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Family Experiences in Critical Decision-Making During the Perinatal Period: A Phenomenological Study

Dewi Setyoningsih, Wulandari, Lisna, Lathifatul
ITB AAS Indonesia
dewisetyoningsihh@gmail.com

Abstract

The Maternal Mortality Rate (MMR) is one of the indicators used to assess women's health status. Maternal mortality remains a complex issue and is caused by the three delays (delayed recognition of pregnancy complications, delayed decision-making, and delayed access to healthcare facilities). The aim of this study was to identify the role of family involvement, particularly that of husbands, in maternal health and to explore decision-making patterns within families related to perinatal complications. This was a descriptive qualitative study using a phenomenological approach. The study involved six married couples in Klampok, Sidoharjo, Wonogiri. Decision-making in families, particularly regarding maternal health, is generally still dominated by husbands due to cultural factors and their role as breadwinners. Wives' involvement increases when they have better education, knowledge, and economic access. Families with limited access tend to delay the use of healthcare services, highlighting the importance of increasing women's involvement and access to information to support maternal health. Family decision-making, particularly regarding maternal health, is still largely dominated by husbands as the main authority figure. Although ideally decisions should be made through mutual discussion, in reality, only a few families truly reach a joint agreement. This dominance is influenced by various socioeconomic factors, such as knowledge level, education, occupation, cultural values, and the mother's health condition.

Keywords: Family decision-making, Perinatal complications, Maternal health

Introduction

The Maternal Mortality Rate (MMR) is a critical indicator of women's health status and is a key target of the third Sustainable Development Goal (SDG), which aims to ensure healthy lives and promote well-being for all at all ages. In Indonesia, the MMR was recorded at 189 deaths per 100,000 live births in 2020, reflecting a decline from 390 deaths per 100,000 live births in 1991. Despite this improvement, further efforts are required to achieve the SDG target of 70 per 100,000 live births by 2030 (Ministry of Health of the Republic of Indonesia, 2021).

Maternal mortality remains a complex issue, with causes often described using the “three delays” model: (1) delay at the family level in recognizing danger signs and making timely decisions to seek care, (2) delay in reaching healthcare facilities, and (3) delay in receiving appropriate care at healthcare facilities (Thaddeus & Maine, 1994).

Direct and indirect causes contribute significantly to maternal mortality. Direct causes include complications during pregnancy, childbirth, and the postpartum period. Data from the Maternal Perinatal Death Notification (MPDN) system indicates that the leading direct causes of maternal mortality are eclampsia (37.1%), postpartum hemorrhage (27.3%), and infection (10.4%). Indirect causes, which also have a substantial impact, are associated with the “4 Too's” (4T): too young (<20 years), too old (>35 years), too close birth intervals (<3 years), and too many children (>2 children) (Indonesian Ministry of Health, 2020).

Maternal and infant health are widely recognized as key determinants of community well-being. According to the family nursing framework, families have five essential health-related tasks: (1) recognizing health problems, (2) making decisions, (3) caring for sick family members, (4) modifying the environment, and (5) using healthcare services. In many households, these tasks often fall on the mother, who plays the dual role of caregiver and decision-maker (Friedman, Bowden, & Jones, 2018).

One of the main challenges in reducing maternal and neonatal mortality is delayed management of perinatal complications, whether these occur during pregnancy, childbirth, or the postpartum period. Timely and appropriate management is strongly influenced by the speed and quality of family-level decision-making.

In many contexts, including Wonogiri Regency, Indonesia, family decision-making processes are deeply influenced by sociocultural and economic factors. Family dynamics frequently place husbands or male relatives as the primary decision-makers, which directly affects the timeliness of responses to maternal and neonatal health emergencies (Mboi, 2021).

Family knowledge of perinatal danger signs, access to healthcare services, and the involvement of women in the decision-making process are critical elements in ensuring appropriate responses to complications. However, there remains a gap in the literature regarding families' lived experiences in navigating these situations, particularly within local settings such as Wonogiri Regency.

Research Method

This study employed a qualitative design with a phenomenological approach (Creswell & Poth, 2018). The participants consisted of six married couples (n = 12) selected through purposive sampling. Wives were women of childbearing age, engaged in various occupations, who had experienced maternal health issues and family-level decision-making processes, and who lived either in a nuclear family or an extended family setting. Husbands

were adult males identified by their wives as having the capacity to make decisions regarding maternal health.

The study was conducted in Klampok Village, Sidoharjo Subdistrict, Wonogiri Regency, Central Java Province, Indonesia. This location was chosen due to a relatively high prevalence of pregnancy complications reportedly linked to delays in family decision-making. In this community, pregnancy and childbirth are often perceived as normal, routine life events, resulting in families being less likely to treat complications as emergencies requiring immediate action.

Data collection was carried out in May 2025. Written informed consent was obtained from all participants, and the study adhered to ethical principles including privacy, anonymity, confidentiality, and protection from potential discomfort during data collection (World Medical Association, 2013).

In-depth interviews were conducted to collect data. Data analysis was conducted using a cyclical process, beginning with initial data collection and ending with report writing and drawing conclusions. The steps of data reduction, data display, and conclusion drawing/verification were applied as outlined by Miles, Huberman, and Saldaña (2014).

Results and Discussion

Family decision-making in maternal health

Families hold legitimate power, and one of the most dominant indicators of social power is decision-making authority. Within the family system, certain individuals are regarded as having the authority to make decisions for others (Friedman et al., 2018). Findings revealed that husbands generally held the primary authority in family decision-making, regardless of women's interests. This is consistent with previous studies showing that husbands, as the main breadwinners and heads of households, shoulder significant responsibilities and thus wield decision-making power (Mboi, 2021). Fathers were also respected as family leaders, and men were more dominant than wives or grandparents in making decisions.

All six families interviewed confirmed that husbands held greater authority in decision-making, particularly in community-related activities such as social events, maintaining kinship relations, hosting celebrations, collaborating with others, and addressing matters with government and local institutions. Women, whether directly or indirectly involved, expressed respect for their husbands as family leaders and were not objects to the decisions they made. Husbands' acknowledgment of their decision-making role supported these findings, reflecting cultural beliefs that men serve as the "spiritual and practical leaders" of the family.

The dominance of husbands also limited women's mobility, as they often needed permission to travel, which was perceived as a cultural restriction. In all six families, husbands were more dominant in both productive and reproductive decision-making. However, in families 4 and 6, wives participate more directly in decision-making because they contribute

significantly to household income. Women in these families exercised greater control over resources, balancing their husbands' economic power.

Decision-making in maternal health

Decision-making is a process consisting of a series of deliberate actions aimed at resolving issues and achieving family goals (Miles et al., 2014). Results indicated that family discussions were the primary method used to reach decisions, but only participants 4 and 6 were directly involved in maternal health-related decision-making. Participants 1, 2, 3, and 5 were consulted but reported that final decisions were made by their husbands. Decision-making in maternal health often reflects the dominant social power structure within the family, whereby individuals with legitimate authority (eg, husbands, senior male relatives) make the final decisions (Friedman et al., 2018).

Responsibility for maternal health within the family

Ideally, husbands and wives should share responsibility for maternal health, as reproductive health encompasses both men and women (World Health Organization [WHO], 2016). Findings from five families revealed that both spouses acknowledged joint responsibility for maternal health, while one family stated that the husband bore the greater responsibility. Participant 1 explained that gender roles are socially and culturally constructed, with husbands considered as primary breadwinners responsible for financial stability, while wives were mainly responsible for child care and household tasks.

Women were often perceived as less important due to men's economic dominance, a phenomenon reflecting the interpretation of male power in family structures (Mboi, 2021).

Factors influencing family decision-making in maternal health

Multiple factors influence how families make decisions regarding maternal health, including women's health status, knowledge, socioeconomic status, education, culture, and access to health insurance.

a.Women's knowledge of complications

Recognizing abnormal conditions, determining their severity, and identifying the cause are critical steps before seeking medical care (Thaddeus & Maine, 1994). Findings revealed that only six female participants understood pregnancy complications that ultimately led to hospitalization. Most women lacked sufficient knowledge of maternal complications, except participant 6, who demonstrated a better understanding.

Many participants only recognized physical symptoms, such as vaginal bleeding or pain, without understanding the underlying danger. For example, participant 4 failed to realize that decreased fetal movement was a sign of fetal distress. Socio-cultural perceptions that pregnancy and

childbirth are normal events often influence this delay in care-seeking (WHO, 2016).

b. Husbands' knowledge of complications

Only participants 5 and 6 were able to accurately explain their wives' complications, consistent with the medical explanations provided by healthcare professionals. Participants 1, 2, 3, and 4 could only describe events without understanding the complications.

Education played an important role in knowledge and service utilization. Participants 1, 2, and 3, whose highest level of education was elementary or high school, demonstrated low utilization of maternal health services and limited access to maternal health information. In contrast, participants 4, 5, and 6, who had attained senior high school or university-level education, had higher service utilization and better access to maternal health information (Lowdermilk, 2013).

c. Utilization of maternal healthcare facilities

Low socioeconomic status is often associated with higher maternal mortality and poor utilization of healthcare services (WHO, 2016). Participants 1 and 2 were classified as lower-middle-income families with irregular monthly income and low educational attainment. In contrast, participants 4, 5, and 6 had higher socioeconomic status, better education (up to the university level), and health insurance, enabling greater utilization of healthcare facilities.

Families from lower socioeconomic groups viewed maternal healthcare services as a luxury rather than a priority, with antenatal visits conducted only when symptoms became severe. Families 4, 5, and 6 consistently used healthcare services such as midwives, doctors, and hospitals, partly due to health insurance coverage. Meanwhile, participants 1 and 2 would only seek care when pain becomes unbearable.

d. Maternal health status

Considering the complications experienced during pregnancy, childbirth, and postpartum, the maternal health status of the six wives was not optimal. Timely family decision-making likely prevented complications from progressing into more severe outcomes such as maternal death. Family dynamics, economic conditions, and coping mechanisms significantly influence maternal health (Lowdermilk, 2013). Cultural beliefs also play a crucial role in determining maternal health quality within families.

Discussion

The findings of this study indicate a strong relationship between family socioeconomic status, level of knowledge, family decision-making patterns, and preparedness in facing perinatal complications. Families with lower

socioeconomic status, no health insurance, and lower educational attainment often face significant limitations in accessing health information. In addition, entrenched cultural values strongly influenced decision-making patterns, where critical decisions related to maternal and infant health were primarily made by husbands. In such circumstances, the involvement of wives in decision-making was very limited, posing a risk for delays in responding to perinatal complications.

Conversely, families with better socioeconomic conditions, health insurance, and adequate education tend to have a stronger understanding of danger signs, complications, and causes of illness during the perinatal period. In these families, decision-making was not only the husband's responsibility; wives were actively involved, leading to faster and more accurate decisions. Families in this group were better prepared to face the emergency because they had a basic understanding of maternal health issues and better access to healthcare services.

The decisions made by families during perinatal complications significantly impacted maternal health outcomes. Delayed decision-making could place women—the primary subjects of maternal health—at risk of severe health complications, including maternal or fetal death (Campbell & Graham, 2006).

Several factors were found to influence family decision-making related to maternal health, including education level, knowledge about complications, women's status in the family, family socioeconomic conditions, health insurance ownership, and cultural norms. Maternal health status was directly influenced by these factors.

For example, one participant's poor maternal health status was likely due to low family socioeconomic status, classifying the family as economically disadvantaged. Other contributing factors included a lack of education and limited knowledge about maternal health, particularly perinatal complications. Cultural factors also played a role, particularly in influencing the choice of birth attendants (Thaddeus & Maine, 1994; Lowdermilk, 2013).

Conclusion and Recommendation

Conclusion

Family decision-making is generally still dominated by men, particularly husbands, who hold the main authority in determining the direction of decisions. Although family decision-making processes are ideally carried out through mutual deliberation, in reality, only a small number of families achieve true consensus. Most families ultimately grant the final decision-making authority to the husband. Several factors influencing family decision-making in the context of maternal health are closely related to socioeconomic conditions. These factors include the level of knowledge, educational attainment, type of occupation, prevailing cultural values, and the mother's health status itself.

Recommendation

The results of this study can be used by local governments and related agencies as a reference for designing policies to reduce maternal mortality rates. Efforts should focus on improving access to health information and services, increasing family health knowledge, and encouraging women's active involvement in family decision-making. Collaboration between government, health workers, and community leaders is also important to ensure these programs run effectively.

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