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PROCEEDINGS OF THE 2ND INTERNATIONAL SYMPOSIUM OF PUBLIC HEALTH

Achieving SDGs in South East Asia: Challenging and Tackling of Tropical Health Problems

Editors:
I Wayan Gede Artawan Eka Putra
Agung Dwi Laksono
Yulis Setiya Dewi
Nikmatur Rohmah and
Darrimiya Hidayati

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Organized by
Faculty of Public Health, Universitas Airlangga

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Erlina Suci Astuti, Politeknik Kesehatan Kemenkes Malang, Indonesia

Agustina Abuk Seran, Politeknik Kesehatan Kemenkes Kupang, Indonesia

Rahayu Listianingsih, Universitas Airlangga, Indonesia

FOREWORD

The point of Sustainable Development Goals (SDGs) has been determined in the consistent meeting in all countries. The health sector position is one of the key components in achieving the indicators. Special attention to the health sector focuses on community nutrition, national health systems, access to reproductive health and family planning and sanitation and clean water.

Based on that, Southeast Asian countries are seen as important part in formulating strategic and policy efforts to improve the effectiveness and efficiency of achieving the various goals of the SDGs. Therefore, the Doctoral Program of Health Science, Faculty of Public Health, Universitas Airlangga held The 2nd International Symposium of Public Health. This remarkable event is in collaboration with Faculty of Medicine, Widya Mandala Catholic University Surabaya and Magister Program of Public Health, Jember University. It's an honour to present **"Achieving SDGs in South East Asia: Challenging and Tackling of Tropical Health Problems"**.

We have tried to give our best contributing of our knowledge in the field of public health especially our contribution to help the problems on tropical health, health equity and quality of health care, clinical and community relationship to enhance public health, emerging and re-emerging diseases, nutrition-enhancing as strategic investment, global strategy framework for food security and nutrition, environmental and occupational health and mental health for achieving SDGs in South East Asia.

The aim of this symposium is to disseminate knowledge and share it to the public, especially in the scientific community, such as academics and practitioners in the field of health. The symposium focusing on formulation of policy recommendations for related parties to accelerate the achievement of the target of SDGs in the field of health. The results of this symposium are also expected to be an input for policy makers, from various levels in formulating programs to accelerate the SDGs goals' achievement. This international symposium will help us, to grasp and share more knowledge especially in public health science.

At last, we would like to ackowledge for all parties which are provide the valuable materials as well as financial support for the successful symposium. As chair of organizing committee, I would also like to say deep thank you for all committees; my colleagues, and also students in faculty of Public Health Universitas Airlangga, who have been working to be part of a solid team and amazing committee.

I am looking forward to seeing you at ISoPH in the near future.

Rachmad Suhanda
Chairman of the Committee

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Care Culture of Pregnant Mothers

Agustina Abuk Seran[1], Stefanus Supriyanto[2], Alberth M. Bau Mali[3]
[1]*Student of Doctoral Programme of Health Science Faculty of Public Health, Universitas Airlangga, Mulyorejo Street, Surabaya, Indonesia*
[2]*Lecturer of Public Health Faculty, Universitas Airlangga, Mulyorejo Street, Surabaya, Indonesia*
[3]*Program of Health Polytechnic of Kupang Ministry of Health, Kupang, Indonesia*
agustinaseran07@gmail.com

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Abstract: Factors of belief and traditional practice have a negative impact on the pregnancy and fetal growth. This research aims to learn the care culture of pregnant mothers. The design of this research is a qualitative study with the case study design approach. The informants of this research were pregnant women and family, midwives, and the birth attendants. The method of this study are observation and in-depth interviews. The data was analyzed with descriptive qualitative. The pregnant mothers consider pregnancy as normal and natural; there is an the abstinence to eat eggs and salted fish for the reason of causing itching all over the body, and there is a belief and fanaticism about the birth attendants for pregnancy care, the pregnant mothers involve or get support from their husband/family to keep the pregnancy of the spirits by always carrying objects that are believed to keep the pregnancy in the form of iron types such as scissors, nails or pins) while they are outdoors. This has been done from generation to generation. Pregnant mothers still believe and are fanatical about the birth attendants and family for pregnancy care. Recommendations for midwives are to always make their partners become the birth attendants.

1 INTRODUCTION

The Health development program in Indonesia addressed the prevention of maternal and child health issues which are more focused on efforts to reduce Maternal Mortality Rate (MMR), Infant Mortality rate (IMR) and Child Mortality Rate. A decrease of MMR in Indonesia occurred from the year 1991 to 2007 from 390 to 228 cases, but the Indonesian Health Demography Survey (IHDS) in 2012 showed a significant increase of 359 maternal deaths per 100,000 live births (LBs).

MMR again showed a decrease to 305 maternal deaths per 100,000 live births based on the results of the Intercensal Population Survey (SUPAS) in 2015. However, based on Ministry of Health (Kemenkes) data in 2015, there were 305 mothers who died per 100,000 LBs. MMR in Nusa Tenggara Timur (NTT) Province is still apprehensive. MMR in NTT Province is still high, although MMR tends to decrease, for example from 306 per 100,000 LBs in 1997 to 153 per 100,000 LBs in 2002 and to 167 per 100,000 LBs in 2007. Furthermore, it decreased again in 2015, amounting to 133/100,000 LBs. The high number of MMR in NTT province is inseparable from that of several regencies in NTT Province and one of them is Timor Tengah Selatan Regency (Ministry of Health of NTT Province, 2017). Besides the mortality rate, maternal health issues also involve morbidity, as well as diseases suffered by pregnant women such as anemia, including nutritional problems in pregnant women. Friis et al., (2009) stated that sixteen of the maternal deaths were caused by indirect causes with anemia as the main cause.

The most common nutritional problems in pregnant mothers include: Protein Energy Deficiency (PED), Vitamin A Deficiency (VAD) and nutritional anemia (Health Department of RI, 1996 and Moehji, 2003). Based on Basic Health Research (Riskesdas) in 2013, there was an increase in the proportion of pregnant mothers aged from 15 to 19 years with chronic energy deficiency (CED) from 31.3% in 2010 to 38.5% in 2013. The impact of nutritional problems or pregnancy care by a pregnant mother may cause the risk of death at the moment of, before, or after the childbirth and the baby may have a low birth weight (LBW).

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As they are living in an agrarian country, most of the people live in rural areas with only a primary education level and do not yet have a healthy life culture. Both matters of death and morbidity in pregnant mothers and children are, in fact, inseparable from cultural and environmental factors in society itself. In simple societies, habits and customs are formed to preserve their own lives and aid in the survival of their tribe. Various habits are associated with pregnancy, childbirths that were aimed at successful reproduction and survival of the mothers. From a modern point of view, not all of those habits are good.

Factors of belief and cultural knowledge such as the concept of abstinence, cause and effect relationships between food and health conditions, habits and unawareness often bring both positive and negative impacts on maternal health. Diet is one of the human appetites in which the role of culture is quite significant (Kalangi & Nico, 1995). Each region has a specific diet, including the diet of pregnant, maternal and postpartum mothers (Mahadewi *et al.*, 2003) accompanied by abstinence, taboo and advice on certain foods. Mothers and communities consider pregnancy as normal and natural (Anggoro, 1985). They think that they do not need to have regular medical checkups. There are still many pregnant mothers who are unaware of the importance of a pregnancy checkup and that view causes undetected high risk factors that may be experienced by them (Health Department of RI, 1985).

They are less aware of the importance of the pregnancy checkup, which might cause no detection of any high risk factors that may be experienced by them (Arulita, 2007). This is quite likely due to low levels of education and a lack of information. In a research conducted in Hasan Sadikin Hospital, Bandung, there were 132 mothers who died, 69 of whom had never checked their pregnancy or just came for the first time after 7 to 9 months of pregnancy (Wibowo, 1993). Besides the lack of knowledge of the importance of pregnancy care, problems in pregnancy and childbirth are also influenced by marital factors at a young age that are still common in rural areas. There is still a preference on the sex of the child, especially in some tribes, including patrilineal culture that professes the importance of a son in the succession of the ancestral custom house and clan or tribe.

The impact of having a son for offspring causes a wife to experience what is called the ‘four toos’, namely too young, too old, too often and too close to having another pregnancy (Health Department of RI, 1995). The ‘four toos’ are risk factors for the pregnant mothers and fetus during pregnancy, childbirth and the puerperium (Arulita, 2007) and they might cause mothers to have high-risk facts during childbirth. This research aims to describe the care of pregnant mothers in terms of sociocultural aspects (patrilineal) in Timor Tengah Selatan Regency of Nusa Tenggara Province.

2 METHODS

This research is a qualitative research of descriptive retrospective case studies and a qualitative method is selected to conduct in-depth investigations and analysis of pregnancy care in pregnant mothers based on cultural circumstances (patrilineal).. Informants in this study were pregnant mothers with anemia and chronic energy deficiency (CED) for the period of January to June 2016, women who had anemia and CED during pregnancy (8), family/community members (4), midwives (2) and the birth attendants (2) who are taken purposively.

The writers decided that the sample size of 5 to 10 cases was acceptable in terms of generating a comprehensive assessment of the causal factors of anemia and CED. Guest *et al.* (2006) identified the actual sample size guidance ranging from 5 to 60 and the sample size according to Mason M. (2010) ranged from 1 to 95. The sample size allows it to reach saturation point. The principle of saturation or data collection completed in this research occurred when there were no new concepts emerging or when the informants began to repeat the similar problems they had faced during pregnancy (Hesse & Leavy, 2006).

Data collection is done by interview with a community-based questionnaire: reviewing a culture-based pregnancy care (patriarchy). The data identified is a Maternal and Child Health book that is used to retrieve important information about pregnant mothers such as parity, gravidity, medical history and antenatal visits. An interview questionnaire was given to midwives who take care of pregnant mothers. This includes open and semi-structured questions to document notes about pregnancy care and nutritional problems experienced by pregnant mothers, and the challenge of providing care.

The interview questionnaire contains the following three sections:

- The background which is primarily concerned with the demographics of pregnant mothers, husbands and children;

- The observed symptoms or pregnant mothers carrying out pregnancy care include culture as a factor causing pregnancy problems and assessing what women and people are caring of between pregnancy and having pregnancy problems;
- Family/community and the birth attendants' records of pregnancy care and the disease/pregnancy problem.

The interviews were conducted at the participants' homes and lasted for 1 month in total. Most interviews were recorded (8 of 13 troubled pregnant mothers). The care culture and pregnancy problems (nutritional problems) experienced by pregnant mothers were traced to the community. Data was analyzed qualitatively.

3 RESULTS

Five pregnant mothers suffered from chronic energy deficiency (CED) and three pregnant mothers were with anemia. They were all between the ages of 19 and 36, and there were only two women who were educated and graduated from secondary school, while the others only graduated from elementary school. There was a lack of recognizing the signs, symptoms and severity of the situation; using traditional birth attendants' service; women with low literacy rates; delayed access to transportation; remote area and physical difficulties; rapid obstetric emergency care; delayed treatment while in hospital due to patient rejection or observed concealment. One family lives in a densely populated area near the hospital. However, the husband still has problems in finding transportation at the right time when an emergency occurs at dawn.

Case # 1 Informant: Pregnant woman with anemia and CED: Mrs. S. (31 years' old) is pregnant with the second child, 8 months of pregnancy with moderate anemia. This is the first time of performing the Antenatal Care (ANC) at 7 months of pregnancy due to past pregnancy experience.

"Since my first child's pregnancy, before I went to the midwife in primary health care (Puskesmas), my mother-in-law and I had seen a birth attendant intending to touch my stomach and make sure of my pregnancy, she also gave me the traditional potion for the uterus that is applied to the stomach… the birth attendant was very experienced in determining the age of pregnancy, the fetus in the stomach and when the fetus is in abnormal position she can restore it to a normal position... I am a housewife and every day I accompany my husband to work in the fields/garden. I do not feel dizzy because it is common, when I was pregnant with the first child, my midwife said that I was anemic, but I gave birth with no problems... I gave birth at home helped by the birth attendant, then the midwife was called to give vitamin injections the next day."

Mrs. N. (who is 36 years' old) is pregnant with the third child, 9 months of pregnancy with anemia. The first time of ANC was at 7 months' pregnancy with the reason that the previous pregnancy had no problem. They are still fanatic with the birth attendants because they are considered very understanding in seeing the sex of the fetus and helping childbirth.

"Since I was pregnant with the first child, before my mother-in-law and I saw a birth attendant to make sure of my pregnancy, I also made sure of the sex of my fetus. My husband and his family wished for a son. The first and the second children are daughters… A son is the offspring of the family while the daughter, when married, will be living with the family of the husband… My family really takes care of my pregnancy… After we get a son, I'll stop getting pregnant and giving birth… My husband and family are happy with this pregnancy because it will be a son... my husband and I plan to give birth with the midwife present, but the birth attendant will still be present ... our habit is to call the birth attendant first, then a midwife...".

Case # 2 Informant: pregnant mothers with anemia and CED: Mrs. B.B. (19 years' old) is pregnant with her first child, the last education is secondary school, 6 months' pregnancy with moderate anemia and CED. The first time she had ANC was after 5 months of pregnancy due to past pregnancy experience.

"Since I was pregnant, I have felt tired... then my mother and mother-in-law said that dizziness for pregnant mothers is normal and all pregnant mothers must experience what I feel… I myself have gone to a birth attendant three times, before pregnancy I went there once to have a massage to get pregnant quickly because I had already been married 6 months but I still had not been pregnant yet… I was given a traditional potion on my stomach and a month later I was able to menstruate again... I went there for the second time to the birth attendant to have traditional potion for strengthening the uterus to prevent miscarriage… I checked for pregnancy at the puskesmas then midwife asked me to check my blood. My midwife said that I looked pale and might have a lack of hemoglobin… finally I went to Puskesmas… Our

custom is... a husband is upheld including the number of food, it becomes the main priority because he is a hard worker… I eat neither side dishes nor vegetables, the first priority is husband and the second one is child .... also because daughters always succumb to sons ... Actually I want to get pregnant for a son to be the family offspring and to grow the clan"

Mrs. K.N. (36 years' old) is pregnant with her third child, and has had 9 months of pregnancy with anemia. The first time she had the ANC was at 7 months of pregnancy for the reason that the previous pregnancy was with no problems. She is still fanatic with the birth attendants because they are considered very understanding in looking at the sex of the fetus and helping the birth.

"Since I was pregnant with my first child, before my mother-in-law and I went to the birth attendants to get both the certainty of pregnancy and the certainty whether I will give birth to a son or daughter, my husband and his family wished for a son. My first and second children are daughters… A son is the offspring of the family while the daughter, when married, will be living with the family of the husband… My family really takes care of my pregnancy… After we get a son, I will stop getting pregnant and giving birth… My husband and family are happy with this pregnancy because it will be a son... my husband and I plan to give birth with the midwife but the birth attendant will still be present ... our habit is firstly to call the birth attendant then a midwife...".

Mrs. Q. (27 years' old) is pregnant for the second child, educated until junior high school, 4 months of pregnancy with anemia and CED, no ANC because it is the early pregnancy.

"I have felt the movement of the fetus in the stomach, but I am still busy in the field so I have not checked it with the midwife… I have gone to the birth attendant twice before pregnancy… I want to have a son again in my next pregnancy, but if it is a daughter, it will be fine… our habit here is always being treated by the birth attendants during pregnancy… for eating during pregnancy, it is three times a day as usual... the abstinence that we should avoid is eating pineapple both unripe and ripe pineapple to prevent miscarriage, salted fish to prevent the body of the fetus being itchy and wounded, some types of bananas to prevent big fetus and later it will be difficult to deliver, especially in late pregnancy all kinds of food must be in the usual portion...".

Case # 3 Informants: Husband, mother-in-law and father-in-law.

"We expect the first child is a son who can later help the parents to make a living. Sons are the descendants of our custom house here, daughters will follow her husband and join her husband's family and their clan will also become the husband's clan. So we really want to keep this pregnancy healthy to survive giving birth to our male grandson. The mother works as a housewife and still has a usual pregnant woman's diet. Dukun beranak is given as a traditional potion to strengthen the uterus and we have checked the pregnancy with the midwife once. We plan to give birth with both the birth attendant and midwife present".

Case # 5 Informant: midwife

"There is a pregnant mother whose house is very far from Puskesmas, and, she has to go along the hill and damaged road so that she has the ANC only when a problem occurs. In fact, the family thinks that a pregnant mother is only in problems when she is really sick and when she is not able to get up from bed, and then they will meet the midwives. Before going to the midwife or puskesmas they had already called the birth attendant and the decisions for this were all in the family, especially the husband and father-in-law. Being pregnant with a son becomes their pride because the son will be the offspring but the utilization of health facilities still lacks. There is a pregnancy check when it is approaching the childbirth time or when it is known that the pregnancy is having problems. Often, these pregnant women with nutritional problems do the first ANC in the second trimester and even in the third trimester. The previous pregnancy and childbirth experiences become their benchmark. If the previous pregnancy and childbirth did not have any problems. (The problem for them is when the man riding the motorbike several times and has to step off the motor and, according them, it will have an impact on the next pregnancy.) For example, if the previous childbirth was helped by a birth attendant, this means the next childbirth will be helped by a birth attendant as well. When they are asked, when doing ANC, about birth plans, they answer that they will do it in Puskesmas and with the help of midwives. In fact, they still rely on the birth attendant. We have done counseling especially with those who have high risk factors. We will improve the birth planning program and complication prevention (P4K) to prevent home childbirth and being helped by the birth attendant".

Case # 6 Informant: The Birth Attendant

"I have helped the childbirth process for a long time. All pregnant mothers around this village always call me when they are willing to give birth. I

also take care of the pregnant mothers. They come to ask me to strengthen the womb to prevent miscarriage. I can feel the position of the fetus in the womb. If the fetus' position is not normal, I can justify it back to a normal position in our way. Sometimes they come to ask traditional potions to apply on the stomach to get a son or a daughter."

Case # 7 Informants: village midwives and heads of puskesmas:

"The program is still continuing the partnership with the birth attendants as we continue to appeal to community leaders and religious leaders for the utilization of health services, especially for pregnant mothers, postpartum mothers and the fetus. The birth attendants are still their family and they strongly believe that they have the ability to take care of and help the pregnancy and childbirth up to baby care. Village midwives are under heavy duty to convince the public that abnormal fetal positions are very dangerous for the fetus and the mother. This is more for the birth attendants who practice to restore the fetus into a normal position. Sons have an important place in the family structure of the local community (patrilineal culture) ... The impact of the importance of the position of a man in a family makes the 'four toos' (too young, too old, too often and too close) become repetitive problems. There are many dietary restrictions and prohibitions for a pregnant mother such as: prohibition of certain fruits and portions of food for the reasons of fear of a big child that affects the process of childbirth".

4 DISCUSSION

The summary results in this research indicate that many factors influence the use of pregnancy care by pregnant mothers and local people, and these include sociocultural factors. The cultural background in Timor Tengah Selatan Regency (South Central Timor Regency) is the Timor Dawan community. In the Timor Dawan society that embraces patrilineal pattern in family customs, the heredity is seen through the male/father line. This is evident in daily life. The husband is the head of the family and has a very influential role in decision making and fate determinants, including those who control the family's economic resources (Herskovits in Susilowati, 2001). The sociocultural factors that influence the decision-making of pregnant mothers depend on the belief of someone who is considered to have the ability to care for pregnancy and depends on the financial condition, and there is one more important thing, that is those who have a son will get a special position.

Juwita's research results (2015) show that men are the dominant factor in decision-making. Although a wife has a wealth of high-risk pregnancy information, she does not have the opportunity to choose a referral hospital and does not have the same status in the decision making of the referral to the hospital in the family. If viewed from a gender perspective, the role of wives and husbands in households for decision-making of referral to hospitals for a high-risk pregnant mother still emphasizes a patrilineal culture. In patriarchy culture, a husband has a big influence in the family decision making since the husband is the head of the family who has a role as a determinant of the fate and the use of family economic resources.

Another finding in this research is that the community strongly hopes that a wife can give a son as the offspring. Local people believe that the birth attendants can provide traditional potions or a way for a woman to have a son for the sake of succession of their clan. The way they do it is, when the mother is known to be pregnant, she immediately comes to a birth attendant to massage the stomach or give traditional potions to the mother's stomach in the hope that the mother can have the child as expected (male or female). Cultural factors that support pregnancy care are kinship factors (husband, parents, grandmother) who still provide an important role in the care of the pregnancy in the form of providing advice related to the care of pregnancy, delivery and puerperium, although the use of health services are allowed when there are problems in pregnant mothers and they are still having antenatal care.

The results of this research are that the eight pregnant mothers struggle with anemia and CED problems due to the portions of food that are less nutritious because of the ban on certain foods that actually contain vitamins and proteins that are very important. A pregnant mother should eat more portions than usual (before pregnancy), but it is found that a mother's portion of food should not be much during the third trimester on the grounds of obesity in the fetus. Also found in this research, is that all pregnant mothers must firstly search for the birth attendant for their care during the pregnancy.

This is closely related to the public statement that pregnancy, childbirth and the birth of a baby are important events and are normal and natural things. All pregnant mothers have the ANC in the second and third trimester of pregnancy and their admission that their condition is healthy, while the result of the

examination is that they are detected to have nutritional problems. Not being aware of the problems surrounding pregnancy with anemia and CED is due to a low educational background (elementary and secondary school). The low status of women in society, culture and beliefs are factors that cause women to fail to access health services (WHO, 2009). Mrisho in Cham et al. (2008) found a tradition in rural Tanzania, in which the culture and patterns of decision-making power in families prevent women from going to health facilities.

If the antenatal care is not standardized, that results in no detection of risk factors and complications experienced by pregnant mothers. The frequency of ANC service is recommended at least 4 times during pregnancy, namely: at least once in the first trimester, at least once in the second trimester and at least twice in the third trimester (Health Department of RI, 1998).

Pregnant women and the community still need the birth attendant. The local people's opinion is that the birth attendant is capable, experienced and provides full services starting from the mother's pregnancy, childbirth, puerperium and caring for the baby until the puerperal period is over. The birth attendant is ready at any time needed, and gives a sense of comfort and safety because they are mostly older relatives; moreover, there is still a familial relationship to make the presence of the birth attendant that in certain cases is difficult to be replaced by midwives. Koentjaraningrat (1998) argued that social culture is a habit or tradition of society derived from reasoning. The people of Timor Tengah Selatan Regency have a social culture such as myths and customs.

Myths obtained in this research are that pregnant mothers are abstinent or forbidden to eat certain types of food, fruit or certain side dishes and doing certain activities. Those prohibition/restrictions are, among others:

- Prohibition of several types of banana (not all bananas) with the reason that the fetus will be big which causes difficulties during the actual birth;
- Prohibition of eating salted fish for causing itching and body wounds;
- Abstinence from shrimp and crabs because the mother gives birth to a baby with the problem of producing too much saliva;
- Prohibition of being out of the house at night;
- Prohibition of drinking iced water;
- Prohibition of eating large portions during the late pregnancy for fear of a big baby.

Although the perception that pregnancy is a natural thing, pregnant mothers and their families continue to seek pregnancy care for the normal pregnancy.

Muhammad (1996) suggested that sociocultural conditions (customs) and environmental conditions affect reproduction health. The cultural situation, which in this case are customs, are not conducive to help seeking behavior in reproduction health problems in Indonesia. This is based on the reality that Indonesian people generally consider pregnancy as a normal and natural event that does not require antenatal care. This is, of course, also related to the lack of knowledge and understanding of the importance of antenatal care and reproduction health care.

Every culture has its own rituals, taboos and bans on pregnancy and childbirth. These beliefs and practices are strongly held and determine what different cultures consider to be acceptable or unacceptable behavior on the part of pregnant mothers, spouses and families and others who take care of them. Cultural awareness, competence and openness are very important in the relationship between the care and mothers during this important period of their lives. Other researches in West Africa have shown that to solve cultural and social barriers toward providing services on a basic level requires high quality services, effective outreach and referral and emergency support systems (JHPIEGO / MNH, 2004).

Local midwives in charge and the heads of puskesmas who were interviewed realized that the birth attendant is still very important and is still needed by the community. The birth attendant training, coaching and mentoring programs by midwives of the puskesmas are still running. On the other hand, local midwives in charge and the heads of puskesmas seek to improve the role of midwives and to prevent pregnant mothers from giving birth at home or assisted by the birth attendant to prevent maternal and child complications and deaths due to childbirth.

5 CONCLUSIONS

This study found that, in pregnancy, there are still a lot of local people who believe in the birth attendant and cultural perception of patriarchy and family or community habits that if it is reviewed medically, they do not have the benefits of pregnancy, and even sometimes, the hereditary cultures can be somewhat

risky that can be dangerous for the pregnant mothers and the fetus.

The practice of care culture that supports pregnancy includes: the attention of the husband and family members while the mother is undergoing pregnancy. The practices of pregnancy care that need to be eliminated or improved are:

- abstinence against certain bananas;
- large portion prohibition during late pregnancy;
- the birth attendant’s practice that can change the abnormal fetal position to normal position in the maternal womb;
- giving more attention for pregnancy care when a mother is pregnant with a son compared to a daughter.

Here are some roles of a midwife that can be done in handling various culture or social behavior that exist in society. The practice of pregnancy care in this study had a positive impact on women's reproduction health. Supportive practices involve kinship such as parents/other family members as well as local communities. Practices that need to be fixed are:

- becoming pregnant too often;
- giving birth if they still don’t have any boys;
- still having belief and fanaticism in the birth attendant and seeking health facilities and medical officers if pregnant mothers experience illness or having pregnancy problem that cannot be handled by the birth attendant, and the husband and the boy's food portion is prior.

Communication and Information Education must be done continually by involving community leaders to omit the understanding of norms or beliefs that do not support maternal reproduction health. Giving counseling to husbands and pregnant mothers with risk factors or at high risk must be done for planning and preventing pregnancy, childbirth and postpartum complications for mothers. Pregnancy complications are a direct cause of maternal deaths. Common pregnancy complications that often occur include bleeding, preeclampsia/eclampsia, and infection (Abdulla, et al., 2010). Obstetric cases or obstetric emergencies experienced by a mother require adequate handling, and prompt and comprehensive treatment (WHO, 2004).

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