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Experience of Midwives in Carrying Out Their Role of Assisting Pregnant Women

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Abstract. Maternal mortality is often caused by a lack of support which causes problems during pregnancy and delivery that tend to be resolved late. Midwives have a role in implementing assistance and monitoring of maternal and child health. The purpose of this study was to obtain a description of the assistance of pregnant women by midwives in carrying out their roles. This research is a qualitative study with a phenomenological approach involving 5 midwives and 1 public health worker. The results of this study indicate 7 themes including implementers, managers, educators, counselors, collaborators, advocators, and midwifery care. The theme description explains that midwives can carry out their roles well, but there are obstacles during implementation and require support from various parties for cooperation.

INTRODUCTION

Maternal mortality rates throughout the world become difficult to control from year to year due to acute obstetric and postpartum emergencies in the first 24 hours (1–3). The most common causes of maternal death were bleeding with a percentage of 39% and pregnancy anemia by 40%, the rest were eclampsia, infection, and chronic low energy (KEK) (4).

Maternal mortality is unavoidable due to unsolved problems during pregnancy, childbirth, and the puerperium (5). Worldwide, an estimated 830 women die as a result of pregnancy cases (3). Indonesia ranks in the top 5 highest MMR in ASEAN, while Semarang in 2015 was the second city with the highest MMR, then in the following year was third in Central Java(2,6,7).

This incident is one indicator of the lack of health monitoring in pregnant women, especially in traditional communities that have strong traditional beliefs(8). Pregnant women need assistance to be able to adapt well to the birth process (9,10).

Several studies have shown that good assistance from family and health workers can help pregnant women get support for their pregnancy (11–13). This study aims to obtain a description of the assistance of pregnant women by midwives in carrying out their roles.

METHOD

A qualitative study design was used in this study with a phenomenological approach. Participants involved in this study were 6 midwives from the PHC who had not been able to achieve the target of the MCH (Mother and Child Health) program.

The data was collected by conducting a focus group discussion and recorded using a voice recorder device integrated into the Blackberry smartphone, Lenovo, and Cybershot Sony pocket camera. In pocket cameras, the recording is done by taking videos during the FGD. Trustworthiness is carried out by involving external reviewers, conducting member checks on the results of interviews with participants as well as extending contact time with participants, creating and concise descriptions of research results. The triangulation stage is carried out by triangulating theory and triangulating sources through in-depth interviews with participants. The data collected were analyzed using thematic analysis

This research was conducted from August to September 2016 at the Rowosari Public Health Center. Ethical clearance approval from the Health Research Ethics Commission of the Diponegoro Faculty of Medicine number 833/EC/FK-RSDK/VIII/2016.

RESULTS AND DISCUSSION

Respondent Characteristics

Table 1. Characteristics of Respondents

No	Initials	Education	Age (Years)	Working Period (Years)
1.	P1	Diploma in Midwifery	50	25
2.	P2	Diploma in Midwifery	30	1
3.	P3	Diploma in Midwifery	51	27
4.	P4	Diploma in Midwifery	28	2
5.	P5	Diploma in Midwifery	29	2
6.	P6	Master of Health	46	25

Table 1 shows that most of the participants had a Diploma in Midwifery education, with a maximum working period of 25 years and at most over 45 years of age.

Description of the main duties of midwives in assisting pregnant women from the Midwife group is known in seven themes including implementers, managers, educators, counselors, collaborators, advocates, and midwifery care.

The Implementer

The implementing theme is described through two sub-themes, namely ANC by midwives, intranatal by midwives, postpartum by midwives, and neonatal care by midwives. The ANC sub-theme was identified with the pregnancy care focus category. The Midwife group gave the following statements:

> *"Routine checks are by the 10 T protocol, complete laboratory, HbsAg, laboratory examination must go to the PHC, weigh body weight and height, check blood pressure, nutritional status (measure LILA) if there is LILA deficiency, examination of uterine fundal height, fetal presentation and fetal heart rate (FHR), Tetanus Toxoid (TT) immunization if necessary, administration of iron tablets, case management, counseling, class services for pregnant women, classes for pregnant women, providing counseling (counseling) "(Group Midwife)*

The intranatal sub-theme by midwives is known as the category of delivery management. The midwife group gave the following statements:

> *"Intranatal treatment or childbirth is still rare. If it is not possible, usually we will help, evaluate hiss or an opening of more than 4 cm, start using a partograph "(Midwife group)*

The postpartum sub-theme by midwives is known as the focus category of postpartum care. The midwife group gave the following statements:

> *"We also carry out KF (postpartum visit) until the postpartum period is over ... then continued with counseling on the importance of postpartum family planning, blood pressure checks, fundal height, conditions of birth canal wounds, progress on delivery, maternal intake, breastfeeding, breast milk, monitoring of maternal nutrition, counseling, family planning, visits to the patient's home are carried out if there are problems with tension "(Midwife group)*

The sub-theme of neonatal care by midwives is known as the baby care focus category. The midwife group gave the following statements:

> *"Neonatal care is usually seen whether the umbilical cord is dry or not, the general condition of the child, the status of breastfeeding the baby or the ability to breastfeed well or not, the immunization status, counseling at the posyandu about breastfeeding, complementary feeding so you don't rush" (Midwife Group)*

> *"Nursing for newborns...what is studied is usually the baby's condition in general, the umbilical cord, immunization status, body weight, and breastfeeding ... besides that, it also helps with immunization ... Immunization services ... As well as conducting visits... Simultaneously with the visit ... the postpartum mother 4 times... "(P4)*

> "*Nursing for newborns at posyandu, monitoring the baby's condition including immunization, general condition, body weight, breastfeeding or not, the umbilical cord is dry or not ..... Exclusive breastfeeding.... (P5) "*

Midwives carry out their roles well in which all their mandatory roles as an implementer, manager, educator, counselor, collaborator, advocator have been fulfilled. Dhiah Farida Ariyanti agrees with the midwife group that mentoring pregnant women are the authority and responsibility of the midwife (14). The mentoring activities stated by the midwife group are in accordance with the contents of the assistance program for pregnant women formulated in the OSOC (One Student One Client) mentoring program by the Central Java Provincial Health Office(15).

According to the professional service standards of midwives, the role as executor is shown in the implementation of antenatal care, intranatal care, postnatal care, and neonatal care which are included in the provision of primary services (16). The role of the midwife as implementer is to carry out examinations according to 10 T standards such as weighing, measuring LILA, measuring blood pressure, measuring fundal height, calculating Fetal Heart Rate (FHR), fetal presentation, Tetanus Toxoid (TT) immunization, blood booster tablets (Fe tablets), laboratory examinations, case management or handling, pregnancy classes and counseling. This is reinforced by research conducted by Lisa Marniyati regarding ANC services which refers to 10 T checks according to antenatal care service standards according to integrated antenatal care guidelines and midwife professional standards (16-18).

Intranatal services for PHC that do not yet have inpatient facilities and delivery rooms are in the form of providing delivery management by monitoring the progress of hiss (contraction) to decide the action to be taken. This action is to refer pregnant women and manage deliveries at the PHC if conditions are not possible for referrals. However, the incidence of delivery at outpatient PHC is very rare. The obstacle to the unavailability of delivery room facilities

is the main factor that midwives who work in non-inpatient health centers are unable to carry out assistance for pregnant women properly, especially in obstetric care for childbirth and postpartum midwifery care.

This situation is due to the fact that midwives in non-inpatient health centers do not have main or supporting tasks in handling delivery and postpartum care, only postpartum care visit services (first - third postpartum visit). The PPSDM Agency explains that delivery care is carried out in the concept of assisting deliveries to be referred to a more complete health facility (19). This contradicts the professional standards of midwives which explain that midwives are expected to be able to provide high-quality delivery or intranatal care while still paying attention to local cultural wisdom during labor, leading to safe and clean delivery, and being able to handle emergency conditions (16).

The Manager

The management theme is described through the MCH administration category. The Midwife group provided the following statements:

> *"Completing the administrative task of midwifery reports, reports on monitoring local areas, data collection of high-risk pregnant women in these areas, data collection for pregnant women, we work with cadres (Midwife group).*

The role of the manager is shown by the activity of midwives in managing MCH statistics related to reports and administrative data related to MCH cases at the PHC. Through their role as managers, midwives can also act as planners in handling clients of pregnant women, especially high-risk pregnant women. This role is in accordance with one of the professional standards of a midwife in midwifery services, such as administrative and management standards that already have guidelines, service standards, and regular procedures (16).

The Educator

Educator themes are described through categories of providing information. The midwife group stated the category of society in the statement, as follows:

> *"Refreshing cadres to provide basic knowledge of monitoring pregnant women motivates every pregnant woman. There is also a response from the community, especially the families of pregnant women to take them to health services "(Midwife group)*

The role of midwives as educators is here as a provider of information to the community (patient's family) as well as academics or students who carry out education and research. Midwives play a role in educating families, especially as supporting mothers, which is in line with Nurul aeni's research on the importance of providing information to families, especially husbands or people who live in the same house, and research by Nuraeni et al about the importance of education for couples (20, 21).

The Counsellor

The counsellor theme is described through the health service briefing categories. The midwife group gave the following statements:

> *"If pregnant women are found for the first time, they are advised to go to the PHC." (Midwife group)*

The role of the midwife as a counselor in mentoring is shown in community guidance activities to obtain health services. Midwives motivate pregnant women to carry out antenatal care at the PHC. Besides, midwives also provide counseling on family planning and breastfeeding. According to research by Nuning Arsyaningsih, et al, health education or counseling is a very important element for clients, besides it will affect the quality of the interaction between midwives and

patients, which can lead to an interest in repeated visits (22).

The Collaborator

The collaborator theme is described by the category referral by midwives. The midwife group gave the following statements:

> *"If there are risk factors or risks, we will immediately refer to them. Also if there is refer to it. We have to pay attention to referrals, give referrals to general practitioners, we refer to them according to the existing protocol. If there is a labor emergency and it is no longer possible to refer to it, the midwife will supervise and assist the delivery "(Midwife group)*
>
> *"Pregnant women who have risk factors must give birth in the hospital ..." (P4)*
>
> *"... We try to refer patients to higher health facilities ... if they ask for medicine, they will be referred here ...." (P5)*
>
> *"... if there is an emergency (emergency) childbirth ... the average person who accompanies (refers) the midwife ..." (P6)*

Collaboration is a form of midwifery service and the level carried out by midwives is horizontal referrals, while vertical referrals are approved by the PHC doctor (midwife as a companion for the patient) (16, 23). As collaborators, midwives apply a referral system in 3 things as follows: case finding of emergency (emergency), pregnant women with risk factors, and management referrals.

The Advocator

Advocate themes are described through the safety category of pregnant women. The Midwife group made the statement, as follows:

> *"So, when referring patients, we must pay attention to the requirements for referring patients" (Midwife group)*

The role of the midwife as an advocate is demonstrated in the referral procedure that involves multiple professions (nurses and doctors) and the completeness of the terms of reference for the safety of mothers and babies. Refer which is carried out by midwives is a vertical referral after obtaining PHC's doctor approval (23). According to Indarwati's research on National Referral Standards, midwives have started to carry out reconciliation using these standards although there are still shortcomings and obstacles (24).

The Midwifery Care

The theme of midwifery care in assisting pregnant women is described through categories of obligations, mentoring activities, pregnancy assistants and obstacles to midwives. The category of obligations expressed by the midwives group in the statement is as follows:

> *"As a midwife, it is our duty and responsibility if there are pregnant women, they must always accompany them as midwives at PHC. As well as still suggesting that pregnant women during childbirth must be in the hospital, not necessarily in an independent practice midwife because it is not the authority of an independent practicing midwife.)*

The category of mentoring activities is expressed by the midwife group in the statement, as follows:

> *". All pregnant women are provided with services. If we carry out a posyandu, we provide counseling, services, provisioning, examinations, and provide monitoring ... The care of pregnant women up to the postpartum period ... strategy, not checking things. "(Midwife group)*

The categories of other pregnancy assistants were expressed by the midwives' group in the following statements:

> *"We also approach the cadre women who have actually taken part, depending on the coordination of how the cadres want ...*

Gasurkesh also carries out assistance for pregnant women ....." (Midwife group)

"... Cadre members who participate in monitoring and there is usually a routine meeting of cadres who report the results to us too" (P5)

"...there are cadres ... These cadres meet every day or almost every day ... the involvement of PHC's doctors ...the person in charge of all activities both at KIA and at BP is by a doctor ..... Gasurkesh is to monitor pregnant women with certain targets.... "(P6)

Midwives who serve mentoring also experience problems. This is known from the statement of the midwife group in the theme of Midwifery Care for pregnant women assistance with the sub-theme of mentoring coverage and the category of obstacle midwives. The midwife's obstacle category was expressed by the midwife group in the statement, as follows:

"The implementation of posyandu services outside PHC is indeed constrained by the limited space and equipment. On the other hand, technology is getting more advanced, they can search on google and they think that when the obstetrician checks here, the examination is complete so sometimes they don't open the door for us. Another obstacle is the problem of human resources and demographics, the house is far away. "(Midwife group)

"... Sometimes mothers like to find information on the internet (technology) ... gathering pregnant women is rather difficult (limited) ..." (P4)

"Sometimes pregnant women don't want to have themselves checked out because pregnancy is considered a common occurrence, especially if their house is far from PHC" (P5)

The government in an effort to reduce MMR has provided assistance to midwives in the form of mentoring programs by doctors, cadres, and gasurkesh. Mochtar said that pregnant women should be able to get pregnancy assistance services by general practitioners and obstetricians (25). Colti Sist Terbangi, et al in their research explained that assistance by cadres can trigger a mother's activity in maintaining maternal and child health (26). Gasurkes has a working range of the MCH program, including data collection and assistance to all pregnant women in their work area, assisting postpartum mothers, providing MCH counselling, filling pregnant women cohorts, filling delivery bags, ANC guidebooks, and reporting cases of maternal mortality in the coverage area of their work (27).

Midwives have problems in implementing the program. These constraints include the problem of distant patient homes, technological advances that make patients reluctant to visit, the limited availability of infrastructure during posyandu, the patient does not open the door when conducting a home visit, and the status of having checked with an ob-gyn specialist as an inhibiting factor in assisting pregnant women.

Demographic problems such as affordability of health facilities play a role in the success of the assistance program for pregnant women, especially ANC visits, as in the research of Rahma Erlina, et al(28). The effect of technology revealed by the midwife group is in line with Intyaswati's research, namely, currently, pregnant women like to seek information from electronic media including from the internet. (29) Patients' rejection of midwives who carry out home visits should not occur because according to Mediana Dwidiyanti's research, patients can participate become partners in health administration (30). Nuning Arsyaningsih's statement, that clients tend to choose health service places with more complete facilities and infrastructure strengthens the opinion of the midwife group regarding pregnant women who are reluctant to come to the posyandu because of limited equipment (22).

CONCLUSIONS

The role of assisting pregnant women is the main task and task of supporting midwives in both Outpatient and Inpatient PHCs. Obstacles faced by midwives include the problem of the patient's home is far from PHC, technological advances that make patients reluctant to visit PHC, the limited availability of infrastructure, the patient does not open the door when conducting a home visit. Status has been checked by a gynecologist as one of the inhibiting factors for pregnant women to go to the PHC because they feel they have been monitored enough. Assistance from the government in an effort to reduce MMR in the form of participation by doctors, cadres, and GASURKESH.

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