The Role of Culture in Maternal Healthcare Utilization

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Introduction

Social norms and culture govern the behavior of a society and are inseparable from day-to-day interactions. As a country with a significantly dispersed geography, Indonesia is home to at least 520 ethnic groups with a variety of customs. Given this diversity, its national program cannot rely on any one-size-fits-all approach and must instead tailor interventions to fit local conditions.

Maternal health is one indicator used to measure health status, with pregnancy and childbirth serving as two events closely linked to cultural practices in the community. Each culture in Indonesia, from Sabang in the west to Merauke in the east, has its own tradition regarding pregnancy, delivery, and childbirth.

The Government of Indonesia (GOI) has outlined the issue of maternal health comprehensively in the Minister of Health Regulation No. 97/2014, which is further supplemented by the Minister of Health Regulation No. 4/2019 on Technical Standard for Basic Quality Service in the Minimum Service Standard for the Health Sector. However, implementation of these regulations can be improved at the local level by involving provincial- and district-level government to adapt the interpretation of regulations to fit the local cultural context.

Qualitative studies have reported that in several ethnic groups in Indonesia, culture still plays a major role in women's decision to seek care at a health facility. The extent of the influence cannot be quantified in detail due to methodology limitations of quantitative studies. Nevertheless, this policy brief attempts to quantitatively estimate the influence of culture on maternal healthcare utilization using detailed data from the 2010 Basic Health Research Survey (*Riskesdas*).

This brief aims to aid decision-makers—specifically, the Ministry of Health (MOH) Family Health Directorate and its structural units in the MOH—in planning for evidence-based maternal and newborn health (MNH) interventions. It also provides input to local government to adapt MNH interventions to better fit the local context.

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Methods

This study is an ethnographic assessment of nine ethnic groups in Indonesia that aims to highlight the specific socioeconomic and cultural factors that play a role in MNH utilization, with a focus on pregnant women's reproductive health status, health behavior, and access to a healthcare facility.

The study reviewed existing policies that relate to the health of pregnant women, including the following: (1) Minister of Health Regulation (*Permenkes*) No. 97/2014 on healthcare before and during pregnancy, delivery attendance and postpartum care, and family planning and sexual health services; and (2) Minister of Health Regulation (*Permenkes*) No. 4/2019 on the technical standards for fulfilling the Minimum Service Standards for basic health services at the primary healthcare level.

The study also analyzed 2010 *Riskesdas* data to understand how traditional practices influence the continuum of healthcare for pregnant women. *Riskesdas* collected data from 33 provinces and 440 districts/municipalities in Indonesia. A mapping of the traditional birth attendant (TBA) ratio per 1,000 population was conducted based on the 2008 Village Potential (*Podes*) Data. The total sample included 14,798 women ages 15–49 years who delivered between January 2005 and August 2010.

Descriptive analysis and logistic regression are used to illustrate the influence of the main variable/factor and the outcome variable, and controlling for several variables, as highlighted in Table 1.

Table 1. Definitions of Variables

Outcome Variables	1. Antenatal care (ANC) ≥4 times (yes/no) 2. Having health personnel as birth attendant for a mother's first birth (yes/no) 3. Using ANC≥4 times and having health personnel as birth attendant for a mother's first and last birth (yes/no) 4. Use of comprehensive maternal healthcare (defined as use of ANC ≥4 times and use of health personnel for first and last birth, and delivering at a health facility) (yes/no)
Main Variables/ Factor	1. Traditional or "non-medical" practices regarding the following: a. Cord care (traditional/modern) b. Use of contraceptives (influenced by culture or not) 2. Ratio of TBA per 1,000 population, as calculated from the number of TBAs in a village/city per 1,000 population (ratio) 3. Structure of the extended family, whether a woman lives in a nuclear family or in a household with another adult outside of the nuclear family (nuclear/extended)
Control Variables	Demographics (age, education, parity), socioeconomic status (as measured through household expenditure quintile), residence (urban/rural), and geography (five island groups)

Results

Socioeconomic and cultural factors influence pregnancy outcomes, including maternal death. Intermediate determinants include women's health status and reproductive status, access to a healthcare facility, and health behavior, including utilization of healthcare.

Maternal Health Status

Conceptually, a woman's status relates to her socioeconomic level and reproductive status, such as her age, parity, and marital status. The ethnographic part of this study demonstrates that one underlying problem in pregnancy is the age of pregnant women, many of whom are still relatively young as a result of early marriage. Five of the nine ethnic groups included in the study practice early marriage, and women of these groups have a low level of education. They are the Jawa (Cirebon District), Anak Dalam (Musi Banyuasin District), Turuk (Mentawai District), Laut (Inderagiri Hilir District), and Buru (Buru District). Analysis of *Riskesdas* 2010 data shows that a significant proportion of women who delivered between the ages of 15 and 24 years did not go to school (26.6%) or did not complete elementary school (43.1%). They also comprise a notable proportion of the poor population (46.2%) and tend to live in rural areas (48.7%).

Health Behavior and Pregnancy

Behaviors are formed as a result of norms and culture to which a society adheres. Pregnancy can be considered a risk to a woman's health, but many communities regard pregnancy as a natural event that women must experience as part of a marriage. Poor knowledge among members of Turuk and Gayo Tribes and various cultural restrictions to which they adhere put pregnant women and their babies at an increased health risk. Our analysis of *Riskesdas* data shows that 6.6% of pregnant women never attended antenatal care (ANC) visits, and 14.6% of women attended fewer than the MOH recommended number of four or more ANC visits (between one and three ANC sessions).

Women's health behavior was analyzed by looking at several practices recorded in the 2010 *Riskesdas* that serve as markers for women's exposure to traditional practices. They include contraceptive non-use for non-medical reasons and umbilical cord care using traditional procedures. Our analysis found that 14.7% of women did not use proper or hygienic cord care procedures. Common reasons for not using contraception included religious beliefs, husband's disapproval, or misperception about the side effects of contraceptives. As substantiated in other studies, these serve as barriers to maternal healthcare utilization. *Riskesdas* data also indicate several traditional cord care procedures that are still practiced in Indonesia, which can greatly increase the risk of maternal and neonatal death, including use of *sembilu*, a bamboo blade for cutting the umbilical cord, and the use of scouring sand or coffee as an antiseptic.

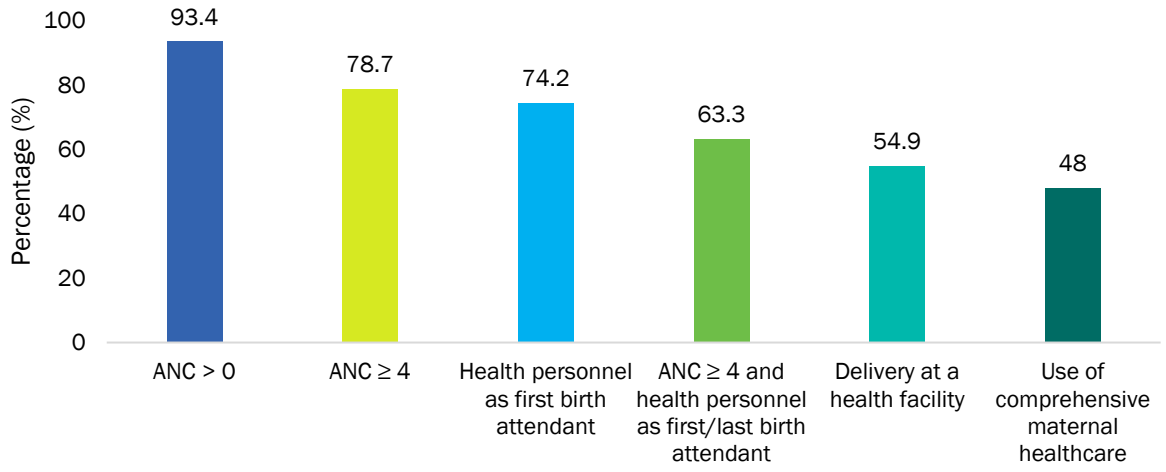
Quantitatively, the percentage of improper practices seems small, but when accompanied by qualitative data, these practices provide evidence of significant culturally driven maternal health issues that may contribute to the low utilization of adequate and safe maternal healthcare.

Cultural Factors in Healthcare Utilization

In rural communities in Indonesia, the family generally plays a significant role in the health status of pregnant women. The ethnographic study reported that the family (not just the husband) participates in deciding on attendance for pregnancy check-ups and childbirth planning, with its influence particularly strong in the Aceh, Dayak (Landak District), and Rote (Rote Ndao District) tribes. In Rote Ndao District, the situation improved after the local government implemented a revolutionary MNH policy that enables families, not the TBA, to be involved in selecting the facility for birth. Our *Riskesdas* analysis demonstrates that extended families positively influence pregnant women's action in seeking ANC and utilizing SBA at a health facility.

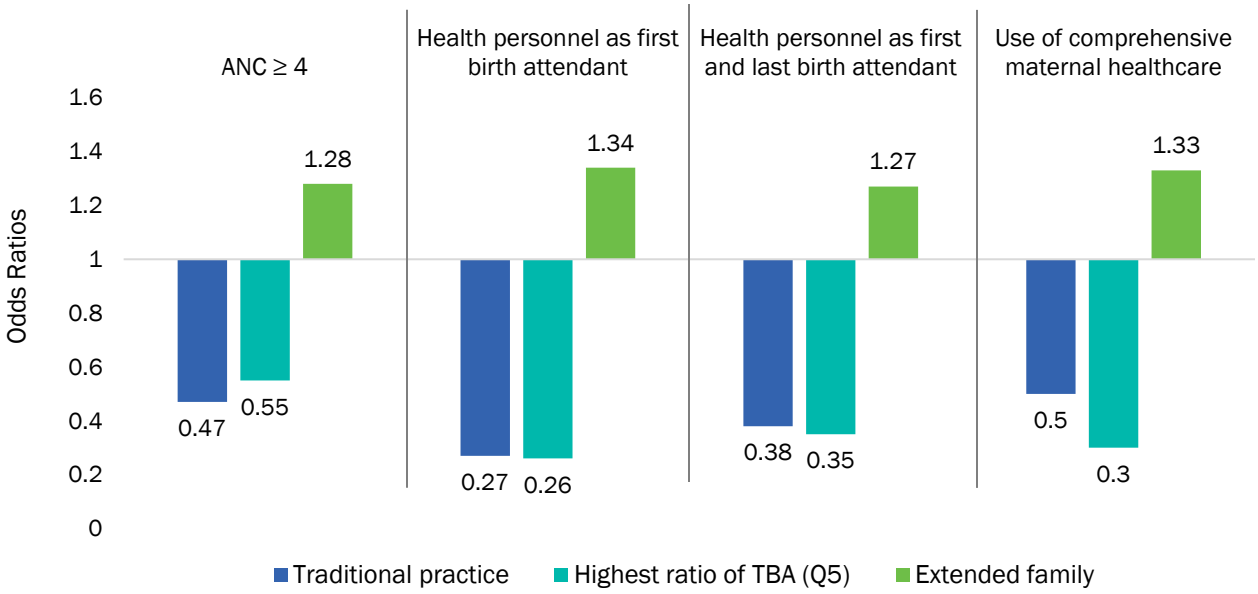
Despite the efforts the GOI has made to continually develop various maternal health interventions, the maternal mortality rate (MMR) in Indonesia remains high. Our *Riskesdas* analysis on maternal health outcomes relative to rate of healthcare utilization shows an increasingly less ideal condition from ANC to facility-based delivery, as illustrated in Figure 1.

Figure 1. Maternal Healthcare Utilization



Qualitative studies report that several ethnic groups in Indonesia still choose TBAs to aid childbirth. In the Aceh Barat tribe, cultural factors and the family's decision has traditionally determined to have a *baliem* attend to deliveries. The Oyog tribe in Cirebon has a close emotional connection with TBAs, tending to choose TBAs over health personnel, even though they are aware that the Indonesian *Jampersal* program (maternity insurance) provides SBA attendance free of charge. Similarly, the Laut (Inderagiri Hilir District) and Buru (Buru District) tribes opt to deliver with a TBA due to limited access to a health facility. The number of TBAs seems to play a role in the decision to choose a TBA; our quantitative analysis of *Riskesdas* data shows that even when 58.9% of pregnant women attended the minimum four ANC sessions, only 17.2% delivered at a health facility. This situation typically occurs in villages with the highest TBA ratio. Midwives are typically utilized for pregnancy check-ups, but TBAs are still preferred over healthcare personnel to aid childbirth.

Figure 2. Logistic Regression Results for Influence of Culture on Maternal Healthcare Utilization



Our logistic regression analysis shows that women's healthcare practices are significantly influenced by the traditional practices prevalent in their community (Figure 2). Some examples include use of TBA for birth attendance, contraceptive non-use, and traditional cord care procedures. These procedures can place women at an increased risk of death. In addition, our analysis shows that a woman's extended family positively contributes to her use of adequate, safe maternal healthcare.

Although Indonesian maternal healthcare policies have specified the ideal health services that should be provided for pregnant women, as we get closer to the ideal or full continuum of maternal health services, from a minimum of four ANC visits through the use of an SBA at a health facility, the proportion of mothers that actually use the full continuum of services decreases. Our analysis indicates that traditional practices and a high TBA ratio have a negative impact on the use of the full continuum of healthcare services for pregnant women, whereas women's extended families have a positive impact on women's decision to seek ANC and choose an SBA.

Discussion and Policy Recommendations

For maternal healthcare utilization, culture serves as a double-edged sword—a barrier as well as a support. Marriage at a young age, low educational level, and rural residence are factors that indirectly influence maternal healthcare utilization. These are compounded by women's low level of knowledge, parental/in-law influence in decision making, and traditional beliefs that negatively influence maternal healthcare utilization. It is considered a woman's nature to become pregnant, and some communities do not understand the health risk to which women and their babies may be exposed during pregnancy. Women continue to work as usual, and the practice in some communities is to hide the early stages of pregnancy, resulting in a higher risk of miscarriage. TBAs are preferred not just out of a feeling of comfort but because they are believed to have supernatural power. That may be the reason the number of TBAs in certain parts of Indonesia is still high. The fact that people go to a midwife for a pregnancy check-up but choose a TBA for birth attendance is an issue that warrants further discussion by policymakers.

We recommend leveraging the large presence of TBAs in the community to fulfill a non-clinical role, such as serving as a source of support for pregnant women (when desired by the woman), with services that include accompanying women to the maternity waiting home and referring women to a midwife. Repositioning the role of the TBA in the community can create a mutually beneficial partnership between midwives and TBAs. Any cost implications can follow the existing market system; in a maternity waiting home, a TBA can be considered as an accompanying family member and can therefore be paid with government funds. When TBAs provide non-medical services (e.g., massage/ritual practice), they can be paid by women's families. An agreement regulated by the Minister of Health Regulation No. 97/2014 can be made for TBAs who refer women to ANC.

The decentralized era is an opportunity to accelerate the reduction of maternal mortality by bringing services closer to the people. District and provincial governments should better understand local culture and involve relevant stakeholders to use locally tailored approaches to communicate maternal health issues more effectively. The MOH regulation can be translated into a Governor/Bupati/Mayor regulation as was done by the revolutionary MNH policy in East Nusa Tenggara (NTT) Province. Innovative, locally led approaches have shown several promising results, such as the establishment of maternity waiting homes in island groups in West Maluku Tenggara District, Maluku Province, and improved use of SBA through the revolutionary MNH policy in NTT Province.

Although decentralization offers many opportunities to improve MNH in Indonesia, it also poses a challenge to provide quality maternal healthcare as part of the 2019 Minimum Service Standard (SPM). To date, the local government remain financially reliant on the central government and also rely on the central government's technical guidance to implement health programs. To ensure the achievement of SPM and accelerate the reduction of MMR, we recommend that the local government allocate its local budget (APBD) to implement health program priorities and ensure that the interventions selected consider local considerations. Funding from the central level (e.g., the Health Operational Funding—BOK) should be considered as supplementary funding and not as a substitute for the local budget.

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