

Gender and Fatalism in The Reality of Pregnancy, Childbirth and Maternal Death in Minangkabau

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Abstract. Maternal death due to pregnancy and childbirth is a reality that leaves many concerns because a mother should not suffer or die because of carrying out reproductive functions. A woman's chances of dying or becoming disabled during pregnancy and childbirth are closely related to her social and economic status, cultural norms, the geographical remoteness of her residence, to the gender relations that surround her. These variables can directly or indirectly affect mothers' access to health services. This paper highlights one of these variables and describes how gender relations in the Minangkabau family can be barriers for mothers to obtain health services during pregnancy and childbirth. Method. This research is qualitative exploratory through cases encountered in the field. They use observation techniques and semi-structural interviews guided by a list of questions to answer the research objectives. Results. Women decide matters relating to reproductive rights and events based on the attitude of their husbands and the experiences of senior women in the family. Educational and financial limitations reinforce this. There are restrictions on women's autonomy in decision-making, which affects their access to health services. The need to obtain health services during pregnancy considers the opinions of husbands, mothers-in-law, and mothers or grandmothers. Conclusion. Gender value systems and traditional experiences of senior women underlie women's procrastination towards their health needs. This attitude fosters an attitude of fatalism that makes women ignore the fulfillment of the demand for adequate health services.

Keywords: gender, fatalism, reality of maternity pregnancy, maternal death

1 Introduction

A woman's chances of dying or being disabled during pregnancy and childbirth are closely related to her social and economic status, cultural norms, gender relations in social circumstances, and the geographical remoteness of her residence. A woman's lifetime risk of dying from pregnancy or childbirth is 1 for every 39 deliveries in Sub-Saharan Africa, compared with 1 for 4,700 deliveries in industrialized countries and 1 in 278 in Indonesia . The fact that mortality rates reflect the difference between rich and developing countries more than any other measure of health, the poorer and marginalized a woman is, the greater her risk of death (UNFPA, 2012) .

Based on the WHO report in 2013, Indonesia successfully reduced the maternal mortality rate (MMR) through the MDGs period (1990-2013), although only 56% of the 75% targeted by the MDGs program . This effort is slower than other Southeast Asian countries. Many studies have been conducted to understand what variables can affect the quality of maternal health during pregnancy and childbirth. Pregnancy and childbirth are biological events that should occur naturally for women. However, this phase is also an additional physical burden for women

when carrying out their reproductive functions: women's risk (morbidity) and death (mortality) increases during this phase. Research on causes of death and maternal mortality in the last two decades between 2003-2015 covers 115 countries, in 23 research units that meet the requirements, as well as 417 data packages and approximately 60,799 cases of maternal death, explaining the fact that 73% of maternal deaths are caused by direct obstetric factors and 25% due to indirect obstetric factors (Jan.J Hofman 2014; Kassebaum 2016).

Obstetric factors or often referred to as direct clinical variables, include Haemorrhage, hypertension, sepsis, embolism, prolonged labor, and abortion. The results of research on maternal mortality report that maternal complications are not always predictable, but medical complications have a chance to be managed, and death can be prevented. The mechanism for early detection of high-risk during pregnancy does not always give the proper signal. Meanwhile, indirect obstetric causes are related to socio-cultural psychology variables and geography, contributing to worsening maternal complications. These factors related to the delay include gender norms and relations, family structure, values and preferences for children, economic and educational status, local geographic conditions, behavior in accessing health facilities, and available health services.

Meanwhile, in another explanation in more detail, dr. Abdullah Cholil.MPH sees from the point of view of social, cultural, and religious factors, among others; husbands and families of pregnant women do not know and are not responsive to the conditions of each pregnant woman who are at risk, the workload of the mother as a breadwinner, and the allocation of household work is still the same when the mother is not pregnant. Religion, on the one hand, legitimizes the tendency of people to have many children, and there is rarely a study of religion that renews the notion of the role of husbands/society to help pregnant women and give birth. Pregnancy and childbirth are considered a woman's nature, and death due to pregnancy and childbirth is given a noble value as a martyr's death.

Indicators of these socio-cultural variables can be interrelated and determine the mother's position and decisions related to the needs of the mother. Gender preferences, for example, will determine the mother's position in the family structure and decision-making patterns. Similarly, the variables of values and preferences for children, economic status, and education are suspected to be related to the meaning of pregnancy and maternal delivery. Meanwhile, more external variables such as low levels of education, lack of health knowledge, problems with poor environmental sanitation, poor nutrition, economic constraints to transportation constraints, and distance to service centers will determine the behavior of mothers in accessing available health facilities and facilities.

This paper aims to describe the reality of gender relations around pregnant women giving birth in the Minangkabau socio-cultural context. First, the issues to be explained are how local cognition comes from the traditional understanding of maternity pregnancy, and secondly, actions that represent gender relations and their influence on maternal access to health facilities and the quality of health of pregnant women in childbirth.

2 Literature Review

Global Concern for Women's Health

The International Conference on Population and Development held in 1994 in Cairo has emphasized equality that men and women can play in women's health issues. The conference started from the lack of involvement of men in women's health issues, especially those related

to reproductive health. Many research results show that belief systems of traditional communities and traditional customs often have decision-making mechanisms and strategies based on gender relations, which can prevent certain genders from participating or limiting their authority in making important decisions related to themselves.

The conference emphasized the need for positive male involvement, which is defined as mental and physical participation, which is believed to improve maternal and fetal survival (USAID, 2009). The conference also recommended that the value of investing in women and girls is the key to improving the quality of life for all and emphasized the importance of sexual and reproductive health, including family planning, as a prerequisite for women's empowerment.

Gender, Culture, and Health Behavior

Gender and culture are two entities that are attached. Both can be seen as realities with interrelationships that give meaning to individuals in their society or become community presentations through unique individual performances. Roles, statuses, and attributes inherent in a person's behavioral system result from the formation of his social system regarding appropriate masculine and feminine roles and become a mental map for individuals to act. In this context, gender is a mental map manifested in various social institutions, belief systems, norms, and behavior systems .

In several studies, experts have found that gender norms sometimes result in an imbalance of power, affecting essential decisions related to maternal reproductive health . Individuals make sense of their identity and social expectations through appropriate masculine and feminine roles. Sometimes gender norms and relations result in power imbalances that influence decisions about maternal health and family planning. Masculinity can be an ideology that can determine men's beliefs about equal rights in obtaining health care. In many cultural experiences, this attention leads to negative attitudes, so it is common to find women's reproductive health influenced by gender relations in society. Interactions between gender norms and other cultural beliefs sometimes work as a factor that exacerbates unsafe sex practices and other health risks .

USAID (2009) campaigned for the importance of positive participation from men for maternal health, which was built through communication, even though this meant breaking through the norms and cultural barriers that limit men's involvement. The passive role of men in the reality of maternal health, such as neglecting the use of contraception methods, lack of understanding and lack of attention needed by mothers during pregnancy to give birth to physical violence; starting from the fact that mothers continue to work during pregnancy and sometimes after childbirth and other intentional physical violence. These facts exacerbate and increase the risk of maternal health.

For the case in Indonesia itself, the program to improve the quality of maternal health was initiated by ratifying the safe motherhood and making pregnancy safer programs from WHO through three mechanisms: prevention of pregnancy, the anticipation of complications during pregnancy and childbirth, and strong management of complications. Indonesia has lowered the program's spirit in the form of the maternal affection movement intending to increase public awareness of the health quality of pregnant women in childbirth and the standby husband program, which aims to educate husbands to understand and accompany their wives during pregnancy and after delivery.

Research by Fadzria (2014) found that most husbands (67.4%) could not stand accompanying during pregnancy and childbirth and found a significant relationship with the husband's knowledge and education level. Another research by Suryondari (2010) found a substantial connection between the husband's knowledge of the standby husband program and

the readiness of the husband to accompany his wife during pregnancy and childbirth. These studies show the need for cognitive changes to change men's understanding of women's reproductive health.

Research by Yunarti in West Sumatra (2014, 2015) found a link between local etiology of pregnancy and childbirth, which plays a role in explaining men's behavior towards pregnant or giving birth. In local knowledge, pregnancy is part of a divine event, and the role of men as the cause of pregnancy is considered passive. There is a traditional understanding that pregnancy and childbirth are special events that only adult women can understand and deal with. Men, adolescent girls, and children are 'distanced' from the reality of pregnancy and childbirth. Married adult women are the people who are considered most relevant to accompany mothers.

3 Methodology

This material is part of research on socio-cultural factors that influence the health behavior of pregnant women in childbirth. This research is qualitative, with the research location being Padang City, Agam Regency, and Pesisir Selatan Regency with purposively selected sub-districts and Nagari following the research objective, namely having cases of maternal mortality in pregnant women. The approach chosen is a naturalistic approach that is considered in accordance with the research objectives. The method used in data collection is an exploratory study and in-depth interview method accompanied by observation.

Gender issues are drawn from relevant information under the theme of socio-cultural factors that affect the quality of maternal health during pregnancy and childbirth. The total informants who have been interviewed are 42 informants who have been pregnant in the last year, 6 cases of maternal death and three critical cases with mothers who survived death, 12 family members of pregnant/delivery women, three village midwives, six health cadres, and six traditional birth attendants as well as formal leaders in the field of health and local government and informal leaders from traditional, religious and community circles.

4 Result and Discussion

There are four types of field data and discussions that I would like to convey. The first is a description of the characteristics of the informant mothers whom we interviewed and observed the variables of their socioeconomic status, fertility status, cases of morbidity, and mortality, which aims to see and understand the background of the informants. The second, third, and fourth sections are related to each other, explaining the community's local cognition about pregnancy, childbirth, and maternal mortality. The following is the finding data matrix:

Field Data Summary Variables and Indicators

Variables and Indicators		Field Data Summary
1	Demography data and Characteristics of pregnant women and giving birth (N:42)	Couples of childbearing age cover 40% of the population Mother's and husband's education level: 10% elementary school, 20% junior high school, 45% high school, and 25% college. Mother's occupation: Not working 67% Average household income: under 3 million rupiahs per month

		<p>The average number of household members is five people Average spending allocation per person per month Rp 523,512 First marriage under 20 years and over 33 years: 28% First pregnancy under 20 years and above 35 years: 23% Age of last pregnancy 37-41 years: 19% Cases of miscarriage 5% Cases of stillbirth 12% The case of the mother died 6 people Critical mother case survived 3 people</p>
2	Local knowledge about pregnancy and childbirth	<p>A blurred understanding of the physiology of pregnancy and childbirth – symbolization Pregnancy as a natural reality with a transcendent charge Curative rather than preventive tendencies Complaints during pregnancy: considered as things that will go away by itself (except bleeding)</p>
3	Gender relations and maternal accessibility to health services and facilities	<p>Pregnancy and childbirth are the realm of adult women: children, youth and men are at a distance from this reality. Adult women in the family as guardians and supervisors of mothers during pregnancy until after delivery. The experience of pregnancy and childbirth for senior women becomes a role model and consideration for the mother's behavior during pregnancy and childbirth Neglect, delay of mothers to get Yankes, is reinforced by variables of financial ability and education level.</p>
4	Culture, gender and fatalism	<p>Culture and traditions about pregnancy limit women in the discourse of maternal traditions. The transcendental value of pregnancy minimizes the mother's best efforts. Discourse on motherhood limits the participation of men (husbands). Maternal deaths due to pregnancy and childbirth are considered as martyrdom/death that is noble and rewarded by heaven. The experience of senior women is an important reference for action.</p>

Source: primary data 2016, 2019

A mother's understanding of how pregnancy can occur in the mother's stomach can explain the rationality of mothers in the care of pregnancy and childbirth. There is a reasonably vague physiological picture where pregnancy is described by symbolizing the growth of plants. The soil is a symbol for the womb, and the plant seed is a symbol for sperm. Rain, water, sun as required conditions for plant fertility are a symbol of God's requirements. The informant's explanation is that it is necessary to have sexual intercourse between a man and a woman, where it is the moment when the sperm fluid enters the woman's womb.

According to the informant, the embryo of a fetus can only be formed if the condition of a fertile uterus is not 'hot' and not 'cold,' the sperm is healthy, and there is permission and 'blessing' from God. And God's intervention is believed to continue in the stages of fetal development in the mother's womb until the time of delivery arrives when the fetus is 'turned on by God on the 120th day, and its fate line will later be outlined as its destiny.

Pregnancy and childbirth are entirely understood as natural phenomena but are filled with destiny and transcendent elements. McCormack (1982) explains that pregnancy and childbirth in many rural communities represent the concept of cosmology and balance, which is manifested in the mother's body as a microcosm vessel. This concept holds that the individual is part of a

whole complex system that continuously maintains its balance, and humans are considered to have limited intervention.

The social environment of senior women around the mother is a source of knowledge about pregnancy and childbirth. Complaints that occur during pregnancy or childbirth are considered as just a matter of pregnancy that will go away on their own, and this is strengthened and linked to the experiences of previous senior women (mothers, grandmothers, aunts, and other adult women), which causes mothers to delay and let complaints with confidence will disappear quickly itself.

Delay and neglect of complaints have the potential to develop into a risky condition for the mother and are often only really treated when the condition worsens. This condition is increasingly driven by the financial situation and the mother's common knowledge and formal education. This situation explains the logic of the consistency of the mother's behavior which tends to be curative, seeking medical help, especially for critical events such as bleeding. At the same time, other complaints are often postponed because they are believed to go away on their own.

The gender norms of Minangkabau society also place pregnancy and childbirth as the domain of married adult women, not something that men and younger family members need to know about. Finally, women are limited by traditional discourses about pregnancy and childbirth (destiny and divine intervention, and the absence of men). The experience of senior women becomes the reference for action. Maternal death due to pregnancy and childbirth is considered a noble death, and in the end, this all minimizes the best efforts that mothers can make in utilizing health facilities.

4 Conclusion

Beliefs and values in maternity health institutions are a reflection of the overall view of life. Pregnancy and childbirth are bound by traditions and belief systems that are unique in symbols and supernatural elements that explain the basics of social balance. According to local interpretations, healthy pregnancy and childbirth are often an effort to maintain a balance of social relations and relationships with transcendent elements through various rituals, imperatives, and taboos. However, sometimes they are counter-productive to modern health principles. The gender value system and traditional experiences of senior women influence and underlie women's procrastination attitudes towards their health needs, fostering a fatalistic attitude that makes women ignore and delay the fulfillment of adequate maternity health services when needed.

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