

QUALITATIVE STUDY OF FAMILY SUPPORT FOR WOMEN'S HEALTH SEEKING-BEHAVIOUR IN RURAL AREAS DISTRICT SLEMAN

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ABSTRACT

Introduction: Health is a field that is very closely related to women's duties because the role of women is the reproductive role that is in the realm of the household. Health seeking behavior is preceded by a decision-making process that requires social support from spouses or other family members so that it can potentially improve the health status of women and children in the family. This study aims to explore the differences in family support for mothers in health seeking behavior when ANC, childbirth, and toddlers are sick in rural areas. **Methods:** The study was conducted using qualitative methods with in-depth interviews with 6 mothers, 6 husbands and 4 mother-in-laws who in their families had toddlers who had experienced illness in the last 3 months. The study was conducted in Banaran subvillage, Sleman District. **Results :** The results found that family support for maternal health seeking behavior during ANC, childbirth and when sick toddlers are always discussed by husband and wife, while the role of in-laws is very small, that is giving advice. In the condition of the childbirth, the family support not only from her husband and mother-in-laws but also from the whole extended family on the part of the mother who does not live in one house. **Conclusions:** In conclusion, mothers get considerable support from their families, both from their husbands, mother-in-laws or large families who do not live in the same house in health seeking behavior, especially during childbirth.

Keywords: family support; health seeking behavior

INTRODUCTION

Life in rural areas in patriarchal culture, men are dominant towards women which means that gender differences tend to be characterized not only in terms of differences, but from imbalances (Agger, Ben, 2009). Various studies of women show the fact is that in various aspects of women's lives it is always left behind, subordinated, marginalized and experiencing inequality and inequality in relations with men. In general, one of the characteristics of community life in rural areas is that family members as an economic unit are involved together in making final decisions.

Health is the main capital of development in a country. The health sector is a sector that is very close to the scope of duties of a woman. The role of care and maintenance of family health is very closely related to the role of women. Women are assumed to be responsible for health care (preventive measures) and care for the sick (curative efforts) therefore women's role is reproductive (in the domestic household). Social

support, especially from spouses and other family members, could be one of those determinants, and improving social support could have the potential to improve women's health.

Based on research into the behavior of women in Egypt including health seeking behavior known to be very strongly influenced by husband and mother-in-law after marriage (Yount KM, Agree EM., 2004)(Yount KM, 2005). Previous research with a cross-sectional study conducted by several researchers shows that women prefer to use Ante Natal Care (ANC) if they live in a large family (extended family) than in the nuclear family (Chiang C et al, 2012).

In many developing countries, where a man is typically the head of a household makes most of the household decisions and the wife experiences no equity in this process (Holland, 2010). For instance, men often control the financial matters no matter who earns the cash and make decisions regarding major household purchases. This translates into financial vulnerability and lack of autonomy of a woman

and more dependent on her spouse. In such cases, a woman who needs antenatal care has to rely on her husband's judgment and willingness to spend money on such cares. So, we hypothesize that the higher the participation in the household decisions making process by a woman, the higher is the likelihood that she would utilize the antenatal care in the developing countries (.Belayer Hossain and Ahmed A Hogue, 2015).

Family support for health seeking behavior indirectly affects the morbidity, MMR and IMR. The MMR in Indonesia ranges from 307/100,000 Live Births and Infant Mortality Rates (IMR) to 32/1,000 Live Births, while the Newborn Infant Mortality Rate (neonatal) is around 19/1,000 Live Births (Dinas Kesehatan Provinsi DIYogyakarta, 2012). Over several years, infant and child mortality rates have dropped both in urban and rural areas, except for neonatal deaths in rural areas which remain constant. According to the 2012 Indonesian Demographic and Health Survey in Yogyakarta Province the number of maternal deaths decreased from 56 cases in 2011 to 40 cases in 2012 according to reporting from the district health office, so when calculated the maternal mortality rate was reported at 87.3/100,000 Live birth. Even though the maternal mortality rate tends to decrease, fluctuations have occurred in the last 3-5 years. The Millennium Development Goals (MDG's) target for 2015 for the national Maternal Mortality Rate is 102/10000 Live Births and for DI Yogyakarta it is relatively close to the target, but it still requires hard and consistent efforts from all parties involved. The Maternal Mortality Rate of 87.6/100,000 Live Births is the number of mothers who died as many as 12 out of 13,697 Live Births. The number of maternal deaths (pregnant women, childbirth mothers, postpartum mothers) in Sleman District in 2012, recorded 12 mothers who died consisted of 3 maternal deaths, 7 childbirth mothers died 2 maternal deaths 2 people. The cause of death is due to ectopic pregnancy, postpartum bleeding, preeclampsia

and amniotic fluid embolism (Dinas Kesehatan Kabupaten Sleman, 2012).

Health is a field that is very closely related to the task of women, especially playing a role in reproduction in the household, including: pregnancy, childbirth, role in children's health and so on, so that family support is needed. A woman is more likely to use antenatal care (ANC) if they live with a large family than a nuclear family. Therefore, this research is very important to be done in order to identify and understand the determinants of maternal health seeking behavior. Especially aspects of social support from spouses or other family members. this form of support can be one of the determining factors that has the potential to improve women's health status (Ohashi et. Al, 2014). Based on this, this study aims to explore differences in family support for mothers. in health seeking behavior when ANC, childbirth, and toddlers are sick in rural areas.

METHODS

This type of research is a qualitative research with a case study design. The main topics to be explored are: a). Health seeking behavior and family support related to maternal health care (ie: decision making processes, selection of health care facilities, and certain family members who support mothers during pregnancy and childbirth; b). Maternal health seeking behavior and family support are related to maternal common illness when the child is sick (ie: decision making process, health service choices) Common illnesses include diarrhea, fever, cough and other common illnesses commonly found in the area. The sampling technique in this study was purposive sampling with certain criteria established by researchers. namely: the head of the family consisting of husband, mother, and in-laws who have children under five who live in one house. The number of research informants is 16 people (6 husbands, 6 mothers, and 4 mother-in-laws who have children under five years

Table 1 Characteristics of informants according to age, work, main breadwinner, and family form

No	Group	Age	Occupation	Main breadwinner	Family form
1	Mother n=6	28-38	House wife (n=5) work (n=1)	Husband	<i>Extended Family</i>
2	Husband n=6	26-46	Work (n=6)	Husband	<i>Extended Family</i>
3	Mother-in-laws n=4	50-60	House wife (n=4)	Husband	<i>Extended Family</i>

Source: Primary Data, 2016

determined by researchers in Banaran Hamlet, Cangkringan District, Sleman Regency who represent rural areas. For the validity of the data in this qualitative study using triangulation source. This study has been conducted in hold principle of research ethics No. 265.4/FIKES/PL/VII/2016.

RESULTS

Banaran is one of the hamlets that was affected by the Mount Merapi disaster some time ago and is located in Cangkringan Sub-district, Sleman District, Yogyakarta Province. The distance to the Cangkringan Health Center is approximately 2 Kilometers from the community's residence with a paved road condition. Transportation that can be used by the community in Banaran Hamlet is a private vehicle because public transportation is not yet available. The population of the resettled Banaran Hamlet is 126 families (402 people) with the majority of graduates from high school and the majority earn a living as farmers/agricultural owners and laborers.

Based on Table 1, the results of research by means of in-depth interviews obtained characteristics of informants that all informants came from large families, namely families consisting of husbands, wives and biological children, as well as other relatives, who came from the husband or wife. The work for all groups of mothers of childbearing age (28-38 years) is

mostly as housewives (IRT). The group of husbands of productive age (26-46 years) all work and are the main breadwinners in the family. The group of mother-in-laws are all elderly, namely 50-60 years.

The informant's knowledge of the ANC showed that all informants knew about antenatal care but were unable to answer precisely how many times the ANC had to be performed. Most of the informants said that routine antenatal care was done once a month. Although all informants did not answer correctly about prenatal care, but all informants had carried out routine pregnancy checks during pregnancy.

The selection of ANC service locations obtained information that the majority of informants in each group preferred private health services to government health services. The government health services chosen by a small number of informants, namely to the health center and Sardjito Hospital, were due to the informants working in the health service. Meanwhile, for the decision making of health services as ANC's place, most of them are in the hands of the husband, although it is preceded by a discussion between the husband and wife. There was a small number of informants from the mother's group who stated that decision making was in their hands.

This phenomenon is somewhat different in the conditions during the decision making process of health services during childbirth. In the

process of selecting health services during childbirth, most of the informants chose private health services and only a small proportion chose government health services. This result is the same as the selection of health services during ANC. A different phenomenon is found in the decision-making process in the selection of health services during childbirth, most of which decide to be a large family either living together or separated and only a small portion is decided by husband and wife. The interesting phenomenon is that the large families that have contributed to the decision to provide health services during childbirth are mostly from the mother's extended family compared to the husband's extended family.

Reasons for choosing health services during delivery 6 informants chose the factors based on the distance between health services and the place of residence. A small number of other informants chose because of the experience of others/relatives or their own experience. The behavior of the mother during illness during pregnancy shows that most of the informants will go to the nearest health service and only a small number decide not to bring it to health services or just leave it as stated by the informants from the group of mothers and husbands below:

"Just at home" (EW, 37 years old, June 13, 2016)

"So yes persevere" (not treated/hushed up) (ASL, (43 years), June 13, 2016)

Data collection by in-depth interviews for child health issues including the selection of health services when a child is sick and decision making for the selection of health services when a child is sick obtained for the selection of health services when a child is sick. family, or Mother and Child Hospital. Only a small proportion of them self-medicate by giving paracetamol if the child has a fever as stated in the statement of the husband's group below:

"Which ... most paracetamol is brought by the mother-in-law, usually ma'am" (EM (32 years), June 12, 2016)

"... yes, it depends on the problem if it's hot or using paracetamol ... I'm always available for those children" (JP (46 years), June 13, 2016)

Whereas for the decision makers in the selection of health services when the child is sick most of it is decided by the husband.

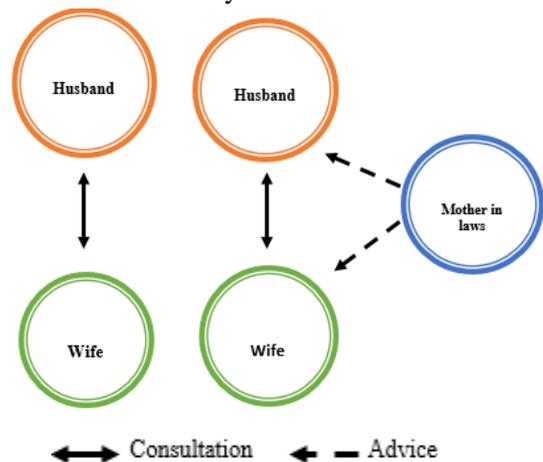


Figure 1 Communication pattern of decision making for ANC

The results of this study can also describe the communication patterns and decision-making processes in health seeking behavior in extended families. One of the patterns of communication that is formed is seen in the selection of health services during ANC (Figure 1), namely the first pattern that communication is only carried out by husband and wife only and the second pattern is the pattern of communication between husband and wife but there is a role of mother-in-laws in providing good advice through husband or wife. But what needs to be underlined is that the main decision maker as well as the largest portion remains in the hands of the husband despite the discussion between husband and wife, as contained in the statement below:

"To check pregnancy on the advice of husband and mother the midwife is still

a relative too" (DM (37 years), 12 June 2016)

"Yes myself and husband" (KR (28 years), June 13, 2016)

This statement is reinforced by statements from the husband group informants which clearly illustrate that the husband holds the main role in decision making as below:

"Yes, it's usually the same with my wife ... but my main decision making remains" (JP (46 years), June 13, 2016)

The role of mother-in-laws in making health service selection decisions when ANC is very small despite living in a large family as stated below:

"Limited to giving advice" (MRS (60 years), 12 June 2016))

"Do not give advice" (MS (50 years), June 13, 2016)

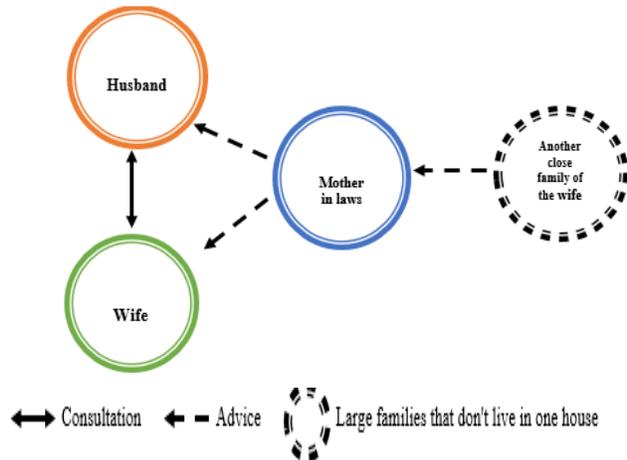


Figure 2 Communication patterns of decision making during childbirth

For communication patterns during childbirth a little different from the ANC (Figure 2), at the time of the ANC, the main decision maker is a husband so for giving birth advice is given by mother-in-laws and also from large families although not living in one house. So that the main decision maker shifts no longer in the

hands of the husband but the decision must be deliberated with a large family, especially a large family on the part of the mother as below:

"There was a discussion with a large family ...husband, my mother, and uncle then decided to the Sleman District Hospital" (EW (37 years) June 13, 2016)

"After being checked by the midwife, my husband and I went straight to the obsgyn doctor and then made a fault ... at that time there was a brother-in-law who was waiting ... I just obeyed (laughed)" (TR (38 years), June 13, 2016)

"Yes brother and aunt ... sir ketut my brother who decided to be referred to the Bhayangkara Hospital because he was a policeman and his wife also gave birth there" (KR (28 years), June 13, 2016)

The statement from the mother group informant was also strengthened by the group mother-in-law as stated below:

"...who decided first ... I, my son and uncle because my aunt worked at the health center and her daughter worked at Sardjito Hospital"(SMR (56 years), 12 June 2016)

"... who decided with her brother ..." (BDY (58 years), June 13, 2016)

The pattern of communication when the sick child is the main decision maker remains in the hands of her husband as shown below:

"Me and you ... but the one who decides is still you" (DM (37 years), 12 June 2016)

The statement from the mother group informant was strengthened by the statement from the husband group informant, namely:

"... If the child is ... me" (HR (26 years), June 13, 2016)

"Me and my wife ..." (ASL (43 years), June 13, 2016)

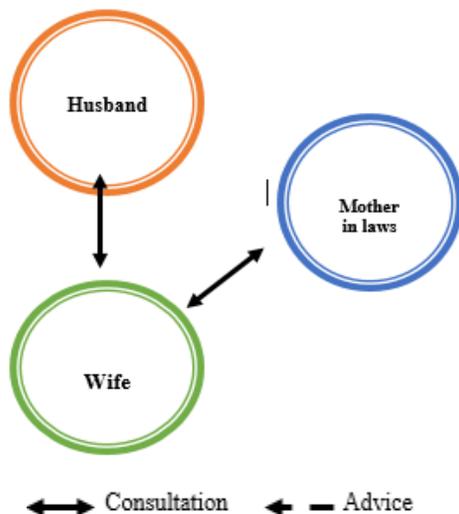


Figure 3 The pattern of communication decision making when a child is sick

The role of the mother-in-law is somewhat different from the decision making at ANC (Figure 3). If the ANC mother-in-law gives advice to the mother and husband while when the child is sick mother-in-law contributes to give advice only to the mother even though in the end the husband decides as the statement below:

"Yes, I myself suggest ... if someone is sick, they will immediately be taken to the midwife or doctor" (BDY (58 years), June 13, 2016)

"Yes ... suggest checking if I am taken to the midwife or to the nearest doctor, namely to Mrs. Joko" (MRS (60 years old), June 12, 2016)

DISCUSSIONS

Knowledge is one of the predisposing factors that determine a person's health behavior (Lawrence Green., 2004). Such knowledge can be obtained from formal education, counseling or

information from the mass media. Factors that influence attitudes and behavior one of them is knowledge. Knowledge is the result of "knowing" and this happens after people perceive a particular object. Sensing occurs through human sensing, namely: the sense of sight, hearing, smell, taste and touch. Most of human knowledge is obtained through the eyes and ears (Notoatmodjo, Sukidjo, 2007). Knowledge or cognitive are very important factors in shaping a person's behavior (health seeking behavior) (Notoatmodjo, Sukidjo, 2003). The behavior of all pregnant women informants who always check their pregnancy to the health service routinely is one form that the mother's knowledge of the importance of ANC for early detection of high risk of pregnancy is very good even though all informants have not been appropriately answered about antenatal care. The results of this study are also supported by behavior theory Lawrence Green. Lawrence Green states that behavior is determined by three factors, one of which is a predisposing factor (predisposing factor) that is manifested in knowledge, attitudes, beliefs, beliefs and values (Lawrence Green., 2004).

Support is an effort given to others, both morally and materially, to motivate that person in carrying out activities (Sarwono Prawiroharjo, 2010). In addition to knowledge, family support is one factor that encourages seeking treatment when needed. This support is usually obtained from the social environment is people who are close around the mother including the husband and close family. For husband support is assistance given by the husband to the wife which consists of information or advice that can be in the form of verbal or non-verbal which causes the effect of action or emotionally beneficial to his wife (Martiyah, L, 2004). Family support can be participatory, that is to take part in monitoring and motivating pregnant women to check their pregnancy regularly to the health service. One tangible form of family support is the husband or other family members participating in suggesting

or delivering pregnant women to ANC. Family support is a supporting factor which, in principle, is an emotional and psychological activity given to mothers in the decision-making process of looking for health both in ANC activities, giving birth, when a mother is sick, and when a child is sick, such as diarrhea management efforts in infants who according to research have a relationship significant with family support (Ambari P, 2010).

Mother-in-laws in this study are mostly limited to giving advice not as a decision maker even though they are in a large family they have a very small share so that all decisions are left entirely to the child. In-laws do not influence the decision making process of seeking treatment in ANC or giving birth so that all decisions are based on discussion and communication between husband and wife (Belayer Hossain and Ahmed A Hogue, 2015). As a person ages, the pattern of technical and psychological maturity increases, and shows the maturity of the soul. Increasing age will also increase one's ability to make decisions, think rationally, control emotions and tolerate the views of others (Siagian, Sondang P, 2001).

The decision making process of seeking health behavior of mothers during ANC, giving birth, when sick mothers and sick children some informants stated that although there was discussion but the main decision maker was still held by the husband as the head of the family and the main breadwinner in the family. The results showed that decisions in child care as in the case of malaria were basically a joint process: 70.9% left home. In the health care process 68.1% of episodes of abnormalities involve several individuals. The involvement of mothers, fathers and other relatives in the management process of health services together follows different logics. Each care giver has a specific and complementary function depending on gender norms, intergenerational relations and family unit characteristics (Lalou, et al, 2009). Women's participation in decision making significantly

increases with increasing age, education and number of children. And women who work and make money have stronger opinions in decision making in a family than women who don't work. Women in rural areas do not play a less role in decision making than in urban areas (Senarath Upul et al, 2009). Based on studies of children's health generally focus on mothers. Mothers are usually a reference in the family for childhood illnesses, and research on child care in the family is usually shown indirectly through mothers (Castle, S, 1993) (Molyneux, S. C, 2002).

CONCLUSIONS

Family support both husband and mother-in-laws to the mother in health seeking behavior both during pregnancy, when the mother is sick and when the child is sick is very good by giving the mother a chance to go to health services. But for communication patterns differ in large families in rural areas. In the decision-making process during pregnancy most of the informants involved the mother but the main decision maker remained in the hands of the husband. When giving birth, most of the informants involved large families, especially from the mother, so at the time of delivery, the main decision maker was not in the hands of the husband, but more in large families, even though they did not live in one house. Most maternal informants choose private health services compared to government health services when they are sick. And a small portion of mother's informants chose to silence by not doing treatment when the condition is sick. Most of the informants stated that the husband as the main decision maker in the search for health when the mother is sick and the child is sick. Mother-in-laws also supports the mother in the search for health to health services both during pregnancy, childbirth, when the mother is sick or the child is ill but mother-in-laws have a share very little in the decision making process. Most of the informants mother-in-laws only limited to giving advice but for the main decision makers

left to husband and wife. Giving an understanding to the husband about gender equality needs to be done so as to increase the role of mothers in the decision making process for health seeking because children's health is generally focused on mothers and mothers are usually a reference in the family for children's illnesses. This research will better result if researched not only in rural areas but can be compared with urban areas and not only in extended families but can be compared with nuclear families for family support for mothers in health seeking behavior.

We would like to thank all those who have assisted in the implementation of research especially in funding the 2019 “Hibah Penelitian Dosen Pemula” by the Directorate of Research and Community Service, Directorate General of Research and Development Strengthening Ministry of Research, Technology and Higher Education of the Republic Indonesia. The parties involved in this research include: Banaran Hamlet Community, Cangkringan Sub-district, Sleman District.

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