involvement in obstetric emergency management is influenced by employment status and perceived quality of healthcare services.	30

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
17	Orr (2004) Social support and pregnancy outcome: A review of the literature	To examine the social support on pregnancy outcome.	The papers and literature related to the support during pregnancy and childbirth.	Literature review	Although there was no strong evidence that social support could reduce the risk of adverse pregnancy outcome, social support programmes can be used to improve the health and antenatal satisfaction during pregnancy and childbirth.	The review is not rigorous with no description of the papers' quality. The study also did not mention any assessment used in the reviewing process, which is necessary to examine the reliability and minimising the paper bias. There was a lack of intention to focus on the analysis which helpful in strengthening the study results.	24
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
18	Perreira et al. (2002) Increasing awareness of danger sign in pregnancy through community and clinical based education in Guatemala.	To evaluate the effectiveness of a set information, education and communication (IEC) strategies design To increase the awareness of danger signs in pregnancy, delivery or the postpartum period among pregnant women.	163 pregnant women (health clinic) 638 pregnant women (community).	• Case study: In depth interview • Population based survey.	• Pregnant women (health clinic based) increase the knowledge nearly triple than before • Pregnant women (community) increase the knowledge 5 times more likely increase the danger sign in pregnancy.	Safe motherhood programmes can effectively increase knowledge of danger signs through clinic and community based educational strategies. However the author did not provide the information on how one setting is more effective in receiving the IEC on danger signs in pregnancy.	27

215

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
19	Prata et al. (2012) Community mobilization to reduce postpartum haemorrhage in home births in northern Nigeria.	To demonstrate the importance of community mobilization in the uptake of health intervention to prevent postpartum haemorrhage.	Community leaders and selected community members in five communities in Zaria, Nigeria.	Qualitative design Group interview Review of programme data.	Community mobilization efforts reached most women with information about postpartum haemorrhage, resulting in high comprehension of intervention and message.	Strong analysis and appropriate to research objectives. By interviewing different participants give multi perspectives and credibility.	30

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
20	Rath et al. (2010) Explaining the impact of a women's group led community mobilisation intervention on maternal and newborn health outcomes: the Ekjut trial process evaluation.	To report the process of evaluation data from participatory learning and action cycle with women's groups to improve maternal and newborn health outcome programme.	A participatory learning programme with 244 women's groups that was implemented in 18 intervention clusters in Jharkhand and Orissa, eastern India (2005-2008).	Comparative study Evaluation process.	Participatory intervention programme with the community groups can influence maternal and child health outcome if key intervention characteristics are based on to the local context, considering on its sustainability and implementation features.	Sources and materials used were related to the context of the study. Strong analysis and comparison as well as clear evaluation process provided. The objectives of each intervention were clearly evaluated. However, minimum description on the method used.	28

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
21	Ronsmans et al. (2009) Professional assistance during birth and maternal mortality in two Indonesian districts.	To examine determinants of maternal mortality and assess the effect of programmes aimed at increasing the number of births attended by health professionals in two district of west Java.	Population in two districts in West Java, Indonesia.	Quantitative Population based study Case control study Midwives census.	Only 33% women gave birth with assistance from health professionals. Among them maternal mortality was extremely high especially for those in the lower middle income.	Maternal mortality ratios still remain high even among women who delivered with professionals' assistance. This is due to the limited access of home based care especially for poor income. Method of data collection and analysis was clearly mentioned and the description of how cases were chosen also provided.	26
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
22	Rosato et. al (2008) Community participation: lessons for maternal, newborn, and child health	To describe evidence of community participation in reducing maternal and neonatal mortality in developing countries.	13 relevant research papers which demonstrated community participation in maternal health.	Systematic Review.	There is evidence that community mobilisation is an effective method for promoting participation and empowering communities among a wide range of other non-health benefits.	The description of the methodology of the retrieved study was clearly mentioned. The inclusion and exclusion criteria were also provided and the analysis process was described.	29

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
23	Sheffner-Rogers and Sood (2004) Involving Husbands in Safe Motherhood: Effects of the SUAMI SIAGA Campaign in Indonesia.	To presents the effects of the Suami Siaga campaign on the acquisition of new knowledge by husbands about birth preparedness.	1,507 husbands age (15-45) in Western Java Province Indonesia.	Mixed-method: Focus group Questionnaire	Focus group: Forty-four percent (N=669) of husbands interviewed stated that the Suami SIAGA campaign messages represented new knowledge Fifty-six percent (N=838) of men did not learn anything new from the campaign. Questionnaire: Screening questions about age & socioeconomic status to ensure that the sample included only males between the ages of 15 & 45 years and from the lower strata of Indonesia's socioeconomic status system.	When husbands were directly exposed to the messages from the Suami SIAGA campaign, new knowledge gain and birth preparedness activities occurred. However, the interaction of direct exposure to the campaign and the interpersonal. Communication stimulated by the campaign about Suami SIAGA was an even stronger predictor of knowledge gain and birth preparedness actions. However limitations of the study included post-only measures and a relatively short time period.	29

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
24	Shehu (1999) Community participation and mobilisation in the prevention of maternal mortality in Kebbi, Northwestern Nigeria.	To describe PMM (Prevention of Maternal mortality) project in Nigeria concerned with community participation and mobilisation to improve maternal healthcare and prevent maternal deaths.	2.029 Pregnant women in Kebbi State, Nigeria During 1990-1995.	Mixed methods (Qualitative and quantitative studies).	There were 3 phase in conducting the project Phase 1 Building the rapport: where the community was educated about the programme and together with the community identified maternal health problem. Phase 2, drawing up action plan with the community and phase 3, improvements in MH services.	The collaboration between local government officials, community (from the leaders to grassroots) and the research team greatly contributed to success of many activities. Using mix method gives this study more strength and validity.	29
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
25	Steen et al. (2011) Non-patient and not-visitor: A metasynthesis of fathers' encounters with pregnancy, birth and maternity care.	To identify and synthesise good quality qualitative research that explores the views and experiences of fathers who have encountered maternity care in high resource settings.	Relevant papers published between January 1999 and January 2010 that studies exploring fathers' involvement in maternity care.	Systematic Review	Fathers can't support their partner effectively during pregnancy and childbirth unless they are themselves supported, included and prepared for the reality of risk and uncertainty in pregnancy, labour and parenthood and their role in this context.	The review is provided with clear description of the quality of the review papers. Inclusion and exclusion criteria were also mentioned clearly. The description of the methodology was also mentioned.	30

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
26	Teela et al. (2009) Community based delivery of maternal healthcare in conflict affected areas of eastern Burma; perspectives from lay maternal health workers.	To provide an opportunity to hear perspective directly from community based workers in a conflict setting.	27 Community based workers Eastern Burma	Qualitative FGD In-depth interview.	There is a supportive network and staff ownership of the maternal healthcare project in the community. The used of health workers from the community will increase the ownership of the programme as well as the independencies from the community.	The study provides strong and thorough analysis process. Data collection was also clearly provided and the rigour of the study was also explained.	30
No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
27	Teitler (2001) Father involvement, child health and maternal health behaviour.	To examine the level and effects of father involvement on child's birth weight and mother's health behaviour during pregnancy.	Fathers and mothers of the child who born in 20 cities USA (random sampling)	Qualitative Series in depth Interview 1st :shortly after the birth of the child (hospital) Next interview: every year for four years.	Most fathers are involved with their children at birth and have intention to remain involved. Fathers can influence mothers to maintain or to adopt healthy pregnancy behaviour. There is no indication that fathers' involvement improves birth outcome.	Conducting series in-depth interview gives this study more strength and validity.	26

No	Paper	Aim	Sample and Setting	Design	Findings	Conclusion/Comments	Score
28	Titaley et al. (2010) Why don't some women attend antenatal and postnatal care services?: a qualitative study of Garut, Sukabumi and Ciamis west Java Indonesia.	To explore community members' perspectives, the services received during antenatal and postnatal care services and cultural practices during antenatal and postnatal periods in study area.	Total of 295 respondents from 6 villages in 3 district of west Java Indonesia.	Qualitative study 20 FGD and 165 in-depth interviews.	The finding show that most women who didn't attend the antenatal and postnatal care services are due to the poor condition and inadequacies of health services in study areas. This happened as in the study areas there are no maternal health programme especially those which based on community applied. As this is also suggested by the author.	The data collection and analysis process were clearly explained. Strong analysis and appropriate to research objectives.	30

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Secretary to Research Ethics Committee 1

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Phone: 0161 375 1360

Ms Suryane Susanti
PhD Student
School of Nursing, midwifery and Social Work

Suryane.susanti@postgrad.manchester.ac.uk

ref: ethics/11276

6 January 2012

Dear Ms Susanti

Committee on the Ethics of Research on Human Beings
Susanti, Lavender, Furber: Community participation in improving maternal health: a grounded theory study in Aceh Indonesia (ref 11276)

I write to confirm that the amendments to the ethics application form, information sheet and the consent form satisfy the concerns of the Committee and that the above project therefore has ethical approval.

The general conditions remain as stated in my letter of 6th December 2011.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by January 2013, whichever is earlier. When completing this form, please reference your project as:

'Susanti, Lavender, Furber: Community participation in improving maternal health: a grounded theory study in Aceh Indonesia (ref 11276)'

We hope the research goes well.

Yours sincerely,

Katy Boyle
Secretary to University Research Ethics Committee

Combining the strengths of UMIST and
The Victoria University of Manchester

Indonesian Research Ethic Approval

GOVERNMENT OF ACEH BESAR DISTRICT OF INDONESIA
DISTRICT HEALTH OFFICE
Jln. T. Bachtiar Panglima Polem, SH. Phone: (62)651 92186, Post Code: 23911
KOTA JANTHO

No : Peg.800/5373
Date : 14 - 10 - 2011
Ref : Suryane Sulistiana Susanti

TO WHOM IT MAY CONCERN: LETTER OF CONCERN

This is to certify that consent has been granted to Suryane Sulistiana Susanti to carry out academic research on Community Participation in Improving Maternal Health: A Grounded Theory Study in Aceh, Indonesia. The outcome of the study, hopefully will contribute meaningfully in our policy efforts.

Please accord her all the necessary co-operation.

Director of District Health Office
Aceh Besar District

Dra. Egi Surayani.MPH
NIP. 0 275 563

Participants Information Sheet
Pregnant Women
(Indonesian version)

School of Nursing, Midwifery and Social Work
University of Manchester
Jean McFarlane Building
Oxford Road
Manchester
M13 9PL

Peran Serta Masyarakat dalam Meningkatkan Kesehatan Ibu Hamil

Kami mengharapkan kesediaan anda untuk ikut serta dalam penelitian ini. Sebelum memutuskan untuk ikut serta, kami ingin anda paham tentang mengapa penelitian ini dilakukan dan apa saja yang terlibat di dalamnya. Silahkan membaca informasi ini dengan seksama, dan memerlukan waktu sekitar 10-15 menit. Silahkan bertanya jika ada informasi yang ingin diketahui tentang penelitian ini.

Apa tujuan dari penelitian ini?

Tujuan dari penelitian ini adalah untuk menyelidiki pengalaman selama kehamilan dan kelahiran dalam kaitan penggunaan program kesehatan ibu hamil dan keterlibatan masyarakat, anggota keluarga dan tim kesehatan.

Mengapa saya terpilih?

Penelitian ini ingin mengetahui pandangan dari ibu hamil, anggota keluarga, tim kesehatan dan masyarakat tentang kehamilan dan kelahiran.

Apakah saya harus ikut serta?

Tidak, semua terserah kepada anda. Kami akan menerangkan tentang penelitian yang akan dilakukan melalui lembar informasi ini. Jika anda bersedia ikut serta, maka anda dipersilahkan untuk menanda tangani formulir persetujuan. Anda berhak untuk mengundurkan diri kapan saja.

Apa yang terjadi jika saya bersedia ikut serta?

Jika anda bersedia ikut serta dalam penelitian ini, maka anda akan diwawancara. Anda akan diberi pilihan tentang waktu dan tempat wawancara.

Apa yang harus saya lakukan?

Bagi yang bersedia untuk ikut serta dalam penelitian ini di wajibkan untuk membaca dan mengisi formulir persetujuan, beserta alamat dan nomor yang dapat dihubungi. Formulir dapat dikembalikan kepada peneliti dengan menghubungi peneliti.

Apa kemungkinan kerugian dan resiko dari keikut sertaan saya?

Penelitian ini akan memakan sedikit waktu anda. Jika anda bersedia ikut serta, anda akan dipersilahkan untuk mengisi dan mengembalikan formulir persetujuan, kemudian anda akan diwawancara selama lebih kurang 1 jam. Jika anda memilih untuk tidak ikut serta maka anda tidak harus merespon undangan ini. Jika anda merespon undangan ini dan kemudian memutuskan untuk tidak ikut serta, anda berhak untuk mengundurkan diri kapan saja. Jika anda keberatan dengan pertanyaan yang diajukan makan anda berhak untuk tidak menjawab dan dapat menghentikan wawancara kapan saja. Saya akan mendiskusikan dengan dan menginformasikan kepada atasan dari Bidan setempat jika anda terkena resiko. Jika situasi bertambah parah, keputusan akan dibuat setelah berdiskusi dengan anda dan tindakan lebih lanjut akan di jelaskan kemudian.

Apa keuntungan dari keikutsertaan saya?

Kami berharap bahwa hasil penelitian ini dapat memberikan informasi terkait dengan masalah kesehatan ibu hamil. Kami juga berharap dapat memberikan kontribusi bagi peningkatan Pelayanan kesehatan ibu hamil.

Berapa lama penelitian ini berlangsung?

Proses perekrutan peserta dan wawancara akan berlangsung lebih kurang 8 bulan. Akan ada 3 tahap wawancara yang dilakukan. Serta observasi akan dilakukan dengan izin dari anda, berdasarkan isu yang muncul dari wawancara yang memerlukan observasi . Transkrip dari wawancara dan observasi akan disediakan selama pengoleksian data yang diikuti tahap analisis data. Selama wawancara anda diharapkan untuk dapat mengungkapkan pengalaman anda selama kehamilan dan kelahiran.

Bagaimana jika saya menemukan kesulitan?

Kami berharap anda tidak mengalami kesulitan selama proses wawancara berlangsung. Namun jika anda menemukan kesulitan dan anda dapat menghubungi peneliti di alamat email suryane.susanti@postgrad.manchester.ac.uk. Jika ada pertanyaan yang bersifat formal maka anda dapat menghubungi pihak komite etik dari University of Manchester dengan menghubungi research-governance@manchester.ac.uk atau di nomor telepon +44 (0)161 275 7583 atau +44 (0)161 275 8093 Pihak ini dapat dihubungi dalam bahasa Inggris.

Apakah keikut sertaan saya bersifat rahasia?

Ya. Kami akan memastikan bahwa penelitian ini akan mengikuti prinsip legal dan etik serta segala informasi akan dijaga dan bersifat rahasia. Wawancara akan direkam dan observasi akan ditulis. Segala alat rekaman dan transkrip hasil wawancara dan observasi akan disimpan dengan aman, dan hanya peneliti saja yang punya akses terhadap dokumen tersebut. Segala informasi tentang anda akan tanpa nama dan akan diidentifikasi menggunakan kode. Ketika hasil penelitian ini ditulis dalam bentuk laporan, pernyataan anda mungkin akan ditulis, namun identitas anda tidak akan diberikan.

Apa yang akan terjadi dengan hasil penelitian ini?

Hasil penelitian ini bertujuan untuk menyelidiki pengalaman selama kehamilan dan kelahiran dari sudut pandang ibu hamil, anggota keluarga, tim kesehatan dan masyarakat. Peneliti berharap dapat mempublikasikan hasil penelitiannya di beberapa jurnal kesehatan. Jika anda tertarik untuk memilikinya, maka peneliti akan dengan senang hati memberikannya.

Siapa yang mengorganisasikan penelitian ini?

Penelitian ini merupakan salah satu bagian dari tahap studi PhD Keperawatan dari peneliti di University of Manchester.

Siapa yang menelaah penelitian ini?

Penelitian ini akan ditelaah oleh Komite etik dari University of Manchester dan Komite Etik Lokal dari Propinsi Aceh.

Pihak yang dapat dihubungi untuk informasi lebih lanjut.

Jika anda memiliki pertanyaan lebih lanjut maka dapat menghubungi peneliti di suryane.susanti@postgrad.manchester.ac.uk atau di nomor telepon 081536645320. Jika ada pertanyaan yang ingin diajukan selain kepada peneliti maka anda dapat menghubungi pembimbing dari peneliti yaitu Professor Tina Lavender di Tina.Lavender@manchester.ac.uk atau anda juga dapat menghubungi Dr. Christine Furber di Christine.Furber@manchester.ac.uk. Mereka berdua dapat dihubungi dalam bahasa Inggris.

Terima Kasih atas Kesediaan Anda dalam Membaca Lembar Informasi Ini

Participants Information Sheet
Pregnant women
(English version)

School of Nursing, Midwifery and Social Work
University of Manchester
Jean McFarlane Building
Oxford Road
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M13 9PL

Community Participation in Improving Maternal Health

We would like you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve. Please take time to read the information carefully; we would suggest this should take about 10-15 minutes. Please ask questions and talk to others about the study if you wish.

What is the purpose of the research study?

The study aims to gain understanding of pregnancy and childbirth's experiences from the perspective of pregnant women, relevant community members and health professionals in relation to the use maternal health services and the involvement of the community.

Why have I been chosen?

We are interested in finding out the views of pregnant women, relevant community members and health professionals about their experiences during pregnancy and childbirth.

Do I have to take part?

No, it is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I agree to take part?

If you agree to take part in the research study, you may be invited to take part in an interview and/or observation. You will have the option to choose the time and the place of interview including the observation.

What will I have to do?

Anyone interested in taking part within the research study should read and complete the attached consent form, along with your contact details and the best time to be contacted. Please return them to me by contacting me by phone or email to address provided.

What are the possible disadvantages and risks of taking part?

The study will require a small amount of your time. If you choose to take part you will be asked to complete and return the consent form, and will be invited to participate in approximately 1 hour interview. An observation will also be made by your permission. If you do not wish to take part you do not have to respond to this invitation. If you do respond and later decide you do not want to participate, you can withdraw at any time. If you are unhappy with any questions asked during the interview you do not have to answer, and you can stop the interview at any point. I will discuss with you and may have informed the midwives' supervisor as you may be at risk. If the situation arises, the decision will be made and discussed with you and any further action taken will be explained.

What are the possible benefits of taking part?

We hope that the research study will provide the information regarding maternal health problems and give contributions to improve the Maternal Health Services.

How long will the study last?

The initial recruitment of participants and subsequent interviews will last for about 8 months. The potential observation on certain aspects will also be made with your permission based on the issues which might rise from the interview. Transcriptions of interviews and observation will be on-going through-out the collection of date. This will be followed by an analysis of data collected. During the interview you will be asked to express your experiences during pregnancy and childbirth.

What if there is a problem?

We do not anticipate that taking part in the study will cause you problems. However if you consent to an interview you are under no obligation to proceed. You do not have to give a reason for changing your mind and at no time will your care and treatment be affected by your decision to be involved in this study. If anything about the study upsets you or raises questions for you, while you are taking part or afterwards, please email me at suryane.susanti@postgrad.manchester.ac.uk. If you have questions or concerns that the researchers cannot answer or if you want to make a formal complaint about the research, please contact a University Research Practice and Governance Coordinator by email on research-governance@manchester.ac.uk or via phone on 0161 275 7583 or 0161 275 8093. This could be contacted in English.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information collected about you and during the interviews and observations will be handled in confidence. The interview will be recorded and the observation will be taken notes. All digital recording and transcription will be placed safely and I am the only person who has access to them. All recordings and transcription will be destroyed at the end of the study. Your detail will be anonymous and will be identified with code. When the report is written about the study, I may mention some of your comments but your name will not be mentioned or any details which might directly to identify you.

What will happen to the results of the research study?

The result of the study will aim to explore the experience during pregnancy and childbirth from the perspective of pregnant women, family members, health professionals and community. We hope to publish the results in a medical, nursing and midwifery or other health journals. If you would like a copy of the results, we would be happy to send you one.

Who is organising the research study?

The study is being undertaken as part of my PhD in the School of Nursing, Midwifery and Social Work at the University of Manchester.

Who has reviewed the research study?

The research study has been reviewed by the Ethics Committee of the University of Manchester and by the Aceh province Local Research Ethics Committee.

Contact for further information.

If you have any questions or concerns about the research, please contact me at suryane.susanti@postgrad.manchester.ac.uk. If you have questions, but would rather contact one of the research supervisors, you can email Professor Tina Lavender by email at Tina.Lavender@manchester.ac.uk. You can also contact Dr. Christine Furber by email at Christine.Furber@manchester.ac.uk. Both of them could be contacted in English.

Thank You for Taking the Time to Read this Information Sheet.

Participants Information Sheet
Family Members and Health Professionals
(Indonesian Version)

School of Nursing, Midwifery and Social Work
University of Manchester
Jean McFarlane Building
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Peran Serta Masyarakat dalam Meningkatkan Kesehatan Ibu Hamil

Kami mengharapkan kesediaan anda untuk ikut serta dalam penelitian ini. Sebelum memutuskan untuk ikut serta, kami ingin anda paham tentang mengapa penelitian ini dilakukan dan apa saja yang terlibat di dalamnya. Silahkan membaca informasi ini dengan seksama, dan memerlukan waktu sekitar 10-15 menit. Silahkan bertanya jika ada informasi yang ingin diketahui tentang penelitian ini.

Apa tujuan dari penelitian ini?

Tujuan dari penelitian ini adalah untuk menyelidiki pengalaman selama kehamilan dan kelahiran dalam kaitan penggunaan program kesehatan ibu hamil dan keterlibatan masyarakat, anggota keluarga dan tim kesehatan.

Mengapa saya terpilih?

Penelitian ini ingin mengetahui pandangan dari ibu hamil, anggota keluarga, tim kesehatan dan masyarakat tentang kehamilan dan kelahiran.

Apakah saya harus ikut serta?

Tidak, semua terserah kepada anda. Kami akan menerangkan tentang penelitian yang akan dilakukan melalui lembar informasi ini. Jika anda bersedia ikut serta, maka anda dipersilahkan untuk menanda tangani formulir persetujuan. Anda berhak untuk mengundurkan diri kapan saja.

Apa yang terjadi jika saya bersedia ikut serta?

Jika anda bersedia ikut serta dalam penelitian ini, maka anda akan diwawancara. Anda akan diberi pilihan tentang waktu dan tempat wawancara.

Apa yang harus saya lakukan?

Bagi yang bersedia untuk ikut serta dalam penelitian ini di wajibkan untuk membaca dan mengisi formulir persetujuan, beserta alamat dan nomor yang dapat dihubungi. Formulir dapat dikembalikan kepada peneliti dengan menghubungi peneliti.

Apa kemungkinan kerugian dan resiko dari keikut sertaan saya?

Penelitian ini akan memakan sedikit waktu anda. Jika anda bersedia ikut serta, anda akan dipersilahkan untuk mengisi dan mengembalikan formulir persetujuan, kemudian anda akan diwawancara selama lebih kurang 1 jam. Jika anda memilih untuk tidak ikut serta maka anda tidak harus merespon undangan ini. Jika anda merespon undangan ini dan kemudian memutuskan untuk tidak ikut serta, anda berhak untuk mengundurkan diri kapan saja. Jika anda keberatan dengan pertanyaan yang diajukan makan anda berhak untuk tidak menjawab dan dapat menghentikan wawancara kapan saja. Saya akan mendiskusikan dengan dan menginformasikan kepada atasan dari Bidan setempat jika anda terkena resiko. Jika situasi bertambah parah, keputusan akan dibuat setelah berdiskusi dengan anda dan tindakan lebih lanjut akan di jelaskan kemudian.

Apa keuntungan dari keikut sertaan saya?

Kami berharap bahwa hasil penelitian ini dapat memberikan informasi terkait dengan masalah kesehatan ibu hamil. Kami juga berharap dapat memberikan kontribusi bagi peningkatan Pelayanan kesehatan ibu hamil.

Berapa lama penelitian ini berlangsung?

Proses perekrutan peserta, wawancara dan observasi akan berlangsung lebih kurang 9 bulan. Akan ada wawancara dan observasi yang dilakukan. Observasi akan dilakukan berdasarkan isu yang muncul dari wawancara. Observasi akan dilakukan dengan izin dari anda. Transkrip dari wawancara dan observasi akan disediakan selama pengoleksian data yang diikuti tahap analisis data. Selama wawancara anda diharapkan untuk dapat mengungkapkan pengalaman anda selama kehamilan dan kelahiran.

Bagaimana jika saya menemukan kesulitan?

Kami berharap anda tidak mengalami kesulitan selama proses wawancara berlangsung. Namun jika anda menemukan kesulitan dan anda dapat menghubungi peneliti di alamat email suryane.susanti@postgrad.manchester.ac.uk. Jika ada pertanyaan yang bersifat formal maka anda dapat menghubungi pihak komite etik dari University of Manchester dengan menghubungi research-governance@manchester.ac.uk atau di nomor telepon +44 (0)161 275 7583 atau +44 (0)161 275 8093 Pihak ini dapat dihubungi dalam bahasa Inggris.

Apakah keikut sertaan saya bersifat rahasia?

Ya. Kami akan memastikan bahwa penelitian ini akan mengikuti prinsip legal dan etik serta segala informasi akan dijaga dan bersifat rahasia. Wawancara akan direkam dan observasi akan ditulis. Segala alat rekaman dan transkrip hasil wawancara dan observasi akan disimpan dengan aman, dan hanya peneliti saja yang punya akses terhadap dokumen tersebut. Segala informasi tentang anda akan tanpa nama dan akan diidentifikasi menggunakan kode. Ketika hasil penelitian ini ditulis dalam bentuk laporan, pernyataan anda mungkin akan ditulis, namun identitas anda tidak akan diberikan.

Apa yang akan terjadi dengan hasil penelitian ini?

Hasil penelitian ini bertujuan untuk menyelidiki pengalaman selama kehamilan dan kelahiran dari sudut pandang ibu hamil, anggota keluarga, tim kesehatan dan masyarakat. Peneliti berharap dapat mempublikasikan hasil penelitiannya di beberapa jurnal kesehatan. Jika anda tertarik untuk memilikinya, maka peneliti akan dengan senang hati memberikannya.

Siapa yang mengorganisasikan penelitian ini?

Penelitian ini merupakan salah satu bagian dari tahap studi PhD Keperawatan dari peneliti di University of Manchester.

Siapa yang menelaah penelitian ini?

Penelitian ini akan ditelaah oleh Komite etik dari University of Manchester dan Komite Etik Lokal dari Propinsi Aceh.

Pihak yang dapat dihubungi untuk informasi lebih lanjut.

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We are interested in finding out the views of pregnant women, family members, health professionals and community about their experiences during pregnancy and childbirth.

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No, it is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I agree to take part?

If you agree to take part in the research study, you may be invited to take part in an interview and/or observation. You will have the option to choose the time and the place of interview including the observation.

What will I have to do?

Anyone interested in taking part within the research study should read and complete the attached consent form, along with your contact details and the

best time to be contacted. Please return them to me by contacting me by phone or email to address provided.

What are the possible disadvantages and risks of taking part?

The study will require a small amount of your time. If you choose to take part you will be asked to complete and return the consent form, and will be invited to participate in approximately 1 hour interview. An observation will also be made by your permission. If you do not wish to take part you do not have to respond to this invitation. If you do respond and later decide you do not want to participate, you can withdraw at any time. If you are unhappy with any questions asked during the interview you do not have to answer, and you can stop the interview at any point. I will discuss with you and may have informed the midwives' supervisor as you may be at risk. If the situation arises, the decision will be made and discussed with you and any further action taken will be explained.

What are the possible benefits of taking part?

We hope that the research study will provide the information regarding maternal health problems and give contributions to improve the Maternal Health Services.

How long will the study last?

The initial recruitment of participants and subsequent interviews will last for about 9 months. The potential observation on certain aspects will also be made with your permission based on the issues which might rise from the interview. Transcriptions of interviews and observation will be on-going through-out the collection of date. This will be followed by an analysis of data collected. During the interview you will be asked to express your experiences during pregnancy and childbirth.

What if there is a problem?

We do not anticipate that taking part in the study will cause you problems. However if you consent to an interview you are under no obligation to proceed. You do not have to give a reason for changing your mind and at no time will your care and treatment be affected by your decision to be involved in this study. If anything about the study upsets you or raises questions for you, while you are taking part or afterwards, please email me at suryane.susanti@postgrad.manchester.ac.uk.If you have questions or concerns that the researchers cannot answer or if you want to make a formal complaint about the research, please contact a University Research Practice and

Governance Coordinator by email on research-governance@manchester.ac.uk or via phone on 0161 275 7583 or 0161 275 8093. This could be contacted in English.

Will my taking part in this study be kept confidential?

Yes. We will follow ethical and legal practice and all information collected about you and during the interviews and observations will be handled in confidence. The interview will be recorded and the observation will be taken notes. All digital recording and transcription will be placed safely and I am the only person who has access to them. All recording and transcription will be destroyed at the en of the study. Your detail will be anonymous and will be identified with code. When the report is written about the study, I may mention some of your comments but your name will not be mentioned or any details which might directly to identify you.

What will happen to the results of the research study?

The result of the study will aim to explore the experience during pregnancy and childbirth from the perspective of pregnant women, relevant community members and health professionals. We hope to publish the results in a medical, nursing and midwifery or other health journals. If you would like a copy of the results, we would be happy to send you one.

Who is organising the research study?

The study is being undertaken as part of my PhD in the School of Nursing, Midwifery and Social Work at the University of Manchester.

Who has reviewed the research study?

The research study has been reviewed by the Ethics Committee of the University of Manchester and by the Aceh province Local Research Ethics Committee.

Contact for further information.

If you have any questions or concerns about the research, please contact me at suryane.susanti@postgrad.manchester.ac.uk. If you have questions, but would rather contact one of the research supervisors, you can email Professor Tina Lavender by email at Tina.Lavender@manchester.ac.uk. You can also contact Dr. Christine Furber by email at Christine.Furber@manchester.ac.uk. Both of them could be contacted in English.

Thank You for Taking the Time to Read this Information Sheet.

Consent Form
(Indonesian version)

Formulir Persetujuan		
Community Participation in Improving Maternal Health: A Grounded Theory Study in Aceh Indonesia		
Peran Serta Masyarakat dalam Peningkatan Kesehatan Ibu Hamil: Penelitian 'Grounded Theory' di Aceh Indonesia		
Formulir persetujuan ini di rancang untuk memastikan anda telah paham tujuan dari penelitian ini. Anda juga paham tentang hak sebagai peserta dan mengkonfirmasikan bahwasanya anda bersedia untuk ikut serta dalam penelitian		
Silahkan conteng di kotak yang tersedia		
	Ya	Tidak
Saya telah membaca lembar informasi yang menerangkan tentang penelitian ini		
Saya telah diberikan cukup informasi tentang penelitian ini dan diberikan pilihan untuk berpartisipasi dalam penelitian ini atau tidakserta berhak untuk bertanya		
Saya paham bahwasanya saya berhak untuk menolak ikut serta dalam penelitian ini		
Saya paham bahwasanya saya dapat mengundurkan diri dari penelitian ini tanpa memberikan alasan apapun		
Saya mengerti bahwasanya saya dapat menanyakan informasi lebih lanjut tentang penelitian ini dari tim penelitian		
Saya paham bahwasanya segala informasi dari penelitian ini bersifat rahasia		
Saya mengerti tentang ketidak mungkinan mengidentifikasi peserta dari penelitian ini		
Saya paham bahwa penelitian ini akan direkam		
Saya paham bahwasanya identitas tidakdimunculkan untuk kepentingan publikasi		
Saya bersedia untuk ikut serta dalam penelitian ini		
Tanda tangan:	Tanggal:	
Nama dengan huruf besar:		
Saya konfirmasi bahwa kutipan dari wawancara dapat digunakan untuk laporan akhir penelitian dan publikasi lainnya. Saya paham bahwa ini akan bersifat rahasia dan tidak ada satu orang peserta pun dapat di identifikasikan dalam laporan.		
Tanda tangan:	Tanggal:	
Nama dalam huruf besar:		
Tanda tangan peneliti:	Tanggal:	

Consent Form
(English version)

The University of Manchester

Consent Form		
Community Participation in Improving Maternal Health: A Grounded Theory Study in Aceh Indonesia This consent form is designed to check that you understand the purposes of the study, that you aware of your rights as a participant and to confirm that you are willing to take part		
Please tick as appropriate		
	Yes	No
I have read the information sheet describing the study		
I have received sufficient information about the study and given the option to decide whether to take part and ask questions		
I understand that I am free to refuse to take part in the study		
I understand that I may withdraw from the study at any point without having to provide a reason		
I know that I can ask for further information about the study from the research team		
I understand that all information arising from the study will be treated as confidential		
I know that it will not be possible to identify any individual respondent to the study report including myself		
I understand that the interview will be audio recorded and observation will be taken notes		
I understand that some of my statements will be quoted anonymously for the purpose of research publication.		
I agree to take part in the study		
Signature	Date:	
Name in block letters:		
I confirm that quotations from the interview can be used in the final research report and other publications. I understand that these will be used anonymously and that no individual respondent will be identified in such report.		
Signature:	Date:	
Name in block letters:		
Signature of the researcher:	Date:	

Interview Topic Guide

Introduction

(Say greeting) Thank you for taking the time to talk to me today

Check: date and venue, tape recording (by permission)

Informed Consent (Can postpone or withdrawn at any time)

Make sure the anonymous of the participants

Discuss the fact that participant can refuse to answer any question

Discuss the fact that the question can be reworded if it is not clear to participant

Questions

Participants: Pregnant Women

1. I would like to hear your views about this pregnancy, tell me about how you feel?
2. Can you describe the support that you have during pregnancy? [Family/professionals/others]?
3. Tell me where do you go to check your pregnancy?

Participants: Family members

1. I would like to hear your views about your wife's/daughter's/sister's pregnancy, how do you feel about it?
2. Can you describe what kind of support that you provide during her pregnancy/childbirth?

Participants: Health professionals (Midwives)

1. I would like to hear your views about this women (name...)'s pregnancy, how do you feel about it?
2. Can you describe what kind of activity does she usually required from you?
3. Can you describe what kind of support that you provide during her pregnancy/ childbirth?

Prompts/ Probes

Tell me what you mean by….

Can you explain little bit more about that?

What happened next?

Are there any reasons for that?

Observation Guide

Observation on Pregnant women and family members

How are the participants interacting? i.e.

- Is there dialogue?
- Where is the dialogue taken place?
- Who is talking / listening?
- What is their body language/non-verbal information?
- Is there evidence in the dialogue that family members (husbands, mothers, sister etc.) giving support during pregnancy/childbirth?
- Whether family members talk about pregnancy?
- What are the family members doing right now
- What is the pregnant woman doing right now?

Observation on pregnant women and health professionals

How are the participants interacting? i.e.

- Is there dialogue?
- Where is the dialogue taken place
- What is their body language/non-verbal information?
- How are they undertaking the activity?
- How is the pregnant woman using help and resources?
- How are the pregnant woman and the midwife interacting to each other?
- How much time in total do they spend in the observation place?

Coding Development Process

Portion of Line by Line Coding

Portion of interview with Linda	Line by line coding
Well…I always <u>want to work in the health service</u> area.	Self-fulfilment
Taking care of other people's health, helping them and <u>make them feel relief will make me feel happy</u> and satisfy inside.	Altruism
So I considered doing Midwifery and I chose to become a midwife <u>since it focused on women's health</u>.	Interesting topic
And I think this is the part where <u>you can interact personally with them and their family</u> and provide them much health information during their pregnancy and childbirth…<u>I feel I am important</u>.	Self-fulfilment Pride
I like the midwives whom <u>very supportive and guide you</u> during your placement time.	Figure admiration Role model
But I found some of my friends find it difficult since <u>not all of us have the skill to deal with people easily</u>. And this is not something that we learn specifically in midwifery school.	Have no skill on dealing with women in the community

Portion of interview with Imas	Line by line coding
I usually go to Yana (the village midwife) in her clinic…Yana is <u>a nice person</u> and <u>her clinic is also comfortable…</u>	Friendly Comfortable place
With the other midwife, <u>most of the time I seen her staffs</u>…not her…because she has many patients…so…yes…	Not being able to see / taking care by the midwife directly
because <u>I cannot afford to go to her clinic</u> many times since <u>it is not very cheap</u>	Not able to pay Expensive
Well…because I thought she is a <u>well-known midwife</u>…so…she might be very expert…well…I didn't go to her clinic very often though…	Reputation
Also if we go to the health centre there some procedure that we have to go through…like the registration…and we have to bring our card…<u>and if we forget to bring our card…they will again take our identity…register again</u>…and yes…which I think it's complicated and little bit annoying…	Complicated procedure

Examples of the Initial Codes

Problem during pregnancy: Tiredness, Illness during pregnancy

Reason to be a Midwife: Status, Pride, Stable livelihood, Gender, Self-Fulfilment, Altruism, Figure Admiration, Role Model, Getting Employment quickly, Interesting Topic.

Student Midwives: need more practice in the school lab before going to the field, more skill on dealing with the women in the community, more supervision in the field

Challenges in midwifery: Challenge in terms of job description, getting restricted in terms of legal ethics, being in the frontline especially in the community to deal with mothers and maternal health, less interest from the senior midwives in joining the update midwifery skill course and trainings and applying in their field work.

Midwives in the community: currently focus in the health centre; rely on the Kaders in doing home visit and health education

Place to go for Antenatal Care: The Village Midwife, Midwife in Private Clinic, Health Centre, obstetrician

Selection of the Midwives/'Good Midwife' Characteristic: Midwives experienced in normal pregnancy and childbirth, comfortable, satisfied, trust, Reputation, relationship, friendly, caring, patient, peer recommendation, distance to travel, communicative, based on family/peer experiences.

Reason to go to Village Midwife/Village Midwife Private Clinic: Getting in-depth pregnancy information, comfortable place, reasonable and affordable payment

Reason not to go to midwife Private Clinic: Expensive, Not being able to see/taking care by the midwives directly

Reason for not going to the village midwife post: The absence of midwife; doesn't get proper medication, uncomfortable with the place, no birth assistance in the village midwife post.

The village midwife post: most of the village midwives already have family and they're not living in the village; the health post could not occupy their family member to live in that place, mostly doesn't appropriate to assist the labour (the design is less private to assist the labour)

Intervention from the Midwives: Providing health education, providing vitamins and medication during pregnancy, Food suggestion, Health discussion, taking blood pressure, taking care the infants, breast feeding education, danger signs in pregnancy, preparation for the birth

Reason for going to the Health Centre: Free services in the Health Centre, staff are nice, getting information

Reason not to go to the Health Centre: Lack of privacy in the Health Centre, many students, family/peer recommendation, no birth assisting process in Health centre, complicated procedures, the queuing system, doesn't get proper medication, mix patients in the same ward, lack of care from the staff

Health Centre: do not provide the labour services, only few midwives perform the birth assisting, no midwives' skill competence evaluation, lack of competence in health technology engagement in the health centre

Reason to go to Obstetrician: Worried Having Problems during pregnancy, to have proper USG (scan), make sure the baby growth normally, knowing the condition of the baby.

Family support: Husband support, Mother/sister/Kader (women) support

Support during pregnancy and childbirth: (Female family member support, Kader's support, practical advice, household work help, accompany to the antenatal visit, antenatal and postnatal care support), (Male family member support, Financial support, Accompany to antenatal Visit and childbirth support)

Lack of support during pregnancy and childbirth: Doing the household by herself, Family distance living, spouse's busy activities

Preparation during pregnancy and childbirth: choosing the place for giving birth

Place to give birth: Village Midwife's Private Clinic, Home Delivery

Maternal deaths: Happened with the women having less antenatal care, happened to the women who previously have the diseases or illness during pregnancy, late to seek the healthcare (unrecognised the emergency from the family), lack of knowledge about maternal deaths,

Feeling about maternal deaths: Fear on maternal deaths, don't like to talk about it, aware about it however less known about it, less worried

Male domination: When to have Babies, Place to go for Antenatal Care

Health Education: More maternal health education in the village, Health Centre

Community Health Workers (Kader): less interest from younger generation to become Kader, only few Kaders are considered to be active in the village, working under supervision of the midwives, chosen by midwives with the village leader's approval, more contact with the community (women) however less intervention.

Intervention from the Kader: Checking the blood pressure, delivering the vitamins and medications from the midwives, home visit

The Initial Code 2 (Constant Comparison)

Decision making	Value for money	Physical context	Cultural context	Control of childbearing	Passage through childbearing	Professional role
• Rational for contacting village/private midwife • Rational for / not going to the village midwife • Rational for / not going to the health centre • Rational for going the obstetrician • Rational for care option • Desire to include family / partner	• Rational for going to the private midwife • Rational for going to the obstetrician • Value of paying for care	• Maternal deaths ✓ Trusting ✓ Lack of awareness of maternal death ✓ Ignorance ✓ Acceptance • Roles ✓ Village midwife post ✓ Midwife in the community ✓ Kader's role • Rational for choosing midwifery / selection for midwives ✓ Village midwife post ✓ Midwife in the community • Location / access for care ✓ Place of birth ✓ Place of antenatal care ✓ Health education	• Male domination • Respect for male opinion • Unmentionable of maternal death • Ignorance	• Male domination • Trusting of midwife • Including men	• Context / background (option /role) • Male as head of family	• In transition • Confused of equipment • Unmotivated • Public expectation high • Trusting • Accepting

Constructivist Criteria for Grounded Theory

Credibility	Has the research achieved intimate familiarity with the setting and topic?
	Are the data sufficient to merit claims? Have systematic observations been made between categories? Do the categories cover a wide range of observations?
	Are there strong links between the gathered data and the argument and analysis?
	Is there enough evidence for the claims to allow the reader to form and independent assessment and agree with the claims?
Originality	Are the categories fresh and offer new insights?
	Does the analysis provide a new conceptual rendering of the data?
	What is the social and theoretical significance of this work?
	How does the grounded theory challenge, extend current ideas and practices?
Resonance	Do the categories portray the fullness of the studies experience?
	Have the studies taken for granted meanings been revealed?
	Where the data drawn links between larger collectivities or institutions and individuals?
	Does the grounded theory make sense to the participants and give deeper insights?
Usefulness	Does the analysis offer interpretations that people can use in their everyday worlds?
	Do your analytic categories suggest any generic process? Have these generic processes been examined for tacit implications?
	Can the analysis spark further work in substantive area?
	How does your work contribute to knowledge and improving a better world?

Source: Charmaz (2006)

Demographic Information

(The Women)

No	Pseudonym	No of Pregnancies	No of Live Children	Any Miscarriage	Age (years)	Marital Status	No of People live in the Household	Education	Occupation
				Village 1					
1	Mardiana	2	1	No	24	Married	3	Junior High School	Housewife
2	Amalia	4	3	No	34	Married	5	Junior High School	Housewife
3	Erika	1	1	No	22	Married	4	Junior High School	Housewife
4	Rosa	1	0	No	21	Married	2	Senior High School	Housewife
5	Rina	3	2	No	36	Married	5	Junior High School	Housewife
6	Ipah	2	1	No	24	Married	3	Elementary School	Merchant
7	Ani	4	3	Yes (1)	38	Married	5	Junior High School	Merchant
				Village 2					
8	Imas	2	1	No	26	Married	5	Junior High School	Housewife
9	Rani	2	1	No	25	Married	7	Diploma	Housewife
10	Yasmin	1	1	No	24	Married	4	Junior High School	Housewife
11	Abia	4	3	No	35	Married	7	Elementary School	Housewife
12	Lydia	2	1	No	26	Married	2	Junior High School	Housewife
13	Dila	2	0	Yes (1)	23	Married	7	Junior High School	Housewife
14	Wati	2	1	No	28	Married	4	Senior High School	Housewife
15	Yuni	3	2	No	25	Married	4	Elementary School	Housewife
16	Eka	1	0	No	19	Married	6	Junior High School	Housewife
17	Fatma	2	1	No	24	Married	4	Junior High School	Housewife
18	Maya	2	1	No	22	Married	5	Elementary School	Housewife
19	Raihan	3	2	No	23	Married	4	Junior High School	Housewife

Demographic Information

(Family Members)

No	Pseudonym	Gender	Age (Years)	Marital Status	Relation to the Women	No of People live in the Household	Education	Occupation
Village 1								
1	Yandi	Male	28	Married	Husband of Mardiana	3	Senior High School	Craftsman
2	Mardi	Female	58	Widowed	Mother of Amalia	5	Elementary School	Housewife
3	Ida	Female	49	Married	Mother of Erika	4	Elementary School	Housewife
4	Mila	Female	29	Married	Sister of Rosa	4	Junior High School	Housewife
5	Zakia	Female	34	Married	Sister of Rina	4	Diploma	Nursery Teacher
6	Sufyan	Male	25	Married	Husband of Ipah	3	Senior High School	Construction Workers
7	Hasan	Male	24	Married	Husband of Ani	5	Junior High School	Merchant
Village 2								
8	Indah	Female	32	Married	Sister of Imas	5	Junior High School	Housewife
9	Ali	Male	32	Married	Husband of Abia	7	Elementary School	Driver
10	Hamdan	Male	30	Married	Husband of Lydia	2	Junior High School	Merchant
11	Siti	Female	62	Widowed	Mother of Maya	5	Elementary School	Housewife
12	Makmur	Male	34	Married	Husband of Wati	4	Junior High School	Construction Workers
13	Laila	Female	40	Married	Mother of Eka	6	Diploma	Housewife
14	Nur	Female	55	Married	Mother of Yuni	4	Elementary School	Housewife
15	Hindun	Female	52	Married	Mother of Raihan	5	Elementary School	Housewife

Demographic Information
(The Health Professionals)
Midwives

No	Pseudonym	Age (Years)	Education	Length of Working
Village 1				
1	Yana	35	Diploma in Midwifery	13 Years
2	Lisa	32	Diploma in Midwifery	8 Years
Village 2				
3	Ratna	38	Diploma in Midwifery	15 Years
4	Mariam	34	Diploma in Midwifery	12 Years
Outside Villages				
5	Rima	55	Diploma in Midwifery + Public Health Bachelor degree	35 Years
6	Darmi	53	Diploma in Midwifery + Public Health Bachelor degree	32 Years
7	Mulyani	51	Diploma in Midwifery + Public Health Bachelor degree	30 Years

Student Midwives

No	Pseudonym	Age (Years)	Education	Length Studying
1	Linda	19	Diploma in Midwifery	2 Years
2	Dewi	18	Diploma in Midwifery	2 Years
3	Wati	19	Diploma in Midwifery	2 Years
4	Nanda	19	Diploma in Midwifery	2 Years

Community Health Workers (Kader)

No	Pseudonym	Age (Years)	Education	Length of Working
Village 1				
1	Zahra	45	Junior High School	20 Years
Village 2				
2	Rahmi	43	Junior High School	15 Years
3	Farah	32	Senior High School	8 Years

(The Head of the Village)

Id Number of Participants	Age (Years)	Education	Length of Working
1	45	University	8 Years

Example of Interview Transcript

Interviewer (L): Researcher

Interviewee (I): Dila, 23 years old, 8 months pregnant, second pregnancy.

Interview Setting: Interview was conducted in Dila's house. The setting was in her front porch where the interviewer and interviewee were sat on chair next to each other. The interview was conducted on Thursday Morning at 10.30 pm

(Introduction)
(Start of Interview)

L:How do you feel about your pregnancy this time?

I: I'm feeling happy…and yes very happy…

L: Was it planned before?

I: Yes…me and my husband already planned it before because we'd lost our baby on my 3 months pregnancy before, so this is already a year since the last miscarriage so…we think this is the perfect time to get pregnant again.

L: And how do you feel about that?

I: I think…this is a precious pregnancy because we planned carefully about it…and…when the first time I got pregnant for my first pregnancy…it was planned as well…but when I got miscarriage I felt very sad…so now…yes I feel very happy that I got pregnant again…however of course I can't lie that I also worried about it….

L: What make you worried?

I: I'm worried that I will experienced the same like the first pregnancy…so sometimes I am very worried…worried if I will get any problems during this pregnancy…however I also see the obstetrician in order to make sure that my pregnancy is fine…

Like last week I went to see the obstetrician and consult about my pregnancy…when he said it is fine I felt relieved but later on if there are problems I might get worried again…

L: What kind of problems do you usually have during your pregnancy?

I: Well…it is not something very bad…like normally pregnant women had, for example on my first trimester, I got hyperemesis…but that was also not very severe…then it was disappear during my second trimester…now in third trimester…my only problem is just now I easily get tired sometimes get sweating easily…so…just normal problems that usually pregnant women had

L: Where do you usually go for the antenatal care?

I: Well….I usually visits both the midwife and the obstetrician in their private clinic. When the first time I found out that I got pregnant I directly visit the obstetrician…because of the history of my previous pregnancy…

L: What happened actually in your previous pregnancy?

I: Well…I had ectopic pregnancy before…then I had miscarriage on my third months of pregnancy…
So when I found out that I got pregnant again I went to see the obstetrician to find out whether my pregnancy this time is normal or another ectopic pregnancy…
When the doctor said it was normal so I felt little bit relieved…because the most important thing that it is not ectopic pregnancy again and it is normal…so I went to see him again on my sixth months pregnancy…during my second trimester…basically just to make sure that everything is okay…
During the third, fourth and my fifth months of pregnancy I went to see the midwives…I didn't see the doctor quite often…so far just three times during the early of my first, second and third semester…because I want to have a proper USG to make sure my baby is fine

L: So basically you go to see the obstetrician for USG and checking the baby's condition?

I: Yes…because I want to make sure that my pregnancy this time is not ectopic pregnancy and the baby growth normally…
I just feel secure if I did the USG because by that I know the condition of my baby…

That's why I regularly checked my pregnancy every trimester in order to find it growth normally based on the age of pregnancy…

I know for some people it is little bit too much…but might be because the history of my previous pregnancy so I have to make sure that I'm taking care of the current pregnancy very well... (Smile)…

Also…maybe because of my background as well…I graduated from the school of Midwifery…so I learnt a lot and knows about the pregnancy things and so on…so maybe the more you know the more you feel…worried (laughing)…you feel that you need to be careful I guess…I'm sure you know what I mean… (Smiling)…

L: So far how many times have done the antenatal visit?

I: Well…I went to the doctor three times every beginning of the trimester…and I went to see the midwives I think every month during my pregnancy

L: Why do you choose to see the obstetrician?

I: Well…like I said to you before I go there to find out very clearly about the condition of my pregnancy and my baby through the USG…and I could discuss with the obstetrician just in case if I have problems…

L: What about the midwives?

I: Well…because the midwives are the person who also have the knowledge best about the pregnancy…as Midwifery school graduated of course I understand that a midwife is understand enough about pregnancy and childbirth especially the normal pregnancy and childbirth…

So yes…sometimes the midwives also dealing with the normal problems…and I don't need to see the doctors quite often because I didn't have any serious one… also usually the midwife gives the prescription with the normal dose…unlike the obstetrician…sometimes they give us the prescription with a very high dose…just to handle the normal problems…so yes…that's why I went to see the midwives as well…

Also…I think the midwives have more experiences in handling the normal pregnancy and the birth processes…unlike the doctor, they usually handle the complicated pregnancy or birth processes…

Also I found out that doing consultation with the midwives is more comfortable…they are women as well and they experienced many normal pregnancies and births processes.

L: What do you usually discuss or consult with the midwives?

I: I discussed with her many things…like for example when I had my hyperemesis during the first trimester…she gave me lots of suggestions like eating with small portion of food but quite often…not eating very strong food like too spicy…too sour and so on…like how to reduce the pain on my knees when I entered the third trimester…
It just…if I had problems whether it is big or small problems I will directly consults and discuss with her…

L: Is that the midwife in this village or in the other part?

I: No…she's not the midwife in this village…from outside the village…

L: May I know the reason why do you choose the midwife from other/ outside the village?

I: Well…firstly I choose her (midwife from outside the village) to be my midwife is because she is one of the senior midwife with good reputation and she is also the sister of one of my friend in the school of midwifery (smile)
My friend just right after graduation she directly started working with her sister in her sister's private clinic…she is one of my best friend and I know her family…so I already feel comfortable with the midwife…with the fact that her sister who is also my friend is also working there…
I think if we got pregnant we want somebody whom we are comfortable with to be taking care of…

L:So you always go to the senior midwife's private clinic for the antenatal care then?

I:I was once went to the one of the village midwife…she is the neighbouring village midwife, because many people said including my neighbours said that she is a good midwife…even better than the midwives in our village…because she is more friendly and patients…more people love to go there…
I also feel that that is the closest place…so I don't need to travel very far to reach the midwife…
However I don't really like the place… I mean…it is not about the small size of her clinic but the delivery room and the examination room is become one…so I wasn't feel very comfortable with it…if we want to be examined and there is women also there who just giving a birth…share the same room so…I'm not

really comfortable…so I just went there once and after that I decided to go to my midwife right now…

L: So you don't feel comfortable because of her place? What about the midwives…I mean in terms of her skill for example…

I: Well…in terms of the skill…I think she is really good…she looks very patient and she explained all of our queries…

And like yesterday one of my neighbours just gave a birth with her…and according to her, the midwife is really patient and her skill in assisting the birth is really good…

Even now most of the women in our village prefer to go to her for assisting the births instead of the village midwife in here…

L:Why do you think that happened?

I: Well…people said…well… I actually never had any experience to do the antenatal care with the village midwife in here…but based on my experience having antenatal care with Mariam (the neighbouring village midwife) and based on what people said…Mariam is more patient…she speaks very gently and very caring person…so that's why many women prefer to go to her.

For me I like her as well but I really don't feel comfortable with her clinic…

L:I see…during your pregnancy…have you ever visited the health facilities in this village? For example the health centres?

I: No…I have never have antenatal care in the health centre…I don't know why…but…I've ever thought of going there once for the laboratory test during my pregnancy…but the obstetrician told me that I don't need the lab test so…yes I didn't go there…

Once…I've ever thought of visiting just once for my antenatal care in the health centre…just want to feel how it is…but my husband told me that many people telling us that there are many students there and the place is also less private so he is afraid that I am becoming the experiments for the students and both him and I didn't like the idea the less private situation for the antenatal care…also we couldn't discuss many things with the midwife there…so that's why finally we still go to the current midwife now…and we are very satisfied with her…

L: I see…during your pregnancy…who is the family member that provide you enough support so far?

I: Well…firstly of course it is my husband…he support me a lot…

And secondly…my parents…both of them my mother and dad…because we are all still living in the same house…my parents are already retired and they provide me many supports especially if my husband is not around for working…

L: Where is your husband working?

I: He is working in the Red Cross…so sometimes he leaves the house early in the morning and come back in late afternoon…

So my parents taking care of me…also they have more experience especially my mother…

But mostly…all my family are very supported…like for example my grandmother who lives behind our house sometimes comes and taking care of me…so yes…it is so lovely…you don't feel alone and feel very supported during pregnancy…(smile)

L: Yes…it is nice…however among all of them who do you think have the most part during your pregnancy?

I: Well…my husband…because he is the one who is responsible to me…so yes I think my husband…and he is also very supporting husband…he takes a good care of me (Smile)

L: I see…so have you both decided where you are going to give a birth for your baby?

I: Yes …we plan to give a birth in the clinic of our current midwife now…

L: Why do you decided to go there?

I: Well…because we are…especially me already feel comfortable with her and she is also a qualified midwife so I don't feel very worry if I have problems during delivery process for example…well of course…we are all don't want something bad happen…so yes…hopefully everything will be going smoothly…

L: What kind of preparation that both of you made so far…for the pregnancy?

I: So far…yes…for example preparing like where the place to give a birth…and if something bad happened which hospital should we go…something like

that…apart from that like room for our baby…his clothes…but all of my family are looking forward to greet the baby at home (Smile)

L: So…you will be expecting a baby boy? (Smile)

I: Yes…we are… (Smiling happily)

L: Ooh congratulation…I hope I could see him while I'm still in here?

I: Yes…sure…hopefully before you comeback there…

L:Right…so Dila…do you have anything more to say before I ended our conversation?

I: Hmm…maybe…I just want to add…sometimes being a mother for the first time is very exciting moment but also stressing moment…especially like me who had bad experience in miscarriage before…
Sometime you worried too much…but again you feel excited…so it is up and down emotional feelings…maybe also because during pregnancy you become more sensitive because of the changing hormone inside your body…so…emotional support…all the support I guess from your family is really needed…
So yes…I think that's all

L:All right…thank you very much Dila…for your time…sharing experience…I wish you a healthy pregnancy and hopefully the birth process will be smooth and easy…

I: Thank you…it's been my pleasure…you too good luck for your study…

L:Thank you

Example of Memo

12 September 2012

Support during Pregnancy and Childbirth

Pregnancy and childbirth are an intense physical and emotional experience for the women. Therefore support during this period is really important for the women. It is comforting to reassure that what is happening is normal and healthy. Both physical and emotional support required by the women from their surrounding environment. Family member can play a vital role in lending support and encouragement to the women. On the other hand, some women may also appreciate the encouragement and help from the caregivers or other people in their community.

Since my research is about community participation in improving maternal health; I think it is important to find out from the women whom I interviewed about how the community participate, or play a role during the period of pregnancy and childbirth. During the interview, I asked the women with a very basic question such as '*who is the most influence person during their pregnancy and/or childbirth?*' This question then, proposed further question on '*what kind of support do they received from this people?*'. From this question I could get an overview on how their surrounding/community participated during pregnancy and childbirth. This question also leads me to conduct the interview with their relevant family member also other community member that influenced the women during pregnancy and childbirth, as part of theoretical sampling in grounded theory.

Most women that I interviewed mentioned that family member is the main support for them during pregnancy and/or childbirth. Some of them referred to their husbands. However, some of the women also mentioned about their mothers or sisters which provide valuable support for them. In general, I divided family member support to be 'male family member support', which is the husband; and 'female family member' support which refer to the mothers and sisters. I found out that some women are more comfortable to get the support from only either the female or male family member. However, in general the women that I interviewed required both female and male family member support. Some women required specific support from their families in a specific

period as well. This was also confirmed by their relevant family members and the community that I interviewed.

Male family member support

Some women mentioned their husbands as the most influence family member during their pregnancy and childbirth. Most of them required their husband to accompany or join them during antenatal visit and mainly during the childbirth process. The majority of them need their husband, especially during the childbirth process and certainly the financial support from them.

Female family member support

Mothers and sisters are the majority of female family member that were mentioned by the women, as the support during their pregnancy and childbirth. Most of them required the female family member support, especially during the antenatal and postnatal care. They refer to female family member at this certain period, since they had some experiences of being pregnant and in a labour process, so they could share their knowledge and experiences. The women also felt more comfortable to discuss about the problems during this period with their mothers and sisters. Some assistance such as household and the childbearing process is the most valuable support that the women need, apart from the practical advices and suggestions during pregnancy and postnatal care.

Other community member

Some women also pointed out several people in the community that influenced and provided valuable support during pregnancy and childbirth. They mentioned about the community health workers or known as kader as the valuable support during pregnancy and childbirth. The kader provide some information and facilitating the women to the midwives, as the health service provider in the village. As most of the kaders are from and part of the community, hence most of the women are already familiar and comfortable to be taken care of by them. (Memo September, 2012)