

Factors Associated With Birth On Site Selection Nias Regency

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Abstract-Every day, Approximately 830 women die from preventable causes related to pregnancy and childbirth. Maternal mortality is higher in women living rural areas and among poorer communities. The main factors causing maternal mortality are the selection of places and facilities as well as birth attendant. Various Efforts have been made to reduce maternal mortality. The purpose of this was to analyze the factors influences with the decision making in the selection of delivery places. Study design using cross-sectional method with Chi square test and logistic regression. The second phase, in-depth interviews in the mother of birth, village midwife, midwife coordinator, coach village, village head, and head of clinic. The study was conducted from September to October 2017. Research results Showed that the factor of family habits (previous experience), have an effect on to decision making in maternity election ($p < 0.005$). The most dominant factor is family Influencing habits.

Keywords: Birthplace, family habits, access to health service facilities.

1. Introduction

Every day about 830 women die from complications during pregnancy and childbirth, which can essentially be prevented earlier by ensuring that all women have access to quality health services, starting before pregnancy, during pregnancy and births attended by skilled health personnel in HCF.¹

There are many factors that cause maternal mortality ratio (MMR) is still high, apart from direct obstetric complications as a cause, the cause is not immediately also have a substantial contribution at 27%.^{1,2}The contribution of indirect causes of high maternal mortality rate one of which is aid delivery is still done at the patient's home. Based RISKESDAS in 2013, cases of deliveries in the home is higher than the utilization of health care facilities in the village as Polindes / village health post or health centers / sub, which is in the second highest percentage of 29.6%.^{1,3,4}

One way of reducing the MMR is to maternal health care facility since birth mothers helped health workers with adequate amenities, including in the prevention of infection. Moreover, in case of complications for both the mother or the baby can be directly addressed so that the third factor that is too late too late can be prevented referred to and handled by health personnel. There are many factors that lead to the mother and family choose to give birth at home, such as access to health facilities that are hard to reach, the limited knowledge of the risks of home birth, lack of communication midwives to mothers and families during antenatal care visits, and behavior in the community seeking help if there had been complications in labor.^{5,6}

The purpose of this study is whether the factors related to decision making in the choice of place of birth in the territory of Nias District Health Office.

2. Method

The design study is cross-sectional to the analysis Chi square test and logistic regression.^{7,8}Research conducted in the working area of Nias District Health Office in the period September-October, 2017, and has been through the study of ethics oleh Komite Health Research Ethics Faculty of Medicine, University of Padjadjaran Letter Number: 842 / UN6.C.10 / PN / 2017.

Population in this study is the mother who has given birth and is domiciled in the territory of Nias District Health Office. The inclusion criteria of respondents who have given birth to spontaneous more than one with a history of pregnancy at term (≥ 37 weeks). The exclusion criteria that respondents who have given birth to referrals from outside the area Nias, early births assisted by TBAs (paraji) then followed by minimum sample Bidan. Jumlah 318 people. For qualitative research, sample selection using purposive sampling techniques. Quantitative stage using Cross-Sectional with analysis Chi square test and logistic regression.

The dependent variable in this study is the place of birth. The definition of place of birth is a good venue for labor performed in health care facilities and non-medical. Health care facilities in question are those used to organize efforts to better health services, promotive, preventive, curative and rehabilitative. Health care facilities consist of independent practice, community health centers, clinics, hospitals, Traditional Faskes.

The independent variables are: (1) Kebiasaan family or experience regarding where previous labor; (2) access to health care facilities is the distance from the living quarters of respondents to a health facility based on mileage, travel time and road conditions; (3) The social, cultural, everything that is prevailing in the society which is becoming a tradition / custom of hereditary and give effect to the society itself; (4) The social economy is standing or position in society related to economic activities such as occupation, education level, income in the fulfillment of the needs of both clothing, food and shelter; (5) a midwife communication communications made between midwives, mothers and families about planning a maternity site selection during pregnancy; (6) family support is assistance provided her husband and family in the birth process the mother,

Characteristics of respondents including age, parity, spacing of birth, level of education, and work is a confounding variables (counfounding) previously done homogeneity test prior to data analysis.

3. Research result

Table 1.
Characteristics of Research Subjects

| characteristics of Respondents | f (%) | Maternity place | | Value ρ * |
|--------------------------------|-------------|-----------------------|-------------------|----------------|
| | | Non Faskes n = 155 | Faskes n = 170 | |
| Age | | | | |
| - 15-19 years | 12 (3.7%) | 9 | 3 | 0.147 |
| - 20-34 years | 266 (81.8%) | 123 | 143 | |
| - 35-49 years | 47 (14.5%) | 23 | 24 | |
| parity | | | | |
| - multiparas | 228 (70.2%) | 103 | 125 | 0.164 |
| - Grandemultipara | 97 (29.8%) | 52 | 45 | |
| distance Childbirth | | | | |
| - <2 years | 142 (43.7%) | 77 | 65 | 0.11 |
| - 2-4 years | 168 (51.7%) | 71 | 97 | |
| - \geq 5 years) | 15 (4.6%) | 7 | 8 | |
| Level of education | | | | |
| - basic education | 262 (80.6%) | 131 | 131 | .193 |
| - Middle education | 47 (14.5%) | 19 | 28 | |
| - higher education | 16 (4.9%) | 5 | 11 | |
| Work | | | | |
| - Does not work | 53 (16.3) | 20 | 33 | 0,113 |
| - Work | 272 (83.7) | 135 | 137 | |

Note: * Chi-Square Test

Based on Table 4.1, the characteristics of respondents showed no significant difference in the group of respondents who chose non faskes and faskes ($p > 0.05$). According to the table above, it is concluded that the characteristics of the study subjects homogeneous, so it deserves to be analyzed further.

Table 2.
Frequency distribution based on place and Auxiliary Childbirth

| Points and Delivery Helper | n = 325 | % |
|------------------------------|---------|------|
| Points of Delivery | | |
| - Non Health Care Facilities | 155 | 47.7 |
| • Patients home | 154 | 52.3 |
| • Shaman house | 1 | 0.3 |
| - Health Care Facilities | 170 | 52.3 |
| • Wait house Birth (RTK) | 19 | 5.8 |
| • Home Midwife / Nurse | 6 | 1.8 |
| • Private clinics | 8 | 2.5 |
| • midwife practice | 60 | 18.5 |
| • PHC | 67 | 20.6 |
| • Poskesdes | 8 | 2.5 |
| • Pustu | 2 | 0.6 |
| Delivery helper | | |
| - Midwife | 191 | 58.8 |
| - shaman Maternity | 72 | 22.2 |
| - In-laws | 28 | 8.6 |
| - Husband | 18 | 5.5 |
| - Other Family Members | 8 | 2.5 |
| - Nurse | 6 | 1.8 |
| - Doctor | 2 | 0.6 |

table 3
Result Analysis of Independent Variables BivariatHubungan Against Decision In Childbirth Site Selection

| variables Independent | f (%) | Maternity place | | Value p * | RP. Adjt (CI 95%) |
|------------------------------------|-------------|--------------------|----------------|-----------|---------------------------|
| | | Non Faskes n = 155 | Faskes n = 170 | | |
| Family habits | | | | | |
| - There is | 191 (58.8%) | 126 | 65 | <0.001 | 3,048 (2.174 to 4.274) |
| - There is no | 134 (41.2%) | 29 | 105 | | |
| Socio-cultural | | | | | |
| - Traditional | 105 (32.3%) | 85 | 68 | 0.007 | 1,385 (1.085 to 1.717) |
| - Modern | 220 (67.7%) | 70 | 102 | | |
| Socioeconomic | | | | | |
| - Lower class | 153 (47.1%) | 121 | 109 | 0,006 | 1,470 (1.093 to 1.976) |
| - High class | 172 (52.9%) | 34 | 61 | | |
| Access to health facilities | | | | | |
| - Difficult | 230 (70.8%) | 63 | 42 | 0,002 | 1,435 (1.151 to 1.789) |
| - Not hard | 95 (29.2%) | 92 | 128 | | |

| | | | | | |
|-----------------------|-------------|-----|-----|--------|------------------|
| communication | | | | | |
| Midwives | 117 (36%) | 67 | 50 | 0,010 | 1,354 |
| - Ineffective | 208 (64%) | 88 | 120 | | (1.083 to 1.692) |
| - Effective | | | | | |
| Family support | | | | | |
| - There is | 181 (55.7%) | 113 | 68 | <0.001 | 2,140 |
| - There is no | 144 (44.3%) | 42 | 102 | | (1.620 to 2.828) |
| Knowledge | | | | | |
| - Low | 121 (37.2%) | 81 | 40 | <0.001 | 1,845 |
| - High | 204 (62.8%) | 74 | 130 | | (1.480 to 2.301) |

* Note: based Chi-Square

From Table 4.3 can also be known that all independent variables related to decision making in the selection of delivery ($p < 0.05$).

1) **analysis Mulivariat**

Based on the results of the bivariate analysis, the characteristics of research subjects and the independent variables eligible for multivariate analysis because it has a value of $p < 0.25$. Multivariate Results can be seen in the following table:

table 4
Regression Analysis LogistikFaktor related dominant in the selection of labor

| variables | Koef. β | SE (β) | Value p^* | RP Adj. (CI 95%) |
|------------------------------------|---------------|----------------|-------------|-------------------------|
| Early Model | | | | |
| - Age | 0.719 | 0.368 | 0.051 | 2.053 (0.997 to 4.226) |
| - parity | -0.285 | 0.334 | .393 | 0.752 (0.391 to 1.446) |
| - distance Birth | 0.351 | .248 | 0,156 | 1.421 (0.875 to 2.308) |
| - Education | -0.169 | 0,305 | .580 | 0.845 (0.465 to 1.535) |
| - Work | -0.496 | .410 | 0226 | 0.609 (0.273 to 1.359) |
| - Family habits | 1,689 | .294 | <0.001 | 5.414 (3.041 to 9.639) |
| - Access to health facilities | 0.403 | .370 | 0.275 | 1.497 (0.725 to 3.088) |
| - Socio-cultural | 0.234 | 0.341 | .493 | 1.263 (0.647 to 2.465) |
| - Socioeconomic | 0,478 | 0.361 | 0.185 | 1.613 (0.795 to 3.271) |
| - communication Midwives | 0.174 | 0.285 | .543 | 1.190 (0.680 to 2.080) |
| - Family support | 1,197 | 0,282 | <0.001 | 3.311 (1.904 to 5.758) |
| - Knowledge | 0,439 | 0.297 | .140 | 1.552 (0.866 to 2.780) |
| Constant | -7.212 | 1,538 | <0.001 | |
| Late Model | | | | |
| - Age | 0.763 | 0,316 | 0,016 | 2.146 (1.155 to 3.987) |
| - Family habits | 1,828 | .280 | <0.001 | 6.220 (3.590 to 10.775) |
| - Access to Health Care Facilities | 0.635 | 0.286 | 0,026 | 1.887 (1.078 to 3.306) |
| - Socioeconomic | 0,622 | 0,293 | 0,034 | 1.863 (1.050 to 3.308) |
| - Family support | 1,235 | 0.269 | <0.001 | 3.437 (2.030 to 5.818) |
| Constant | -7.690 | 1,187 | <0.001 | |

Note: Test Binory Logistic Backward Method with LK

Table 4.4 Based on the results of the logistic regression model showed that age is beginning, birth spacing, work, family habits, socio-economic, family support and knowledge qualifies for further analysis. At the end of the analysis model, there are five of the most influential variables in the selection of labor. Of the five varibabel, family habits factor has the most dominant influence by RP adjt value.6.220 (3.590 to 10.775), which means that mothers who have a habit or experience of

giving birth in a health care facility 6.2 times more likely to choose to give birth in a health facility compared pelayanaan mother who has a habit of giving birth at home.

4. Discussion

1) characteristics of Respondents

The results showed that there was no the relationship of age to decision making in the selection of maternity (the value of $p > 0.005$). The majority of respondents were in the age range is not at risk (20-35 years) amounted to 82.5%. Based on the theory Notoatmodjo, increasing age, also increase the maturity of thinking and being an adult. The research result is in line with research conducted by Wagle in Nepal mentioned that maternal age was not associated with the selection of the delivery. The results of this study differ from peneilitian conducted by Siziya in Iraq which mentions the relationship between maternal age on the election of the place of delivery. That the 21-34-year-old mother who prefer to deliver at home with the shaman as birth attendants by 22% compared to mothers aged > 35 years.^{6,9}

The results showed that there is no parity relationship to decision making in the selection of deliveries in health facilities. The results of this study are not in line with research conducted by Siziya and Eijik which states that the number of children born influence on the selection of home as a place of delivery. Mothers who have children over ≥ 5 more risky to choose a house and shamans as helper persalinan. This occurs if the previous birth mother was satisfied give birth at home with traditional birth attendants and rescuers hoped the next delivery with the help of traditional birth attendants will walk safely.⁹In Table 4.1 the majority of respondents have 2-4 children (70.2%) with 125 people choose the health facility as a place of birth. This suggests that the experience of a good mother in gaining access to health care, availability of health facilities in the environment where mother lived, the program RTK for people who have difficult access to health facilities and do not have a cost, and the midwives who are active for 24 hours a motivation for mothers and families to give birth in a health facility.

The results showed that birth spacing is not related to decision making in the selection of labor. The majority of respondents are in birth spacing is recommended that 2-4 years amounted to 51.7% and 43.7% in the spacing of < 2 years.Short birth spacing resulted in an unprepared mother in the face of the pregnancy, both physically and psychologically. This is also linked to the mother's ability to meet nutritional needs.

In Table 4.4 shows that the educational level is not related to decision making in the selection of labor, in which respondents mayoriats basic education (elementary, middle) amounted to 80.6%. In the region where the research, the majority of people only formal education in primary school stage. It is driven by the understanding of parents first, that the nature of women do not have to carry too high education. Only boys were allowed high school because it is the successor to the descendants. This means that however high education of a woman, still taking care of household duties and meet the needs of families. Such an understanding is still firmly embedded in rural communities today. Besides that, to contribute to the economic problems of educating girls to pursue higher education. Maternal education and family is an indirect factor that contributed to the selection of the delivery. Mothers with primary education 4.6 times likely to choose to give birth at home daipada in health care facilities. Maternal education can influence behavior in seeking health care, such as site selection and birth attendants. High education level of women who show a greater female autonomy. Mothers who live in a community of highly educated families often reflect high socioeconomic status. 6 times choose to give birth at home daipada in health care facilities. Maternal education can influence behavior in seeking health care, such as site selection and birth attendants. High education level of women who show a greater female autonomy. Mothers who live in a community of highly educated families often reflect high socioeconomic status. 6 times choose to give birth at home daipada in health care facilities. Maternal education can influence behavior in seeking health care, such as site selection and birth attendants. High education level of women who show a greater female autonomy. Mothers who live in a community of highly educated families often reflect high socioeconomic status.¹⁰

In Table 4.4 shows that the work is not related to decision making in the selection of labor, where majority respondents work (83.7%) with a job as a rubber farmer / field / brown, traders, part time teachers and civil servants. Mothers who work the majority chose the health facility as the place of birth (137). This is according to research conducted by the Princess and Nurlinda that working mothers have more information consumption patterns than mothers who do not work (IRT). Working mothers have the opportunity interacts with other mothers who have given birth experience in a health care facility. Mother's workplace environment can have positive effects like a mother to work as civil servants, educators (teachers honorer).¹¹ However, not always the mother who already work selecting health facilities, there are 135 working mothers who give birth at home. Information obtained from the mother who has experience of giving birth at home.

2) Factors relating to the selection of the persalina

a. Family habits

The results showed that the habits of the family is the most dominant factor in the selection of delivery ($p < 0.001$; Rp.Adjt6.220 (3.590 to 10.775). Mother habit or experience giving birth in a health facility 6.2 times more likely to choose to give birth in a health facility in the next childbirth than mothers who give birth at home. Habits that are carried out on a bear again the same situation or condition will be settled on an individual's behavior. So if it is the same situation a person tends to do the same thing on the previous situation. The results are consistent with research conducted by Koguna in the district of Rakai, Uganda states that one of the factors that influence the choice of where labor is self-efficacy (habit or experience in labor before) apart from access to delivery care, social influence of her husband, shaman childless, other family members and the concept of a normal delivery.¹²

In taking the decision to give birth mom usually discussed beforehand in a forum involving the family of the husband. Generally a married woman in Nias culture can not take autonomous decisions without asking the consent of the husband. The meetings are usually occur when the mother and husband stayed at home with the family-in-law (extended family). *The role of the biological family of birth mothers in decision making is not dominant. They can only give advice through his daughter (maternal) without getting involved in the family council. This is because, in the cultural perspective Nias, a married woman be fully authorized by the husband and his family.*

Results of research conducted by Gebrehiwot in northern Ethiopia during the interview process conducted, revealed that pregnant women pressed by the mother-in-law and their relatives to give birth in the same manner as in the previous generation, namely those at home.¹³

mother assumes used as guinea pigs for student practice, while the mother was expecting only birth attendants and family were present. This was disclosed by the participants:

b. Access to health facilities

Based on the geographical conditions of the study area, there are still areas which is quite isolated and difficult to reach. Condition of the road, muddy, rocky, past the river where the current is quite heavy, the water level is high enough in the rainy season, and quite difficult to be reached in a short time make the local people prefer to give birth at home or assisted by TBAs than to a care facility health.

The results showed no correlation between access to health care facilities in the selection of labor (Table 4.5). The results are consistent with research conducted by Hancon, etc stating utilization of primary level health care facilities in rural areas of Tanzania. The results showed that people who use health care facilities are those who live in nearby services 76.1%, while only 17.4% of people living a bit away with the distance > 5 km which utilize health care facilities as a place of birth,¹⁴ Results of research conducted in Indonesia by Titaley in 6 villages in Ciamis revealed that the major cause of mothers prefer to give birth at home with the shaman as birth attendants is the distance to distant health care facilities.⁶

There are many efforts made by the government in increasing the motivation of people to give birth in a health facility. In 2015, their acceptance Variable Employee Midwife

(midwife PTT) with a big enough salary (according to the placement area: close, isolated, farthest) with a scale large enough to help local governments to cover any health issues concerning maternal and child health in the village. Placement of one village one midwife was very helpful in facilitating the community to get health care.

However, there are still 47.3% of women choose to give birth at home. In addition to the difficult access, the availability of facilities and infrastructure in aid delivery are important in the success of the service. From several villages attended by researchers, there are villages that do not have health infrastructure (no poskesdes / polindes / pustu), the absence of midwife for 24 hours, especially in the villages to which access is difficult, the limitations of equipment for labor, as well as help with emergencies newborns that do not exist, contributing the reason for the mother and family choose to give birth at home.

c. Socioeconomic

The results showed that socioeconomic factors related to decision making in the selection of labor. Low economic status of mothers who do not become a barrier for women in utilizing health facility as a place of confinement. In Table 4.5 shows that out of 230 respondents by socioeconomic class that there are 109 choose the health facility as a place of confinement and 121 people chose the home as a place of confinement. Changes in people's behavior under the economic class chose a health facility as a place of birth, because there is a fear if labor at home have problems or concerns. Results of an interview to one of the women who chose health facility in the last delivery, because it does not want to experience the same events as its neighbors,

In the area where the study, the majority of people are on the socioeconomic underclass to work as farmers and laborers as many as 243 respondents, income less than the minimum wage Nias Regency, and the majority of respondents receive social protection cash transfer or the Family Hope Program (PKH) a total of 191 respondents, There were 121 respondents low economic status with a reason to choose a house is much more practical and economical. Birth mothers do not need to carry a lot of baby equipment to health facilities, do not leave small children, could be close to the family, do not have to pay for transport and no intervention from health professionals. Lack of knowledge about the benefits, procedures for handling as well as the premiums paid each month on the program BPJS / KIS is one factor for the families did not complete the file administration. Society takes care card found BPJS / KIS is an absolute work of village head. They felt as if it does not matter even if the village head repeatedly announced to bring the maintenance file BPJS / KIS like KK and KTP. So that when the time of delivery draws near, the mother who does not have a card BPJS / KIS choose to give birth at home with no fees or reason BPJS card / KIS. So that in case of complications during delivery that occurs in the house with helper TBAs, difficult mother and family in the referral process. They felt as if it does not matter even if the village head repeatedly announced to bring the maintenance file BPJS / KIS like KK and KTP. So that when the time of delivery draws near, the mother who does not have a card BPJS / KIS choose to give birth at home with no fees or reason BPJS card / KIS. So that in case of complications during delivery that occurs in the house with helper TBAs, difficult mother and family in the referral process. They felt as if it does not matter even if the village head repeatedly announced to bring the maintenance file BPJS / KIS like KK and KTP. So that when the time of delivery draws near, the mother who does not have a card BPJS / KIS choose to give birth at home with no fees or reason BPJS card / KIS. So that in case of complications during delivery that occurs in the house with helper TBAs, difficult mother and family in the referral process.

The results are consistent with research conducted by Wagle in Nepal that low socioeconomic factor of the most powerful labor occurs in the home as well as research Shiferaw in Etiopia and Titalay in 6 villages in West Java, said that the economic limitations be why mothers choose to give birth in home to the shaman as birth attendants.^{6,15,16}

d. Family support

The results showed the influence of family support in the selection of labor (Table 4.5), with a value of $p < 0.001$. Family support to be crucial for the mother in determining the place of delivery. In this study, 52.3% of women choose the health facility as a place of confinement

with the support of family, especially her husband. Family support is the most important factor in supporting the autonomy of mothers choose the place of delivery. Family support be one contributing factor that can change the behavior of the mother seeking health services.

In Table 4.4 the majority of women get family support in determining the choice of the place of delivery (55.7%). There are 113 maternal family support home birth and 68 give birth in health facilities. These would be the mother have their own autonomy in decision-making or the possibility of getting pressure from their families to choose to give birth in the area where the research community rumah. Pada still embrace patrilineal culture. All decisions are determined by the child's birth parents or husbands and elder relatives, particularly with regard to where the woman is in labor, who birth attendance, and whether or not the mother was taken to a health care facility if anything happened. Maternal merely as recipients of the decision.

The results are consistent with research Sychareum in Laos menyatakan that one of the reasons mothers choose to give birth at home is the support of her husband, other family members, and influence in decision-making mother-in-law.¹⁷

e. Age

The results showed that there was no effect of age on decision making in the selection of the delivery. The majority of respondents were in the age range is not at risk (20-35 years) amounted to 82.5%. Based on the theory Notoatmodjo, increasing age, also increase the maturity of thinking and being an adult.¹⁸ The research result is in line with research conducted by Wagle in Nepal mentioned that maternal age was not associated with the selection of the delivery.¹⁶ The results of this study differ from research conducted by Siziya in Iraq which mentions the relationship between maternal age on the election of the place of delivery. That the 21-34-year-old mother who prefer to deliver at home with the shaman as birth attendants by 22% compared to mothers aged > 35 years.⁹ Results of research conducted, more mothers choose to give birth at a health care facility rather than at home (52.3%). This happens because of the level of public awareness of the health services increases with the presence of a midwife in every village who always provide counseling and health education on the benefits of giving birth at health care facilities as well as equity in terms of infrastructure development such as roads, health care facilities (Polindes, Poskesdes).

However, there are 47.7% of mothers choosing a home as a place of confinement. In addition to already be an experience on previous deliveries, this decision is due to the mother does not have its own autonomy in choosing. Every decision made maternal health issues, must be negotiated with the husband and the family of the husband. This is confirmed if the mother stays at home parents husband (not independent). In the culture of Nias, the first male child should stay at home parents, acts take the place of a parent (for a living) if married. This is the underlying role of mother-in-law to the decision makers in the family, especially the mother in labor is very strong. Mothers play a role as a receiver in the family decision.

5. Conclusion

Based on the results of quantitative research, conclusions can be drawn correlation family habits, access to health care facilities, social, cultural, social, economic, communication midwife, family support, and knowledge to decision making in the selection of labor. The dominant factor in the selection of maternity is a family habit.

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