Change and continuity: the influence of policy on the practice of a traditional birth attendant in Eastern Indonesia

Emma Grimes

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Menzies School of Health Research
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Abstract

Indonesian women continue to experience high rates of maternal mortality despite decades of policies and programs designed to improve maternal health outcomes. The Indonesian province of East Nusa Tenggara (NTT), one of the poorest in Indonesia, has disproportionately high rates of maternal deaths and many women deliver at home with a traditional birth attendant (TBA). This case study explored the experiences of one TBA working in NTT and her perceptions of how maternal health policies have impacted on her practice over three decades. The TBA lives on a remote island in NTT where the district centre and nearest hospital are located on a nearby island. Travel between the islands is by boat, however travel between the islands can be cut off due to inclement weather. This qualitative case study used ethnographic methods including narrative style interviews and participant observation. Information collected was thematically analysed and categorised into three themes: ‘becoming and being a TBA’, ‘attitudes towards maternal health policy’, and the ‘impact of maternal health policy’.

Although a range of health policies have influenced the TBA’s practice, the TBA identified the NTT province Revolusi Kesehatan Ibu dan Anak (Revolusi KIA) policy as the most prominent maternal health policy impacting her practice. This policy mandating facility deliveries has dramatically decreased her role in delivering babies, with many births now taking place at the health clinic where homebirths had previously been the norm. Although her role has changed, the TBA continues to play an active and arguably essential role in the provision of acceptable and adequate maternal health care services to the women in her village. The TBA’s role in the provision of maternal health care is integral as there continue to be barriers to women accessing formal health care services. These barriers include poor acceptability of services to women, difficulties accessing health care, and widespread health system dysfunction. In these circumstances, the TBA continues to provide assistance in pregnancy, childbirth and postnatally where women may
otherwise receive little or no quality care. However, as current policies restrict the involvement of TBAs in delivery and TBA training has ceased, TBAs are at risk of becoming deskilled and ceasing to exist in the community. This is problematic as it will increase women’s reliance on a system that is currently undependable, and potentially remove the only option for experienced attendance at birth for many women. These findings demonstrate the importance of understanding the impact of policy at the local level and why policies should be locally tailored. It is argued that TBAs should be acknowledged as part of the solution to improving maternal mortality in Indonesia, particularly in remote areas and must be genuinely partnered with as valuable and respected providers of maternal health care. Improvements to the current health system and addressing social and economic determinants of health are also critical to improving health outcomes for women in this province.
I declare that this thesis is my own work and has not been submitted in any form for any other degree or diploma at any university or other institute of tertiary education. Information derived from the published and unpublished work of others has been acknowledged in the text and list of references.

Signed: ____________________

Date: 29th of January 2016
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### Glossary

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<td>Bidan</td>
<td>Midwife</td>
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<td>Bidan di desa program</td>
<td>Village Midwife program</td>
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<td>Desa Siaga program</td>
<td>Alert Village program</td>
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<td>Dukun Bayi</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>Jamkesmas</td>
<td>Community Health Insurance</td>
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<td>Jampersal</td>
<td>Maternity Health Insurance</td>
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<tr>
<td>Kabupaten</td>
<td>District</td>
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<td>Kemitraan</td>
<td>Partnership</td>
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<td>Nusa Tenggara Timur</td>
<td>East Nusa Tenggara</td>
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<td>PONED</td>
<td>Basic emergency obstetric and neonatal care</td>
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<td>PONEK</td>
<td>Comprehensive emergency obstetric and neonatal care</td>
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<td>Puskesmas</td>
<td>Community Health Centre</td>
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<tr>
<td>Revolusi KIA</td>
<td>Maternal and Child Health Revolution</td>
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<tr>
<td>Rumah sakit</td>
<td>Hospital</td>
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<td>Rumah tunggu</td>
<td>Maternity waiting house</td>
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<tr>
<td>Tangan dingin</td>
<td>Cool hand</td>
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## List of Abbreviations

<table>
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<th>Abbreviation</th>
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<tr>
<td>BDD</td>
<td>Bidan di Desa</td>
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<tr>
<td>BEONC</td>
<td>Basic emergency obstetric and neonatal care</td>
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<tr>
<td>CEONC</td>
<td>Comprehensive emergency obstetric and neonatal care</td>
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<tr>
<td>Jamkesmas</td>
<td>Jaminan Kesehatan Masyarakat</td>
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<td>Jampersal</td>
<td>Jaminan Persalinan</td>
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<tr>
<td>MDG-5</td>
<td>5(^{th}) Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>NTT</td>
<td>Nusa Tenggara Timur</td>
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<tr>
<td>PONED</td>
<td>Pelayanan Obstetri Neonatal Emergensii Dasar</td>
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<tr>
<td>Puskesmas</td>
<td>Pusat Kesehatan Masyarakat</td>
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<tr>
<td>Revolusi KIA</td>
<td>Revolusi Kesehatan Ibu dan Anak</td>
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<tr>
<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<td>SM</td>
<td>Safe Motherhood</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UNFPA</td>
<td>The United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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A - Information sheet (English and regional variety of Malay)

B - Interview guide

C - Ethics approval from Menzies School of Health Research, Northern Territory, Australia

D - Extension of ethics approval from Menzies School of Health Research, Northern Territory, Australia

E - Supporting letter from the Rector of Nusa Cendana University, East Nusa Tenggara Province, Indonesia (Original and English translation)

F - Supporting letter from Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) (Original and English translation)

G - Research permission letter from East Nusa Tenggara Governor (Original and English translation)

H - Research permission letter from district Mayor of study site (Original and English translation)

I - Consent form (English and regional variety of Malay)

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1 In order to maintain the anonymity and privacy of the TBA participant, following examination I removed details from appendices that disclose the location of this research.
Photo: Beach near study village

Source: Author’s personal collection 2015
CHAPTER 1

Introduction

1.1 Maternal mortality

Despite decades of maternal health policies implemented at global, national and provincial levels, the rates of maternal mortality and morbidity remain stubbornly high in Indonesia (UNICEF 2012). It is estimated that approximately 303,000 women died during pregnancy and childbirth globally in 2015 (Alkema et al. 2015) with the leading causes of death in Indonesia being haemorrhage and hypertension (Supratikto et al. 2002). Whilst no single intervention can significantly reduce maternal mortality (Campbell & Graham 2006), skilled professional attendance at birth and improved access to lifesaving emergency obstetric care are key (Starrs 2006). Many countries in the South East Asia region have made significant improvements in maternal and child mortality, however these improvements are unequally distributed between countries (Acuin et al. 2011). For example, Malaysia and Thailand have made rapid and significant reductions in maternal mortality. However, despite experiencing initial declines Indonesia’s progress has stagnated (Acuin et al. 2011) and Indonesia’s maternal mortality ratio (MMR) remains one of the highest in the South East Asia region (Mize et al. 2010). The current MMR for the South East Asia region is 150 (WHO 2012), while Indonesia’s MMR is now 359 per 100,000 live births (BPS et al. 2013).

1.2 Maternal mortality in Indonesia and Traditional Birth Attendants

The Indonesia government has long recognised the high levels of maternal mortality in the country and has subsequently made maternal health a top priority, implementing a range of different policies, programs and action plans tackling this
issue (Mize et al. 2010). This study is based in the NTT province of Eastern Indonesia. NTT is one of the poorest provinces in Indonesia (WFP 2013) and it experiences high rates of maternal and child mortality, which are well above the national average (Dinas Kesehatan NTT 2009). Physical access to health care in NTT is often challenging, particularly in the wet season, due to the province’s geographical remoteness, rugged terrain, vast numbers of small islands, and the poor conditions of roads (Belton, Myers & Rambu Ngana 2014). Furthermore, research has shown that there are many socio-cultural, geographical, and economic factors that can and do influence a woman and her family’s choice and ability to access skilled birth attendance or delivery in a health centre (Belton, Meyers & Rambu Ngana 2014, D’Ambruoso, Byass & Qomariyah 2010, Gabrysch & Campbell 2009, Ronsmans et al. 2009, Ronsmans et al. 2001, Supratikto et al. 2002, Titaley et al. 2010a, Titaley, Dibley & Roberts 2011). Similar to other parts of Indonesia, TBAs remain integral to maternal and infant health care in many areas of NTT. In the NTT, recent policy changes have required all women to deliver at a health facility (Dinas Kesehatan NTT 2009). Despite this, approximately a third of women in NTT continue to give birth at home assisted by a TBA (BPS et al. 2013). In Indonesia, rates of birth attendance by a TBA are particularly high for those women who are poor, live in remote locations, have low levels of education and for high birth orders (BPS et al. 2013). For many women, a TBA is the only experienced birth attendant they may be able to access. Unfortunately, TBAs continue to be frequently blamed for lack of progress in reducing maternal mortality and are generally undervalued by health workers and policies (Kruske & Barclay 2004).

1.3 Rationale for study

There are multiple factors, including policies and programs, which influence maternal health outcomes and the relationship between these factors are complex and varied. Past research on maternal health and mortality in Indonesia has focused on causes of maternal death, health care provision, and barriers to and
determinants of uptake of services by women and their families. Much of the past maternal health research has tended to cluster around the Java province with very little research completed in the Eastern provinces, such as NTT, which is culturally, linguistically and ethnically unique. There is little research that has privileged the perspectives of the TBAs who continue to play a valuable part of maternal health care. Furthermore, the effect of past and present maternal health policies on the role and practice of the TBA in NTT have not been explored.

1.4 Significance of study and purpose statement

For policies to be effective and accepted, understandings of health and use of health care at the local district level is essential (Shaikh & Hatcher 2004). This is a case study of one TBA’s work on a remote island in NTT, set alongside various maternal health policies of Indonesia. This research gives a voice to a TBA who would have otherwise gone unheard and creates a record of her experience and knowledge. This research has also significantly increased knowledge of the TBA role and practice in the NTT context and how maternal health policies impact on maternal health care in a remote area.

Purpose statement

The purpose of this ethnographic study was to examine the impact of maternal health policies on the provision of informal maternity care by one TBA, over a number of decades, who works on a remote island in the NTT province of Eastern Indonesia. This research sought the perspectives and experiences of one TBA to gain insight into how maternal health policies impact on informal maternal health care in the local setting.
Research questions

The central research question for this study was:

How does maternal health policy impact on the provision of birthing services by a traditional birth attendant in one district of East Nusa Tenggara (NTT), Eastern Indonesia?

There are three sub-questions that followed this central research question:

a) How does a TBA describe her role and how she was prepared for this role? ;

b) What changes has a TBA observed in the birthing culture on her island over time? ;

c) How does a TBA perceive the impact of local and national maternal health policies on her practice over the previous decades?
Photo: Typical house in study village

Source: Author’s personal collection 2015
CHAPTER 2

Literature Review

2.1 Maternal mortality

Unacceptable levels of maternal mortality continue to be grappled with in many countries around the world despite decades of focused action. Maternal mortality is often measured using the MMR, which is calculated by the “number of maternal deaths during a given time period per 100,000 live births during the same time period” (WHO 2012, p. 6). In 2015 the calculated global MMR was 216 per 100,000 live births (Alkema et al. 2015). Although this is significantly less than the 1990 global MMR of 385 (Alkema et al. 2015), too many women continue to die. Alongside the global community, the Indonesian government has made concerted efforts to address high maternal mortality rates. However, their progress has slowed in recent years and Indonesia did not reach the fifth Millennium Development Goal (MDG-5) to reduce maternal mortality rates by two thirds by 2015. Indeed, the latest 2012 estimates of Indonesia’s MMR is 359 per 100,000 births which is a substantial increase from 2007 data where the MMR was estimated to be 228 (BPS et al. 2013). In reality, as Indonesia has a very large population, this growth in MMR is a significant increase in the actual numbers of women dying each year. Furthermore, the calculation of this MMR may also be underestimated due to underreporting of maternal deaths in Indonesia (Ansariadi 2014). In Indonesia maternal deaths are primarily reported by midwives at the district health office, but where there are no midwives, there is often no reporting (Ansariadi 2014).

The challenges of accurate and reliable data recording is not unique to Indonesia. Most often it is the poorest countries, with the highest rates of maternal mortality, which have the poorest data capturing maternal mortality (Ronsmans & Graham 2006). Improved data collection and reporting were key prerequisites to strategies
targeting maternal mortality in Malaysia and Sri Lanka, two countries which have dramatically reduced maternal deaths (Pathmanathan et al. 2003). Others have also argued that improved collection of data around maternal deaths, including causes, is essential in order to make more targeted action in maternal health (Bustreo et al. 2013).

2.2 Causes of maternal death

Maternal death is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.” (WHO 2012, p. 4). Globally, the most frequent causes of maternal death are haemorrhage, hypertensive diseases and infection (Khan et al. 2006). Women are most at risk on the first and second days following birth (Ronsmans & Graham 2006). Studies on causes of maternal deaths in Indonesia have found similar results with haemorrhage and hypertensive diseases accounting for 41 percent and 32 percent of maternal deaths respectively (Supratikto et al. 2002). Obstructed labour and unsafe abortion also commonly contribute to maternal deaths (Pagnacella et al. 2012). In addition to these direct medical causes of maternal death, indirect causes of maternal death include diseases such as HIV and malaria (Ronsmans & Graham 2006, WHO 2004).

2.3 Safe Motherhood and key interventions

Recognising the high rates of maternal mortality and an increased understanding of the causes of maternal death, the global Safe Motherhood (SM) program was launched in 1987. The SM program’s purpose was to raise awareness of the high rates of maternal mortality, particularly in developing counties and to generate
action for change (Shiffman & Smith 2007). The key message that ‘every pregnancy faces risks’ (Starrs 2006) became a focus as although the causes of death are well understood, there are no established links between risk factors and obstetric complications; thus it is not possible to predict which women will experience childbirth complications (Campbell & Graham 2006). Despite this, most obstetric complications can be treated effectively with timely access to emergency obstetric care services (Maine & Rosenfield 1999). For example, whether or not a woman dies from haemorrhage, primarily depends on timely and competent access to obstetric care (Ronsmans & Graham 2006). Thus, the current international discourse on key interventions to reduce maternal mortality are to increase skilled professional attendance at birth (WHO 2008) and improve access to quality health care services that can provide lifesaving emergency obstetric care (Starrs 2006). Researchers have argued that no significant improvements will be made in maternal mortality without a focus on improving quality, access and use of emergency obstetric services (Maine & Rosenfield 1999) including institutional delivery (Campbell & Graham 2006). Despite the enormous efforts and achievements of the SM program globally, it is estimated that 10 million women died in the first 20 years of the safe motherhood initiative (Campbell & Graham 2006).

2.4 Inequalities in maternal health

Although many regions have made significant progress in reducing maternal mortality, regional estimations of MMR can hide variations in MMR between individual countries in that region (Alkema et al. 2015). Countries with the highest rates of maternal mortality have made the least progress in reducing maternal deaths (Islam 2007, Koblinsky et al. 2006). Koblinsky et al. (2006) propose that nearly one in four women in developing countries continue to deliver babies alone or with only a family member or neighbour in attendance. Pagnacella et al. (2012) suggest that the key difference in maternal mortality between low and high income countries is the difference in timely management of obstetric complications.
Inequalities in research agenda is also being observed as focus is more frequently placed on exploring differences in maternal mortality between countries rather than within populations (Ronsmans & Graham 2006). However, not only does there remain an inequality in maternal health between countries, there is also disturbing inequality within countries (Khan et al. 2006). Disparities in maternal mortality within countries are particularly concerning as they are often characterised by disadvantage and exclusion (D’Ambruoso, Byass & Qomariyah 2010). In Sri Lanka, during the decade between 1962 and 1971, Sri Lanka experienced significant differences in MMR between districts. However, by 1980 this disparity had levelled out and there was little variation between districts (Pathmanathan et al. 2003).

Indonesia on the other hand, continues to experience inequities in maternal health between provinces, with higher rates of maternal mortality in the poorer eastern provinces. For example, a 2006 report by the United Nations Population Fund, cited that Central Java had a significantly lower MMR (248) than other eastern provinces including Maluku (796), Papua (1025) and NTT (554) (Sauvarin 2006), which is the setting for this research. At the provincial level, there are also health inequalities for women based on geographical location and socioeconomic status. Research has shown that those women who are at most risk of dying in pregnancy or childbirth are poor (Ronsmans et al. 2009) and live in rural areas (D’Ambruoso et al. 2010), whilst risks have been “virtually eliminated for people with the means and status to access health care” (Ronsmans & Graham 2006, p. 1189). This inequality in health outcomes, particularly for the poor, rural and uneducated, has added momentum for further research into determinants of access to and uptake of health care services.

2.5 **Barriers to access and uptake of maternal health care services**

Access to timely and quality emergency obstetric treatment has long been recognised as essential in preventing maternal mortality (Thaddeus & Maine 1994).
Research in this area led to the development of a three delays model which highlights the complex and interrelated barriers that can prevent access to health care (Thaddeus & Maine 1994). These include; delays in deciding to seek care, delays in arriving at a health facility and delays in the provision of quality care (Thaddeus & Maine 1994). A mixed methods study conducted in two rural districts of Java, Indonesia and one rural district in Burkina Faso found that delays in seeking, reaching and receiving care were reported by two thirds of participants (D’Ambruoso et al. 2010). Another study auditing maternal deaths in Kalimantan, Indonesia, found delays in deciding to seek care were reported by 77% of cases (Supratikto et al. 2002). A recent maternal death ethnographic study conducted in NTT, also found delays featured in each of the cases examined and that either a single delay or a sequence of delays in accessing emergency care can prove fatal (Belton, Myers & Rambu Ngana 2014).

Thus, better understanding the barriers that women face in both accessing and utilising maternal health care is essential in order to improve health outcomes for women. Even in areas where maternal health care services are available, many women continue to have little interaction or delayed interaction with the formal health care system including antenatal, delivery and postnatal care. Gabrysch and Campbell (2009) conducted a comprehensive literature review and identified four major themes of determinants influencing skilled birth attendance and institutional delivery. These included socio-cultural factors; perceived benefit and need of skilled attendance; economic accessibility; and physical accessibility (Gabrysch & Campbell 2009). In Indonesia, maternal education, religion, income, and antenatal care visits are shown to be significant determinants of birth attendant choice (Thind & Banerjee 2004). For example women who have antenatal care are more likely to give birth with a skilled birth attendant (SBA) (Ansariadi 2014, Thind & Banjeree 2004). Other Indonesia based research found that the odds of using a professional birth attendant increases with first births, exposure to mass media, and knowledge of or prior experience of obstetric complications (Titaley, Dibley & Roberts 2011). A qualitative study in Java found a common perception that professional birth
attendance was only necessary in the event of complications (Titaley et al. 2010a). This finding was echoed in the findings of Belton, Myers and Rambu Ngana (2014), who found that the interviewed families of deceased women in NTT had been willing to seek the assistance of a professional attendant only when a problem became evident. Many women in Indonesia continue to choose a TBA, even when a midwife is available, as they are viewed as more socially acceptable (D’Ambruoso et al. 2009) including for cultural and traditional purposes (Titaley et al. 2010a).

Economic barriers to accessing health care have also been demonstrated in a number of studies in Indonesia (D’Ambruoso, Byass & Qomariyah 2010, Ronsmans et al. 2001, Ronsmans et al. 2009, Supratikto et al. 2002, Titaley et al. 2010a, Titaley et al. 2010b). Social and economic barriers arising from the health system itself was also identified by D’Ambruoso, Byass and Qomariyah (2010) and were considered to cause further exclusion and disadvantage for the poor. Ronsmans et al. (2001) suggests that high cost is the biggest barrier to accessing emergency obstetric care in Indonesia. Issues with distance and transport to health centre are also barriers to using a SBA in Indonesia (Ansariadi 2014, Titaley et al. 2010a, Titaley, Dibley & Roberts 2011), with increasing distance from a health centre lowering use of a SBA (Scott et al. 2013). Importantly, the study conducted by Scott et al. (2013) based in Bangladesh and Indonesia found that even with a professional attendant at a birth, the odds of dying were higher with increasing distance to a health centre. An analysis of NTT puskesmas (Community Health Centre) data found that rates of maternal death doubled where women lived more than two hours from the district centre (AIPMNH 2015a). Thus professional attendance alone is inadequate without the support of a functional health centre. Geographic barriers, including remoteness, poor roads and seasonal inability to access health care due to rain, flooding and landslides were also demonstrated to have contributed to maternal deaths in the NTT province of Indonesia (Belton, Myers & Rambu Ngana 2014). In his research in South Sulawesi, Indonesia, Ansariadi (2014) found that maternal deaths from postpartum haemorrhage occurred most frequently in the mountainous regions of the study. There are many social, cultural, geographical and
economic factors that influence a woman’s access to and uptake of maternity health care services and the interaction between these factors is complex. Additionally addressing the problems of exclusion and disadvantage for the rural, poor and usually uneducated women remain essential in efforts to reduce maternal mortality.

2.6 Maternal health policies and programs

**Indonesian national policies and programs**

*Bidan di desa program*

Over the past decades, Indonesia has implemented a range of maternal health policies and programs, many of which have been influenced by the global SM movement. In response to the SM program and ongoing high maternal mortality rates in Indonesia, the national government launched the *Bidan di desa program* (BDD) (village midwife program) in 1989 (Shankar et al. 2008). The aim of this program was to place a midwife in every Indonesian village and thus increase professional assistance at birth (D’Ambruoso et al. 2009), particularly where provision of birthing care by traditional birth attendants (TBAs) had been the norm. By 1997, 54,000 midwives had been placed across Indonesia in the BDD program (Shankar et al. 2008) and a number of studies have since conducted evaluations of this program. Two key studies found that although the BDD program has dramatically increased access to professional attendance at birth overall, it has not provided emergency obstetric care for all women (Hatt et al. 2007, Ronsmans et al. 2001). In fact the study by Hatt et al. (2007) found an increase in inequality in both access to professional attendance at birth and emergency obstetric care between the wealthy and the poor (Hatt et al. 2007). In their sample group, 90 percent of women in the wealthiest quintile had access to professional birth attendance compared with only 16 percent of women in the poorest quintile (Hatt et al. 2007).
In addition to issues of access to a SBA for the poor, research has also demonstrated an imbalance in midwifery coverage between urban and remote districts. Studies have found that isolation of midwives in rural areas (D’Ambruoso et al. 2009) has led to issues with recruitment and retention and subsequently poor midwife coverage (D’Ambruoso et al. 2009, Makowiechka et al. 2008, Rambu Ngana, Myers & Belton 2011). In a qualitative study conducted in Java, Titaley et al. (2010a) also found less access to professional birth attendants in remote areas. In a NTT study, it was found that 28% of villages had a resident midwife, 48% of villages had a visiting midwife, and 24% of villages had only monthly access to a midwife via a mobile clinic (Rambu Ngana, Myers & Belton 2011). Although midwives are supposed to reside in the village and be supervised locally (Supratikto et al. 2002), village midwives often travel out of the village or are in another village and consequently coverage is limited (Titaley et al. 2010a). This deficit of midwives in rural and remote areas is another source of inequality for maternal mortality (Makowiechka et al. 2008).

Furthermore, issues with the quality of care provided by many village midwives have been well researched and documented. One study found that although village midwives accurately diagnosed problems and referred appropriately, their clinical competence was poor (D’Ambruoso et al. 2009). In their report on Indonesia’s workforce, Rokx et al. (2009) argue that the education of health professionals overall is of poor quality with poor regulation, accreditation, and certification. Other research on the use of village midwives found that village midwives are often considered socially unacceptable to families, with midwives being viewed as too young or untrustworthy (D’Ambruoso et al. 2009). Makowiechka et al. (2008) found in their Java study that village midwives were poorly trained, generally had low obstetric workload, were professionally isolated and as most deliveries took place outside a health facility, midwives had limited access to support in an obstetrical emergency. These findings were echoed by Shankar et al. (2008). Other findings indicated that midwives in rural areas often feel compelled to provide services for which they are not trained (Rambu Ngana, Myers & Belton 2011). In summary,
although the BDD program has assisted in making gains in maternal health, addressing issues relating to equitable access, the qualification and skills of midwives, and the quality of services in rural areas and public hospitals is essential (Titaley, Dibley & Roberts 2011).

_TBA Training_

Before the implementation of the _BDD_ program, many of the efforts to improve maternal health in Indonesia were based around the training of TBAs, preventative activities such as vaccinations and nutrition, and also developing partnerships between TBAs and midwives (Koblinsky 2003). Training of TBAs was initially a priority in addressing maternal mortality in the 1980s (Buekens 2003), but by 1997 efforts had moved from emphasising TBA training to prioritising interventions at the health system level in order to increase access to professional care (Starrs 2006). Despite the vast number of women who continued to deliver with a TBA, TBA training in Indonesia was ceased in areas where a village midwife was available (Koblinsky 2003). There was a lack of evidence globally that TBA training was effective in reducing maternal mortality and thus funding for training was ceased (Kruske & Barclay 2004). TBAs were excluded from the definition of a SBA as they did “not have the clinical skills, drugs and equipment, or infrastructure to manage complications such as haemorrhage, eclampsia, or severe infection” (Starrs 2006, p. 1130).

Kruske and Barclay (2004) argue that by this sole focus on obstetric emergencies “policy makers have ignored other skills and expertise of the TBA” (p. 307). Additionally, research suggests that a trained TBA may in fact significantly increase the uptake of formal antenatal care (Sibley, Sipe & Koblinsky 2004a), and antenatal care in turn is linked with increased skilled birth attendance (Ansariadi 2014, Thind & Banjeree 2004, Wang & Hong 2015). Other evidence has indicated a small but significant decrease in peri-neonatal mortality (6 percent) and birth asphyxia (11 percent) linked with TBA training (Sibley & Sipe 2004). There have been arguments
for continuing TBA training, particularly in countries where the current health system is weak and unable to meet the needs of all the women needing care (Kamal 1998). For example, Samoa and Cambodia, are two countries who have continued training of TBAs over decades as there are insufficient midwives and health professionals available to meet the current need (Hoban 2002 in Cambodia & Homer et al. 2012 in Samoa). Recent research in Samoa found that despite this training there has been continued problems with TBAs adequately recognising when to refer in the event of high risk or complications (Homer et al. 2012). However, a meta-analysis of TBA training research found that it is very difficult to evaluate the overall effectiveness of TBA training without the consideration of the larger context in which this training occurs (Sibley, Sipe & Koblinsky 2004b). In her ethnographic work looking at home births in Guatemala, Berry (2006) asserts that the ‘failure’ of TBAs to alter their practice after receiving bio-medically based childbirth information is not an issue of knowledge acquisition. Rather, it is that “this information fails to fit into an already existing social system of understanding birth and birth-related knowledge” (Berry 2006, p. 1958).

Desa Siaga – Alert Village program

A key maternal health initiative that began in Indonesia in 2000 is the Desa Siaga (Alert Village) program (Mize et al. 2010). Indonesia adopted the WHO Making Pregnancy Safer strategy in 2000 and the principles of this strategy now underpin many of the maternal health initiatives in Indonesia (Mize et al. 2010). The Desa Siaga program promoted community responsibility for increasing awareness of risks in pregnancy and childbirth and supporting pregnant women to access funding and transport for emergency obstetric care including identifying blood donors (Hill et al. 2013). This program focuses on community empowerment and preparedness and has since been expanded to incorporate other areas of health including communicable disease, healthy living and disaster preparedness (Hill et al. 2013).
Maternal health insurance

In 1999, the Social Health Insurance schemes for the poor and near poor began (Mize et al. 2010). These schemes evolved into the Jamkesmas health insurance scheme in 2007 (Mize et al. 2010). However, there are many millions of people who are eligible for this service who as yet are not on the plan (Mize et al. 2010). There are also costs related to health care, such as transport that are not covered under the plan and these present barriers to accessing health services (Mize et al. 2010). In 2011, there was the creation of the Jampersal maternity health insurance scheme (Ansariadi 2014), but again, this does not yet reach every woman in need (National Academy of Sciences 2013). In their research, Titaley et al. (2010a) discovered women often had inaccurate understandings of the scheme and their eligibility. Women also expressed concerns about being discriminated against and receiving substandard care if they were to use the insurance (Titaley et al. 2010a). In 2014, Indonesia launched the National Health Insurance Scheme which is designed to provide universal health coverage by the year 2019 (Sciortino & Tjong 2015). However, a review of the first year of this scheme has identified major issues, including that the current health human resources are inadequate to reach National Health Insurance expectations (Sciortino & Tjong 2015).

Health care expenditure

In 2001, administration of health care services in Indonesia was decentralised to the district level (Kristiansen & Santoso 2006). The management of services, funding and quality control became the responsibility of individual districts, which resulted in a dramatic reduction in expenditure on health (Kristiansen & Santoso 2006). In turn, this has particularly burdened the poor and resulted in a returning trend to the utilisation of traditional healers and medicine (Kristiansen & Santoso 2006). Kristiansen and Santoso (2006) propose that since decentralisation “social and geographic disparities in access to and quality of health services” have been increasing (Kristiansen & Santoso 2006, p. 248). The poorer, low-income provinces of Indonesia are having difficulty allocating adequate funds for health care.
particularly in view of other competing development priorities (UNDP 2004, p. 58), which is another issue of equity. A similar finding was noted in China after a policy change delegated financial responsibility for health care to the local government (Liu et al. 1995). Evidence indicated that the gap between the rich and poor is growing in China as it struggles to finance and organise health care services for rural areas (Liu et al. 1995).

**NTT provincial level policies and programs**

*Revolusi KIA*

This study is based in the NTT province of Eastern Indonesia. NTT is one of the poorest provinces in Indonesia (WFP 2013) and it experiences high rates of maternal and child mortality, which are well above the national average (Dinas Kesehatan NTT 2009). Consequently, in 2009 the NTT provincial government launched the *Revolusi KIA* (Maternal and Child Health Revolution) policy, aimed at accelerating decreases in maternal and child mortality rates in the province (Dinas Kesehatan NTT 2009). This policy is based on the SM objectives of skilled attendance at birth and access to obstetric care in emergencies in order to reduce maternal mortality. This policy directs that in order to reduce maternal and infant mortality rates, all women must change their behaviour and deliver in adequate health facilities (Dinas Kesehatan NTT 2009). Women who live a long way from the nearest health facility are directed to stay at a *rumah tunggu* (maternity waiting house) in the lead-up to their delivery. The policy directs that all women, husbands and families are obligated to obey all advice from health staff, and pay for health services received (Dinas Kesehatan NTT 2009).

The *Revolusi KIA* policy defines adequate health facilities as those equipped with human resources, equipment, medicine and medical supplies, building infrastructure and budget (Dinas Kesehatan NTT 2009). Women are instructed to deliver at either a *puskesmas PONED* or a *rumah sakit* (hospital) *PONEK*. In the Indonesian health system, the *puskesmas* provides primary health care services,
including health promotion and prevention activities (National Academy of Health Science 2013). *PONED* is an Indonesian acronym for basic emergency obstetric and neonatal care (BEONC) and *PONEK* is an acronym for comprehensive emergency obstetric and neonatal care (CEONC), which includes surgery and blood transfusions (Dinas Kesehatan NTT 2009). In the early 1990s, WHO, UNICEF and UNFPA outlined the key standards for BEONC and CEONC (Jhpiego 2012), see Table 2.1. It is important to note however, that although the average *puskesmas* in Indonesia does not meet the requirements for BEONC status, a government regulation requires a minimum of four *puskesmas* to meet the BEONC requirements in each district (National Academy of Science 2013). In Eastern Indonesia this regulation is fulfilled less than half of the time, and much of the time the clinics do not meet the personnel and equipment minimums (National Academy of Science 2013).

Table 2.1 Signal functions for emergency obstetric and newborn care

<table>
<thead>
<tr>
<th>SIGNAL FUNCTIONS FOR EMERGENCY OBSTETRIC AND NEWBORN CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic emergency obstetric and newborn care (BEmONC)</strong></td>
</tr>
<tr>
<td>- Parenteral treatment of infection (antibiotics)</td>
</tr>
<tr>
<td>- Parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants)</td>
</tr>
<tr>
<td>- Parenteral treatment of postpartum haemorrhage (uterotonic)</td>
</tr>
<tr>
<td>- Manual vacuum aspiration of retained products of conception</td>
</tr>
<tr>
<td>- Vacuum-assisted delivery</td>
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<tr>
<td>- Manual removal of placenta</td>
</tr>
<tr>
<td>- Newborn resuscitation</td>
</tr>
<tr>
<td><strong>Comprehensive emergency obstetric and newborn care (CEmONC)</strong></td>
</tr>
<tr>
<td>- All components of BEmONC plus</td>
</tr>
<tr>
<td>- Surgical capability</td>
</tr>
<tr>
<td>- Blood transfusion</td>
</tr>
</tbody>
</table>

Source: Jhpiego 2012
With the Revolusi KIA policy, the NTT government and health department are attempting to enforce a shift in the childbirth culture from a majority of home births in the province, many attended by TBAs, to facility based deliveries with SBAs. A study in the NTT district found that women were fined for delivering only with a TBA (Rambu Ngana, Myers & Belton 2012). Similar policies have been implemented in other provinces and districts of Indonesia where very large fines are given to women, TBAs, and midwives who participate in home births (Arwan 2014). China is an example of another country where the poor and rural women continue to deliver at home despite the introduction of punitive measures designed to be a disincentive to women (Gao et al. 2010). Examples of such disincentives include making home birth and the practice of TBAs illegal, fining TBAs if they assist women at home and restricting access to birth certificates for babies born outside the hospital (Gao et al. 2010). Kamal (1998) argues that despite making laws against TBAs and home births and at times introducing punitive measures, TBAs continue to exist in many countries because a realistic alternative is not available.

**Partnership programs**

Similar to other provinces of Indonesia, there have also been maternal health initiatives in NTT which focus on models of midwife and TBA partnership (kemitraan). The goals of these models are to increase skilled attendance at birth and to facilitate a shift in the TBA role (Plan Indonesia 2005). Generally this shift excludes the TBA from providing delivery care and relegating them to providing emotional or spiritual support only (Plan Indonesia 2005). Many of these partnership models also require TBAs to operate as referral agents of women to formal health care services (Dawson et al. 2011, Druhan & Legendre 2013). In some areas, TBAs are given monetary incentives to escort women to a health facility for delivery (Dawson et al. 2011). In some NTT sub-districts, these partnership programs have been incorporated into government regulation and provisions made for the fining of women and TBAs who engage in home births without a midwife (Plan Indonesia 2005). Malaysia, which dramatically reduced their MMR over a number of decades, implemented a partnership model between midwives and TBAs
whilst also promoting the cessation of harmful traditional practices by TBAs, for example abdomen binding (Karim & Mohamad Ali 2013). A recent study in Samoa, on the other hand, found that the TBAs in Samoa most frequently operated autonomously with very little partnership or collaboration with the formal system (Homer et al. 2012).

2.7 Safe Motherhood and Traditional Birth Attendants

Many programs and policies have been implemented across Indonesia aiming to decrease rates of maternal mortality, and increase professional attendance at birth and access to emergency obstetric care. However, this care “must be sought if it is to be received, and women neither seek nor receive it uniformly” (Spangler 2011, p. 481). Despite the enormous push to place a midwife in every village and the increased, although not universal, access to midwife services in Indonesia, many women continue to prefer birth at home with a TBA (Titaley et al. 2010a). In NTT, many women continue to choose the services of a TBA despite prohibitive and sometimes punitive policy such as the Revolusi KIA policy and other regulations mandating that women deliver in a health facility. TBAs have been the core providers of maternal and infant health care in many communities around the world for generations. The WHO defines TBAs as “traditional, independent (of the health system), not formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period” (WHO 2004, p. 8). TBAs are usually highly valued in their community, importantly sharing the same culture and language as the women they assist (Kamal 1998). Despite their critical role in many communities, TBAs have been excluded from the definition of a ‘skilled birth attendant’ (Starrs 2006) and there has been a subsequent move away from TBA training globally (Kruske & Barclay 2004).

Recent statistics from the 2012 Indonesian Demographic and Health Survey, estimate that in NTT half of all women still deliver at home with one third of women
assisted by a TBA and 11 percent assisted by a friend or relative (BPS et al. 2013). Research and analyses in other parts of Indonesia have shown similar rates of home births attended by TBAs (Ronsmans et al. 2001, Thind, & Banerjee 2004, Titaley, Dibley & Roberts 2011). A recent study in Java found only a third of women delivered with a health professional at birth (Ronsmans et al. 2009). Thus although rates of professional delivery attendance vary across provinces in Indonesia (Titaley et al. 2010a), a large number of births continue to be attended to by TBAs in the home setting. The use of TBAs for assistance with childbirth is particularly prominent in rural areas (20 percent), for women with no education (34 percent), high order births (30 percent) and for women in the lowest wealth quintile (32 percent) (BPS et al. 2013).

So why do women, in particular the women who are poor, live in rural areas, and have little education, continue to use the services of TBAs? It is suggested that some women continue to choose the services of a TBA because the TBA provides a better quality and continuity of care, physically, culturally, socially and economically (Izugbara, Ezeh & Fotso 2008). In Cambodia, Hoban (2002) found that the *yi ey maap* (TBA) continued to be women’s favoured birth attendant as formal services were unfamiliar, expensive and health professionals provided poor quality care. Issues with quality of care was more recently found in research conducted in Cambodia with the conclusion that “women expect, but do not always receive humane, professional, supportive and respectful treatment from public skilled birth attendants” (Ith, Dawson & Homer 2013, p. 71). After her research in Guatemala, Berry (2006) argued that the medical preventative stance that every woman should deliver in hospital with a highly qualified attendant, “underestimates the importance of women’s desires to have normal, vaginal home births surrounded by their families” (Berry 2006, p. 1968). In other scenarios, women utilise the services of a TBA not by preference but out of necessity. Around the world, including the NTT, there are women who cannot physically reach health services to deliver due to geographical remoteness, isolation or lack of transportation. In other areas, the services simply do not exist. As such, for many women the TBA is the only
experienced birth attendant they may be able to access. Without a TBA, some women are at risk of delivering alone or with inexperienced family members attending to them.

2.8 Conclusion

In summary, despite their ongoing and arguably integral contribution to maternal health care in many areas, TBAs continue to be frequently blamed for lack of progress in reducing maternal mortality and are generally undervalued by health workers and policy makers (Kruske & Barclay 2004, Walsh 2006). Although the involvement of TBAs in childbirth is contested and generally not supported at a policy level, many women around the world continue to engage the services of TBAs both out of necessity and choice. Women in NTT experience disproportionately high rates of maternal mortality, and they have low rates of skilled birth attendance and access to emergency obstetric care, and they continue to utilise the services of TBAs despite policies that dictate otherwise. It is recognised that there are many social, cultural, and geographical factors which influence the access to and uptake of maternal health services by women throughout Indonesia. Some women continue to employ the services of a TBA for home deliveries out of choice, and some because there is no feasible alternative. Shankar et al. (2008) suggests, therefore, that efforts and policies must be locally driven and tailored to each district in order to be effective.

Women around the world continue to die from maternal causes that with timely access to treatment are largely preventable. There is a growing shift towards professionalisation of childbirth from a previously considered social occurrence. The key biomedical interventions that are being promoted at a global level are skilled birth attendance and access to emergency obstetric care. Although Indonesia has attempted to improve maternal health outcomes for women, the MMR has actually increased. Inequalities continue to exist with disadvantage and exclusion from accessing maternal health care particularly for the poor, uneducated and those who
live in remote provinces. Although Indonesia has trained and deployed a massive number of midwives through the BDD program, there are still significant issues with midwife coverage and quality of care affecting women’s access to health care. This research sought the perspectives and experiences of one TBA to gain insight into how maternal health policies impacted on informal maternal health care in the local setting.
Photo: Harbour at sunrise – transport boats

Source: Author’s personal collection 2015
CHAPTER 3
Methodology

3.1 Research Design

The aim of this study was to explore the perspectives and experiences of one TBA in relation to her work as a TBA and how past and current maternal health policies influenced her practice. The philosophical assumptions underpinning this research are those of social constructivism. A social constructivism worldview perceives research as an interpretive, discovery based process (Gerber 1999), aimed to capture the meanings and perspectives of participants (Minichiello, Fulton & Sullivan 1999). A combination of these underlying philosophical assumptions combined with the aims of this study, led to the selection of a qualitative, ethnographical strategy of inquiry. Ethnographic methodology is a common qualitative research strategy employed within a social constructivist worldview (Creswell 2009). Ethnographic research involves prolonged interaction with an individual or group of individuals in their natural setting, most commonly using research methods of observational and interview data (Creswell 2009). As such, ethnographic methods allow a deep and rich understanding (Liamputtong 2013). However, it can also be useful in providing insight and bringing about change, for example in health practices (Liamputtong 2013). The narratives of individuals can be used to illustrate a broader phenomenon, and this study used narrative style interviews which involved collecting the in-depth stories and life experiences of one individual (Liamputtong 2013). Additionally, this research draws upon policy analysis in order to compare the TBAs experiences and narratives alongside public health policies.
3.2 Sampling and recruitment

This study required only one participant to capture an in-depth life narrative. The participant for this study was recruited through purposive sampling according to predetermined inclusive criteria (Liamputtong 2013). The inclusion criteria was a TBA who has lived and worked in a remote area of NTT over a period of several decades. Access to this research participant was facilitated through my pre-existing networks within the NTT context, where I reside. I am currently involved with a local organisation which conducts linguistic research and documentation, and translation of materials into local languages. Through networks in this organisation, TBAs were known and willing to record their traditional practices. I approached one TBA, provided written and verbal information about the study (see Appendix A), and asked her to consider participating. The written information was written in the regional variety of Malay spoken in the province. The name of this language and the participant’s local language are not cited in this thesis for confidentiality purposes. The TBA recruited was a 59 year old woman who had worked as a TBA in her village for the past 30 years. The TBA was pleased that I was interested in her story, and she and her family were excited to have her experiences and stories of working as a TBA documented.

3.3 Study site

This study was based in a village located on a small island in the NTT province of Indonesia, which is one of the poorest provinces in Eastern Indonesia (WFP 2013). This island has a population of around 13,000 people. The island on which the study was set is very dry and has a very low annual rainfall. At the end of the dry season the water sources on the island frequently dry up and access to safe drinking water diminishes. Most people living on the island are subsistence farmers and some people farm seaweed as their source of cash income. The staple foods on the island are cassava, corn and fish. However, food security is a critical concern. ²

² References removed for confidentiality purposes
Protestant Christianity is the main religion on the island. People communicate primarily in their local language whilst also communicating in the regional variety of Malay spoken in the province. Schooling and government services on the island are conducted in the national language of Bahasa Indonesia. Infrastructure on the island is very weak and the island only obtained telecommunication access in 2012. Before telecommunication access was obtained in 2012, all communication with government and health services including referral to the closest district hospital on a nearby island, occurred via written letters.

Figure 3.1 Map of East Nusa Tenggara Province

Source: The Provincial Tourism Department of Nusa Tenggara Timur (NTT) Indonesia website 2015.
3.4 Data collection

Overview

This research took place over a period of one year with ongoing interactions with the participant. This prolonged engagement with the participant enhanced rapport and allowed me to check my developing understandings of the data (Creswell & Miller 2000). During the study period, three visits were taken to the village where the participant lives, one visit being 5 days in length. Travel to the village included travelling via boat, hired utility vehicle and motorbike. Access to the village was difficult with multiple trips delayed or cancelled due to weather conditions. The participant also travelled on one occasion to my residence on another island. Contact throughout this research period was maintained via mobile phone.

Methods

This study used the methods of interviews and participant observation, techniques commonly employed in ethnographic research (Gribich 1999). Although the participant predominantly preferred to discuss her experiences and ideas in more informal interactions, a total of eight life narrative interviews were audio recorded of varying length, totally approximately 6 hours. Narrative style interviews were used to encourage the participant to tell stories about her experiences and perspectives as a TBA. “Stories can be regressive, progressive or relate to the biographical present and they act as a way of both individuals and groups making meaning out of their social situation” (Paulson 2011, p. 151). There is recognition of the overlap between narrative and ethnographic research (Gubrium & Holstein 1999), and the use of both ethnographic methods and narrative interviews has been argued to produce rich qualitative data (Paulson 2011). An interview guide was developed to cover the areas contained in the research question (Liamputtong 2013) (See Appendix B). This guide was flexible however, which allowed the ongoing incorporation of discussion that I had not anticipated (Smith 1995) and included open ended questions designed to elicit the participant’s views and opinions (Creswell 2009). The audio recorded interviews were transcribed at a later date.
Additionally, this research incorporated the method of participant observation, which included informal conversations that occurred in the field (Liamputtong 2013). Field notes were used to document these informal conversations and to also incorporate observations and my experiences, thoughts and feelings (Liamputtong 2013). This aided me to consider areas to follow-up in subsequent conversations and interviews. I attempted to complete these notes as soon after the interaction as possible and in the instance of my five day visit, I completed field notes each evening. During visits to the study village I participated in the TBAs daily activities including carrying water, cooking, cleaning and gardening. I attended a number of community activities including a wedding, and visiting neighbours and other family members in the village. As I was pregnant whilst conducting this research, I also received antenatal massage and advice from the TBA regarding nutrition and preparations for labour. Reciprocity for participation was provided to the participant in a number of ways. This included practical assistance with garden and house work during the data collection phase, and the provision of small items including rice, oil, and soap. Respect was also shown to the TBA through provision of feedback of the research findings (Liamputtong 2013) including a number of photos as a record of her involvement.

The regional variety of Malay spoken in the district was the primary language utilised in all parts of this research. A female interpreter, independent of the formal health system or other maternal health services, was used throughout the first 5 day long data collection period. This enabled the participant to speak her primary local language and the interpreter translated from this local language into the regional variety of Malay and some English. Other interviews and informal conversations throughout the research period were conducted by myself in the regional variety of Malay or Bahasa Indonesia. I have formally studied Indonesian, and I have also informally learnt the regional variety of Malay spoken in the province since residing in Indonesia. Interviews were transcribed in the language of the interview in order to minimise issues with the translation and interpretation of
the data (Liampittong 2013). Initial transcription was completed by an independent person and checked by the researcher for accuracy. Cultural and linguistic guidance was sought from local colleagues throughout the study, including a locally based anthropologist and linguist.

### 3.5 Data analysis

In addition to continual reflection and interpretation throughout the data collection phase, I used thematic data analysis to make sense of the collected data (Liampittong 2013). Transcriptions of the interviews and field notes were read and reread to gain a general sense of the overall data (Creswell 2009) with reflective notes made on tone, meaning, impression and so forth. The data was coded by organising sentences into categories, labelling these categories (Creswell 2009) and then collating categories into emerging themes (Liampittong 2013). A key focus of the analysis was the influence of maternal health policy on the TBA. The process was cyclical and each stage revisited multiple times to check the accuracy of interpretations and to consider alternative meanings and understandings. Key narratives and quotes were translated into English for the write-up of the research outcomes.

### 3.6 Strategies for rigor

**Triangulation**

This research used the strategies of triangulation of data methods and reflexivity to enhance credibility of this study (Creswell 2009). Triangulation is used to “search for convergence among multiple and different sources of information to form themes or categories in a study” (Creswell & Miller 2000, p. 126). In the study this included data from interviews, field notes of observations and informal conversations, and my reflective journal.
**Member checking**

Member checking occurred ongoing throughout the data collection and analysis phases, with preliminary analysis and interpretations of early interviews discussed with the participant during subsequent interactions. This member checking allowed for the negotiating of interpretations of the data (Fine et al. 2000). In the study, the member checking of initial data analysis was critical as it resulted in a shift away from what I had originally thought to be a key theme. This member checking was audio recorded, transcribed and the input from the participant integrated back into the findings and data analysis. The themes generated from all analysed data were also presented back to the participant to allow her the opportunity to confirm or challenge the analysis (Creswell & Miller 2000).

**Prolonged engagement**

Prolonged time spent in the field is also an appropriate rigour strategy for ethnographic research (Creswell 2009). This research was undertaken over a period of a year and included a number of visits to the participant’s village and many interactions with the participant. This enabled the development of rapport, many opportunities for informal conversations, and also gave me opportunity to explore the data and my “hunches” (Creswell & Miller 2000, p. 128).

**Rich and thick description**

Rich and thick description has been used to describe the setting, participant and research outcomes, particularly in the Findings Chapter. This strategy enables the researcher to transport the reader into the research setting (Creswell & Miller 2000) and thus allow the reader to assess the credibility and accuracy of the data analysis and findings.

**Reflexive journal**

Lastly, reflexivity was used as the credibility of a qualitative study can be enhanced through making personal and intellectual biases explicit (Mays & Pope 2000). A researcher’s hopes and theories not only influence data analysis (Liamput...
Ezzy 2005) but also what is heard and found (Hsiung 2008). In this study I used a reflexive journal to reflect on my role in the research (Creswell 2009) and to process thoughts, emotions and experiences (Liamputtong 2013). Through doing this, I sought to make my own ‘conceptual baggage visible’ (Hsiung 2008) and acknowledge my influence on the data.

3.7 Reflexive considerations

A researcher’s own agenda, assumptions, beliefs and emotions all influence what is both heard and found in research and thus it is imperative that the researchers personal ‘conceptual baggage’ be made visible (Hsiung 2008). This study was completed as part of my Masters of Public Health. Whilst my professional background is in Occupational Therapy, I have an interest in maternal and child health issues which led me to undertake my Masters in Public Health. Prior to selecting a topic for my research project, I moved to the NTT province of Indonesia with my family to work at a Language and Culture Centre in NTT. I was aware of the high rates of maternal and infant mortality in the region and through connections I made at work and personally, I began to have conversations about maternal health issues. It was clear that the use of TBAs was still prevalent in this province but that there were many factors, including current policy, influencing where, when and with the assistance of whom women delivered.

My own experiences of childbirth also influenced my choice of topic and personal views. I have experienced childbirth complications three times, for which I required emergency obstetric intervention. I also experienced loss of control and autonomy over my body upon entering the formal health system, and the fear and dissatisfaction that this brought. I had to learn how to engage with the health system and professionals who sought to disempower my ability to make choices through use of language such as ‘you are not allowed’ and ‘you have to’. It is with this lens I embarked out to hear the experiences and perspectives of a TBA on how
policies dictating when, where and how women should give birth, and who is ‘allowed’ to assist have influenced her practice.

The second issue that I wish to reflect upon is the cross-language and cross-cultural nature of this research. Conducting research in another language and in another cultural setting is complex. There are many factors to consider and the impact of the researcher on the findings must be considered. This research was challenging as it involved the use of four different languages. These included the participant’s mother tongue local language; the regional variety of Malay spoken in the province; Indonesian; and English. I am able to communicate in varying levels of proficiency in Malay, Indonesian and English. However, the language the participant was most fully and completely able to express herself in was her local language. Thus an interpreter needed to be utilised. Reliance on an interpreter in research however, creates an additional layer of ‘interpretation’ by the interpreter and this has been demonstrated to influence research findings (Ballantyne, Yang & Boon 2013).

Acknowledging this, much consideration was given to the appropriate choice of interpreter. The interpreter needed to be female in light of the private and sensitive nature of the interviews. The interpreter also needed to be independent of the formal health system or other maternal health services so as to allow the participant to talk freely and openly without fear of negative consequences. The interpreter selected had considerable experience interpreting and translating written materials. She was also a family member of the TBA. This interpreter however, was quite likely the only person available that was proficient in all four languages involved in the research.

A recent research article demonstrated how the findings of a study was influenced by “not only what/how we asked, but also by how the interpreter ‘heard’ and conveyed dialogue to (and from) the study participants” (Ballantyne, Yang & Boon 2013, p. 404). This was also an issue in this study as after the initial round of interviews were transcribed, it became evident that the interpreter had both
enhanced and added content to the findings, perhaps indicating her interest in the subject (Ballantyne, Yang & Boon 2013). This presented a challenge however, and in subsequent interviews I needed to ask clarifying questions to ensure that the data collected reflected the participant’s view and not that of the interpreter. In some cases this resulted in data not being used. In addition to this member checking, another strategy implemented to mitigate the effects of cross-language and cross-cultural nature of the research was transcription of the interviews into the original language of the interview (Liamputtong 2013). Additionally, narrative style interviews were used, which allowed the participant to explore the topic through telling stories. Over the study period, as I was living in Indonesia my language fluency increased dramatically and consequently I was able to complete follow-up interviews without the use of an interpreter. I found that removing this layer of interpreter made the interactions between myself and the participant more natural, and it also improved the quality of the data collected. The only voice that I was hearing was the participant, without the contributions of another person.

3.8 Ethics

Process

The ability to weigh the proposed benefits of a study against the risk of harm is essential for all researchers (NHMRC 2007) and researchers must ensure that participants’ physical, emotional or social wellbeing are not adversely affected by the research process (Liamputtong 2013). The possible risk of harm versus potential benefit was considered at length in this study, and a comprehensive analysis of this was completed in the ethics application submitted to the Human Research Ethics Committee in May 2014. This research was designed to ensure that the study was conducted in an ethically safe and responsible manner. Ethical clearance for this research was obtained from the Human Research Ethics Committee (#2014-2218), Menzies School of Health Research in the Northern Territory of Australia (see Appendix C). This involved submitting an initial ethics application and research proposal for consideration by the ethics committee. Ethics approval was granted for
a period of one year from July 2014 to July 2015, and later extended until July 2016 (see Appendix D). Support was also gained from a public Indonesian University (See Appendix E) and a locally based international NGO focusing on maternal health (See Appendix F). Although approval from an ethics committee in Indonesia was not necessary, permission was required from the NTT Governor and the Mayor of the research district. After providing the required comprehensive documentation, permission was obtained from both the NTT Governor (See Appendix G) and district Mayor (See Appendix H).

Consent

Another key issue in ethical research is consent. Participation in research needs to be voluntary and consent must be based on “sufficient information and adequate understanding of both the proposed research and the implications of participation in it” (NHMRC 2007, p. 17). As the participant was literate, she provided both verbal and written consent to participate in the study. This consent was obtained after a discussion about the project, what participation would entail, and also any concerns the participant had about participating. The participant was provided an information sheet explaining the research, which was written in the regional variety of Malay spoken in the region (See Appendix A). This information sheet was read aloud and each point discussed with the participant. The written consent form, also written in a regional variety of Malay (See Appendix I), was read and discussed with the participant. This process of obtaining consent was audio recorded. Consent to audio record interviews was obtained each time a recording device was used.

Confidentiality

The main ethical consideration for this study was the protection of the participant’s anonymity and confidentiality. This was particularly pertinent as this research only had one participant who lives in a small community and thus would be identifiable if her name, village, or language was not kept confidential. Confidentiality was essential as the study explored TBA practice that is not supported by current
government maternal health policies. Confidentiality and anonymity was needed in order to minimise the risk of any negative consequences for the participant as a result of participating in the research. Thus extensive efforts were made to protect the participant’s confidentiality and privacy. Firstly, the participant directed where, when, how and in the presence of whom (if any) the research occurred. It is important to recognise, however, that maintaining confidentiality in a small village setting is not possible. This concern was discussed with the participant before she consented to participating in the research and an offer for research to occur in a location other than the participant’s village was made. However, the participant did not perceive confidentiality and privacy at the village level to be an issue. She requested that the research occur in her village and she readily involved me in both activities at home and in the community.

To further protect the participant’s anonymity, care has been taken to ensure no identifiable information such as location and local language spoken is included in any written documentation including transcripts. All electronic data, including audio recordings, have been placed on a password protected computer or a password protected electronic storage device. All written data has been kept in a locked office. No raw data has been provided to any third parties. At the completion of this research project, all data will be kept at a secure location at Menzies School of Health Research for a period of five years, after which point it will be shredded and destroyed. All the information and direct quotes that have been included in this thesis was provided to the participant in the final member checking interview and opportunity provided to remove any information that she did not wish to be included.³

**Safety**

To ensure safe and responsible ethical research, a discussion of personal safety was also included in the risk management strategy of my ethics application. I currently reside in NTT with my immediate and extended family and have significant social

³ Identifying information contained in appendices was also removed following examination.
supports in place. There were no travel warnings in place for travel to the NTT province in Indonesia according to the Australian Government DFAT website during the research period. Travelling to the participant’s village posed the most risk as it involved travelling via small boat, truck and/or motorbike. Risk management strategies were put in place such as carrying a mobile phone, checking weather and tide conditions prior to travelling and use of protective clothing and a life jacket.

3.9 Conclusion

This chapter has presented the key components of the research methodology of this study. The overall qualitative research design was outlined alongside the philosophical assumptions underlying this study. A description of the study site and process for recruiting the participant was provided. Data collection methods included interviews, participant observation, and informal conversations. The thematic data analysis process was described alongside the methods used to improve the rigour of this research. Finally, reflexive and ethical considerations particular to this study were explored.
Photo: Woman cooking for a wedding in study village

Source: Author’s personal collection 2015
CHAPTER 4

Findings

This chapter presents the findings from this research. Details about the participant and rationale for use of the term TBA and additional information regarding the study setting, in particular distances and travel between the study village and health facilities, is provided. The themes that were categorised from an analysis of collected data are then discussed. The three themes are ‘becoming and being a TBA’, ‘attitudes towards maternal health policy’ and perceptions of the ‘impact of maternal health policy’ on the role of the TBA and maternity care on the island.

4.1 Participant

One participant was recruited to this case study. The participant is a 59 year old married woman, Mary (pseudonym), who has worked as a TBA in her village for over 30 years. Mary is the youngest trained TBA on her island. Although Mary did not finish primary school she is literate. She and her husband are subsistence farmers with her husband at times growing seaweed as a source of cash income. Mary has given birth to five children, one of whom died in infancy. For each of her deliveries, Mary was attended by a TBA at home. She herself experienced a life threatening postpartum haemorrhage with her fifth delivery, which she attributes to the poor practices of the untrained TBA assisting her. Mary began her work as a TBA after her fifth child was born.
4.2 TBA Terminology

In Indonesia, the term commonly used for a TBA is *dukun bayi*. The term ‘*dukun*’ means ‘shaman’ or ‘indigenous medical practitioner’ and ‘*bayi*’ is the term for infant (Echols & Shadily 1989). In the first interview of the study, I asked Mary what term she used to describe herself. The term used in Mary’s local language translates as ‘the cool hand’ (similar to *tangan dingin* in Indonesian) which is a positive word that in this context describes a person who is successful in healing. When I asked Mary if she uses the term *dukun bayi*, she laughed and replied, ‘I don’t know witchcraft’. As Mary does not view the term *dukun bayi* to accurately reflect her role, I have not used the term *dukun bayi* throughout this thesis. I am unable to use the term for TBA in Mary’s local language for confidentiality and anonymity purposes, and thus I will continue to use the term TBA.

4.3 Study setting

This research study was based in a village located on a small island in the NTT province. The district (*kabupaten*) centre for the study village is located on a nearby island, along with the nearest hospital. Travel time between the study village and the nearest hospital exceeds 2 hours. Travel between the two islands is by small wooden boats. Although the distance between the islands is relatively short, travel between the islands can be cut off due to heavy rain, wind, and high waves. On the study island, people travel by foot or motorbike, and occasionally by utility vehicle. Private hire of a motorbike or utility vehicle is very expensive. While some residents own their own motorbikes, there are very few cars on the island. Travel on the island is difficult, particularly in the wet season, as the roads on the island are primarily dirt and poorly maintained. Travel time between the harbour and research village using a utility vehicle takes approximately 30 minutes depending on weather conditions. Travel time between the research village and the nearest *puskesmas* is around 15 minutes. Whilst there are two *puskesmas* on the island, neither
puskesmas has PONED capacity (AIPMN 2015b). Patients with complications including the need for blood transfusion and obstetric surgery must travel to the nearest hospital located on another island, which at different times of the year is not possible.

4.4 Theme 1: Becoming and Being a TBA

Sources of knowledge

In 1984, during the SM policy era and just prior to the introduction of the BDD program, Mary (also respectfully referred to as ‘mama’) was selected by her community to attend TBA training run by the Indonesian government. At this point in time there were no health care services on the island. Mary and approximately 25 women from other villages on the island attended a one month residential training program in their sub-district. This training was designed to equip them to provide maternity care to women in their villages. They also received follow-up training four or five times after the initial training. All of the training was conducted in Indonesian. After her training, Mary did not receive any supervision but began sole practice in her village. Upon commencing her practice, Mary was given some basic midwifery implements, such as scales for weighing newborns, but these resources were soon broken and never replaced. Mary felt that the training adequately equipped her to assist women and estimated that she has since delivered approximately 200 babies. Receiving this biomedical health training was central to Mary becoming a TBA and it also formed a critical component of her identity as a trained birth attendant. Mary frequently distinguished herself as different to traditional birth attendants who practiced only according to their experience and knowledge passed down from previous generations without any biomedical or modern health care training.
However, Mary’s story of becoming a TBA first began as a young woman when she regularly assisted a female family member who was working as a TBA. Mary also stated that she was chosen by God for her work as a TBA, ‘it is God who gave me this wisdom’, and that this was the reason she was able to be strong when faced with difficult births. This ability to be resilient was of paramount importance, especially in the early years of Mary’s practice, when there were no health services available on the island and she frequently encountered situations that she was not prepared for by her training. Mary described these experiences as being extremely difficult, but that she had no choice but to persevere.

Mary: I became a TBA…it was actually from my grandmothers. My father’s mother was a TBA.

Interviewer: Oh, true. So your father’s mother was a TBA as well?

Mary: Yes my father’s mother...Maybe it was from there too. If you only just take the training to become a TBA, that’s insufficient. I feel that maybe it comes from God’s choosing too. If God chooses us we can be brave. If we were just doing it alone we couldn’t be brave...

Mary also described two different dreams in which she was given knowledge on making traditional medicines to assist pregnant women and prepare them for delivery. Thus, in becoming and being a TBA, Mary identified a range of knowledge sources including biomedical health training, experience and observation, and also knowledge from God and dreams which guide her practice. Mary viewed these modern and traditional sources of knowledge and practices as complementary and syncretic.
Interviewer: So according to Mama, for the TBA, can practical [biomedical] and traditional ways work together?

Mary: Yes. The two can work together. Use whichever as long as it is from the heart. My heart is strong. I use traditional methods or use health [department] methods, both are good...

**Comprehensive and holistic care**

For the past three decades, Mary has provided maternal and infant health care services in her village. These comprehensive services span the continuum of care, with assistance with conception and family planning, antenatal care including massage and traditional medicines, delivery and postnatal care. Mary was motivated by a desire to help women and their families, and did not view her role as pecuniary. Indeed, she rarely received financial compensation for her services but received gratitude gifts of soap, cloth and food. Mary was very diligent in the care of pregnant women and did not leave her village or island if she knew a woman was due to give birth. In the postnatal period, Mary’s care was particularly comprehensive as she often lived with women and their families for up to a week post-delivery.

Mary: It is me who washes her, gives her food, helps her feed the child...
Teaches this woman who has delivered to properly breastfeed the child...
Bathe the woman so she is very clean.

In addition to teaching women how to care for their infants in the postnatal period, an important aspect of Mary’s TBA role centred on washing women. This postpartum routine of washing with very hot water is culturally significant and is a traditionally named practice. Mary also attributed the lack of infection in the women she assisted to washing the women twice a day in the postpartum period. Prior to the availability of health care services and personnel on the island, bathing...
of the perineum with hot water was how Mary provided care for tearing and monitored healing. Mary also used hot water compresses to enhance women’s breastmilk supply. Mary linked the cultural practice of washing with hot water with the speed of a woman’s recovery and her ability to resume usual household activities.

Mary: [I] use boiling hot water, as hot as the woman can handle. Whatever woman who can handle that heat, within two days she will be able to get out of bed because her body is completely clean.

Importantly, Mary provided both comprehensive and holistic care as she attended to the emotional and psychological safety and comfort of women in addition to their physical needs. The importance of this holistic practice was evidenced by Mary linking emotional and psychological comfort with a safe and easy birth, and the importance of serving from the heart.

Mary: So sometimes when there are women who go five or six days before giving birth, [I] will go sleep with them at their house, talk with them, and comfort them, so that they feel safe.

Mary: The trainers taught that when going to help a pregnant woman, you have to help them with your whole heart, with genuine sincerity. Because if you aren’t genuine and sincere in your help their giving birth will be very difficult.
4.5  Theme 2: Attitudes towards maternal health policy

This research sought to explore how maternal health policies have impacted upon the practice of a TBA working on a remote island in NTT. Overall, the policy that has had the most profound influence on Mary’s work as a TBA over her 30 years of practice is the NTT Revolusi KIA policy, which was introduced in 2009. Before 2009 almost all births in Mary’s village took place at home with the assistance of a TBA and sometimes a health department midwife (through the BDD program). Mary had practiced in this way until the change in policy which stipulated that all births must occur in the puskesmas or rumah sakit. This policy has resulted in a rapid and major transition in birthing practices on this island, with most women now delivering at the local health centre.

Mary: The regulation is that you have to give birth there [at the clinic]... ...not at home. Before you could...and if you gave birth at home, usually it was me who helped. I used to help like that. But now there is a regulation, women are not allowed to birth at home anymore. It has to be at the clinic.

An exploration of these shifting birthing practices on the island illuminated a number of attitudes towards this policy, which include: ‘there is no choice’; ‘it’s our fault’; and ‘clinic birth is medically safe but emotionally unsafe’.

There is no choice

When discussing the Revolusi KIA policy, Mary emphatically articulated that women felt ‘forced’ to deliver at the clinic despite their desire and preference to deliver in their own home. The reason given for this feeling of being forced was simply that that they ‘must’ follow the regulation, as though to oppose or resist government policy was not an option.
Interviewer: So, you said that women feel they are forced to give birth at the clinic. Why do they feel forced?

Mary: They are forced because of the regulation.

Interviewer: What if the mother doesn’t go to the clinic to give birth?

Mary: They are forced to.

This attitude was also demonstrated when Mary described her personal decision not to have any more children as she feared they would be excluded from government services such as schooling, as she had already exceeded the recommended family planning policy of two children per family. In this study, Mary demonstrated a compliance with policy out of a fear of consequences from the government or those in power, such as health staff.

Interviewer: How has the government’s regulation influenced your practice or that of other TBAs?

Mary: If we properly follow all their regulations they [the health clinic staff] accept us... We have to give birth at the puskesmas. If we don’t, they are angry with us.

Interviewer: Who are they angry with?

Mary: Angry with me. And angry with the woman who has given birth as well.

There have been reports of women and TBAs who participate in home deliveries being fined at the district level in NTT (Plan Indonesia 2005, Rambu Ngana, Myers & Belton 2012). Although these fines have not been implemented in Mary’s village to date, she did state that she feared that if there was an adverse outcome related to
a birth the TBA who was involved could be imprisoned. This was a powerful deterrent for Mary to provide delivery care to women in her village.

**It's our fault**

Although Mary had never experienced a maternal death and was confident in her capability to provide safe maternity care for women in her village, she communicated a collective sense of blame associated with maternal deaths on behalf of TBAs. Mary told a number of narratives, where she attributed a maternal or infant death as a result of unsafe practices by TBAs. Mary identified that these unsafe practices were primarily undertaken by untrained TBAs or trained TBAs who had low levels of literacy and proficiency in Indonesian, and thus had limited capacity to understand the training they were given. This sense of culpability included the perception that the provincial regulation enforcing clinic births was introduced directly as a result of poor birthing care provided by TBAs.

Mary: I feel that I am capable of delivering babies. I am capable, a 100% capable. Even if [the baby] dies inside, I care for [her] until the baby comes out. But because of my TBA colleagues who did wrong, now they don’t allow us anymore. That’s the problem. It’s not because of anger from the health [staff]. No. It’s because we ourselves have caused it. [We] aren’t very skilled and as a result did improper things.

Mary: If my colleagues had done things properly certainly we would still be birthing at home. Yes, still birthing at home. But they didn’t. They didn’t know, they didn’t really understand Indonesian and so they did things improperly.
Clinic birth: medically safe but emotionally unsafe

Despite the attitudes that the shift in maternity care and TBA role in Mary’s village was both forced and introduced as a consequence for unsafe practices and maternal deaths, Mary also communicated she thought it was ‘better’ to deliver at the health clinic. This attitude initially surprised me as I had expected to find that Mary was a strong advocate for continued home birthing in her village. After a lot of discussion with Mary however, it was evident that her perception of clinic birth as ‘better’ was not so much based on a perceived superior quality of care received by women delivering at the health clinic, but rather on the risks associated with a home delivery attended by an untrained or poorly trained TBA. As policy changes have long ceased TBA training, there have been no further opportunities to improve the competency of practicing TBAs or train new TBAs. Additionally, Mary discussed issues with the initial training they received in the 1980s, where training was conducted in formal Indonesian, which a majority of the women did not understand. Furthermore many of these women had limited education and literacy levels.

Mary: There were TBAs who were too old during the training at the sub-district. They didn’t understand what the government nurses and doctors were talking about. [I] was the youngest person [who attended the training]. In this village women haven’t died, because [I] understood what the doctors and nurses were saying during the training, but older women who attended the training, who came to learn, didn’t understand...they didn’t understand Indonesian...so their work didn’t follow what the nurses and doctors were teaching. Only [I] was still young, so I could understand and follow exactly what they were saying.

Mary perceived this lack of training and understanding as a significant risk for safe maternity care and thus at a general level perceived clinic birth to be the best option.
Interviewer: So, before you said that delivering at the clinic is safe for mother and baby...

Mary: Yes.

Interviewer: ...but that it can also be safe at home too? Do you feel like that?

Mary: Yes, I feel like that. If it’s me who handles [the birth]. But if they [the woman/ family] handle it on their own and get a village TBA who hasn’t done the training, that’s difficult, there’s a danger there. They don’t understand, they don’t follow the theory in their practices. So that’s the problem. If it’s those of us who have undergone the TBA training, there is no problem. But if it’s the untrained TBAs from the village who they usually use, that’s a problem. There are those who die too, because the TBAs don’t understand.

Interviewer: So where’s the best place for women to deliver?

Mary: The clinic. The clinic is the best.

Upon exploring the attitude that clinic birth is better it became apparent, however, that whilst Mary believed that clinic birth was better for health or physical outcomes, she also believed that clinic birth was emotionally unsafe for women.

Mary: So at the clinic it is good, because at the clinic they can straight away manage for [physical] health. But for [the woman’s] feelings, I feel that it is not [psychologically] safe.

Mary acknowledged that whilst the health staff at the clinic attended to the physical health needs of the women, women were often subjected to treatment at the clinic that caused them to be scared and ashamed. She described situations where labouring women were left unattended for hours at a time and where health staff did not behave respectfully towards women. She believed that an experience of
feeling emotionally unsafe has a direct effect on the physical birthing process, such as longer labours.

Mary: Yes. Birthing at the hospital is safe for [physical] health. But for feelings, the feelings of the woman who is delivering, it is difficult. Because she feels embarrassed/shy. She feels scared. She doesn’t know the midwife very well. That’s what is difficult.

Interviewer: And if the woman has feelings like that, what is the result for the delivery?

Mary: It’s long because she doesn’t want to be naked. If we deliver at home we can cover our stomach...

Interviewer: You use a sarong or what?

Mary: Yes, we use a sarong, use a long cloth so we can [cover] our stomach and front part [vagina]. But there [at the clinic], we must take off our shirt, take off our pants, our underclothes...we have to be naked.

Interviewer: There isn’t any cloth?

Mary: Yes, there is no cloth to cover ourselves. So that’s a problem. So, sometimes they don’t want [to go to the clinic] because of that. They don’t want to reveal their parts for other people to see.

As discussed in the first theme of ‘being and becoming a TBA’, ensuring emotional and psychological wellbeing is a core role for the TBA and an exclusive focus on medical well-being is perceived as unsafe. This was the conflict that Mary reported the women and herself experienced with a maternal health policy that enforced clinic birth.
Mary: ...that’s practice number one. Pray for them. Pray for them, talk kindly to them, don’t be rough with them and encourage them. Like that. But it’s not like that at the clinic. It’s not gentle. People receive rough [treatment]. So maybe that’s why they are ashamed and scared.

4.6 Theme 3: Impact of maternal health policy

The implementation of the maternal health policy Revolusi KIA has resulted in two major implications for Mary and thus many of the women in her village. In response to the forced shift to institutional deliveries and the attitude of clinic birth being medically safe but emotionally unsafe, Mary identified many women delayed or avoided health care services in an attempt to deliver in their own home. Secondly, despite Mary experiencing enormous changes to her TBA role as a result of maternal health policy, she also highlighted why her role must continue to exist into the future.

Avoidance of health care: modern and traditional

There was a passive resistance to the Revolusi KIA policy mandating facility deliveries. This long excerpt explains how women resisted the requirement to deliver at the puskesmas through a series of delays. This includes delaying informing the midwife or TBA that they were in labour and delaying travel to the puskesmas in order to ensure a home birth.

Mary: For example two months ago. [The woman] was already going to the car, but she couldn’t... the baby’s head was already out...so she couldn’t... it forced me to get her down [from the car]. And because of that they [the clinic staff] were angry with me.

Interviewer: Really?
Mary: Yes. They [the clinic staff] said that it can’t be like that. Maybe she tolerated the pain too long so that she would have to give birth at home... Often it takes some time before we can give birth...but this was her second child...So it was quick, very fast.

Interviewer: So, she had planned to go the clinic?

Mary: Yes.

Interviewer: But the baby came too quickly?

Mary: Yes. Too quick. Maybe it was from her too, because they often delay going to the clinic. So in the end they tolerate the pain until it’s time to give birth and by then it’s too late to go to the clinic.

Interviewer: So you were already with her?

Mary: Yes.

Interviewer: They had already called you?

Mary: Yes.

Interviewer: When her labour pains first started?

Mary: They didn’t call me until her pains were already very strong. I came and touched her stomach and she was already close...She was close, but I thought she could still make it to the clinic. But it was God’s plan...We took her back to the front of her house and immediately the baby was born... I told the midwife, the village midwife, and the midwife came to check her. She checked her and she was really angry with me. She said that next time don’t follow the women’s desires. I said, yes that’s true young woman, but this wasn’t our plan, this was God’s plan. We were ready to travel to the clinic but we couldn’t...

This narrative demonstrated that although women in Mary’s village may not be able to openly oppose the regulations directing clinic births, they resisted passively
through avoidance of health care. Unexpectedly this avoidance of health care encompasses not only the formal system, but the services of the TBA also. Mary identified circumstances where women avoided calling her for assistance in pregnancy or delivery as they knew that she was obligated to report their pregnancy to the midwife and facilitate their transfer to the health clinic for delivery.

**TBA role changing but continuing**

Mary’s role as a TBA has changed dramatically since the policy shift to institutional deliveries. Previously, Mary was involved in all aspects of maternity care. However, since the introduction of the policy Mary was mostly excluded from providing delivery care for women. Despite this, Mary still viewed the role of the TBA as an essential component of maternity health care services in her community and that without TBAs the care for women would be not only inadequate but at times dangerous. The excerpt below demonstrates Mary’s perception of current gaps in the provision of care by formal health services, such as in postnatal care.

Interviewer: So, in your opinion if there weren’t any TBAs on [island], what would be the result? If there was only the [health department] midwife, what would it be like if there were no TBAs?

Mary: TBAs must continue. I feel there must continue to be TBAs … TBAs are permanent. There has to be TBAs.

Interviewer: So if there weren’t any TBAs?

Mary: It would be difficult. Difficult because if there weren’t any TBAs who would dare carry out the washing of the woman? If there were no [TBAs] to wash the woman that would mean that her husband has to wash her and
that’s not right. Doing this washing, you have to be careful. If you push down too hard it’s dangerous...you have to be careful.

So why else must the TBA continue to be a part of the maternal health care services on this remote island of NTT? Mary highlighted a number of situations where she needed to provide delivery care services, despite policy dictating otherwise. As explored earlier, there are situations where women delivered quickly and were unable to reach the health clinic. There were also times where women were unable or unwilling to go the health clinic for other reasons. For example, because of the attitude that institutional delivery although safe for health was emotionally unsafe, many women still requested Mary to assist them when they attended the clinic. Many of the women were shy, embarrassed or uncomfortable putting themselves forward to receive care at the health clinic, and Mary discussed her role in helping them to accept the health care.

Mary: They feel embarrassed/shy. Sometimes I get close to them and whisper saying don’t be embarrassed, it doesn’t matter, it doesn’t matter. This baby in your stomach has to come out. It can’t stay in forever.

Mary also told narratives of health system dysfunction that influenced both the quality of care and accessibility to formal maternal health services by women. Gaps in service provision outlined by Mary included a lack of postnatal care with women discharged from the clinic between four and 12 hours after giving birth with little or no follow-up conducted by health staff. Without Mary providing this care, it was suggested that these women would receive no care at all in the postnatal period. Mary also identified many situations where women and their families were unable to access trained and competent health professionals to assist them. For example, although her village had an assigned midwife, Mary reported that the midwife was frequently not locatable in the village or on the island, and that women did not feel confident in her skills to seek her assistance. Mary also stated that midwives
assigned to her village were usually young and unmarried, which affected their acceptability by women.

Mary described experiences where she accompanied a woman to the *puskesmas* for delivery only to find the doctor away and only a general practice nurse in attendance. Other times, as evidenced by the narrative below, doctors did not provide appropriate care when it was needed. In the following example, the doctor was adamant that the woman in labour who had presented to the *puskesmas* must travel to the district hospital on a nearby island for delivery due to her advanced maternal age. Despite Mary making repeated attempts to inform the doctor that the woman would be unable to make the journey as she was close to delivery, the doctor refused to examine the woman.

Mary: [They] had already taken the woman with labour pains, taken her to the *puskesmas* and the doctor was making a letter to send her to [district hospital on another island]. But this woman called for me repeatedly saying ‘come’ because [the baby] is coming out. So I went. The foot and the hand both came out first...and then [the baby’s] bottom.

Interviewer: The doctor was still writing the letter?

Mary: Yes, the doctor was still writing the letter.

Interviewer: [The doctor] wasn’t in the room?

Mary: [The doctor] was in the front office. The doctor was writing the letter in the front with [the woman’s] husband.

Interviewer: You were with the woman in the room?

Mary: Yes. I was with the woman. I called the doctor and said the baby has already been born. Only then did they run to the woman. I had already delivered the baby. Then the doctor asked, ‘How many women have you delivered?’
In addition to these health system dysfunction factors, Mary identified reasons for why TBAs must continue, including remoteness, poor roads, and limited transport options. Heavy rains in the wet season can render travel out of the village impossible, including travel to the *puskesmas* and to the nearest hospital with emergency obstetric care services on the next island. Weather conditions in the dry season can also cause water on the island to become very scarce and wells frequently run dry.

Mary: …but there isn’t water at the clinic [in the dry season], so we from the village have to bring [water], but if it is the wet season it is most difficult.

Interviewer: So, if you go to the clinic in the dry season you have to bring your own water?

Mary: Yes. Water. Bring your own water.

Interviewer: So for bathing, water for washing hands, everything?

Mary: Yes. Yes.

Mary spoke of when she delivered her own daughter’s twins at home. This highlighted a range issues both related to health system dysfunction, namely lack of experience and confidence of the midwife, and also physical barrier issues including a lack of transport and heavy rains causing the unpaved roads to the health clinic to be impassable.

Mary: My daughter had twins at home…. actually the [health department] midwife was there too, the head midwife. She was there but she told me ‘you help her and later I will give her the medicine’.

Interviewer: So your daughter didn’t want to go to the clinic?
Mary: No. Because it was the rainy season we actually wanted to take her on the 18th to get a referral [for the regional hospital on nearby island]. But on the 18th she was already in labour...and at 7 or 8 o’clock in the evening the twins were born.

Interviewer: It was raining so you couldn’t go to the clinic?

Mary: No we couldn’t. The road was muddy so we couldn’t.

Interviewer: So in the rainy season that’s a problem for women travelling to the clinic?

Mary: Yes, it’s a problem because the road isn’t good.

Mary: When those two were born, the [health department] midwife was already at the house. But she only stood there at the side of the bed.

Interviewer: So you delivered the babies?

Mary: Yes, I delivered the babies. The midwife instructed me. She told me ‘you are more experienced then I am, I give my authority to you to deliver [the babies]. Deliver your own grandchildren.’ That’s what she told me...

This theme demonstrated times where women were unable or unwilling to accept or access formal maternal health services. Mary described a range of physical barriers to health care access such as torrential rain, poor road conditions, lack of transport options and remoteness. However, she also identified that even when women did access these services, there were a multitude of health system dysfunction issues which impacted on the quality of care; including gaps in service and limited access to adequately trained health professionals. All of these factors contributed to Mary’s belief that the role of the TBA must continue.
Photo: Traditional weaving in NTT

Source: Author’s personal collection 2014
CHAPTER 5
Discussion and Conclusion

5.1 Introduction

This study explored the perspectives and experiences of one TBA providing maternal health care services in Eastern Indonesia. This case study examined Mary’s role as a TBA, her preparation for that role, changes she has observed in the childbirth culture on her island, and her perceptions of how maternal health policies have impacted on her practice over three decades. Three main themes were identified from the data collected; these were ‘becoming and being a TBA’, ‘attitudes towards maternal health policy’, and the ‘impact of maternal health policy’ at the local level. Although it is evident that a range of health policies have influenced Mary’s work as a TBA, Mary identified the NTT province Revolusi KIA policy as the most prominent maternal health policy impacting her practice since she began working in 1984. Over the past six years, this policy has dramatically decreased her role in delivering babies, with many births now taking place at the puskesmas where homebirths had previously been the norm. Despite these changes Mary continues to play an active and arguably essential role in the provision of acceptable and adequate maternal health care services to the women in her village. This chapter will discuss Mary’s views on how past and current policies have shaped and changed the TBA role, followed by an exploration of why Mary believes TBAs are integral to maternal health care and will continue to be so in the foreseeable future.
5.2 Maternal health policies and the changing TBA role

This research has shown that the formal health care system and maternal health policies have tangibly influenced Mary’s role in her community and that her role has been redefined over time. When Mary first began her practice as a TBA, under the Safe Motherhood policy, she worked alone. There were no midwives or health care services available. She was the only person to provide all aspects of maternal health care to the women in her village. Practically, this meant that in an emergency she had no support and limited options, if any, for referral as the nearest health services were located on another island. Importantly, Mary attributes the government TBA training she received in 1984 as instrumental to her competence and confidence to work as a TBA. TBA training however, was ceased due to global changes in policy direction and the introduction of the BDD program in Indonesia in the late 1980s (Koblinsky 2003).

Once the BDD program was implemented and a midwife was allocated to Mary’s village, Mary began to adapt her practice to incorporate working with the midwife. A lot of women however, continued to request Mary to assist them in childbirth as the village midwife was usually young and inexperienced, and was often away from the village. These issues of age, inexperience and high levels of absenteeism of village midwives resonate with evidence from other provinces of Indonesia (D’Ambruoso et al. 2009, Titailey et al. 2010a). Despite these challenges, Mary communicated a willingness and desire to work with the village midwife, and discussed examples where true partnering had taken place. For example, Mary spoke of working alongside the village midwife in the complex home delivery of twins, where the midwife acknowledged Mary’s advanced experience and expertise and requested that Mary deliver the babies. Later the midwife administered medicines and vaccines. This encouraging narrative demonstrated a situation where the village midwife and TBA worked as colleagues for the best outcome for the
mother and infants. Another study in Java also found TBAs were widely willing to partner with midwives (Titaley et al. 2010a).

From 2009 Mary’s role changed significantly with the implementation of the Revolusi KIA policy, as this policy excludes TBAs from being involved in delivery care. Although delivery care did not encompass Mary’s entire role as a TBA, it was a core component of her practice. Before the introduction of this policy, Mary had been involved in almost all deliveries in her village. Since implementation of the Revolusi KIA however, Mary has only been involved in a small number of deliveries where women have been unable or unwilling to use formal health care services. Mary described how many of the women in her village feel forced by the Revolusi KIA policy to deliver at the puskesmas despite their personal desire to be at home and/or attended by a TBA. What is unclear from the data is whether this desire is primarily to deliver in their home environment or be attended by the TBA, or a combination of both. The Revolusi KIA obligates Mary to encourage women to deliver at the puskesmas and she fears retribution from both health staff and the law if she fails to obey the regulation by participating in a home birth. Since the introduction of the Revolusi KIA, women and TBAs in some NTT districts have been fined for participating in a home birth without a midwife (Rambu Ngana, Myers & Belton 2012). Although Mary herself has not been fined, she is aware of other TBAs being fined. Furthermore, there have been instances where she has been reprimanded by health staff for participating in a home birth, even when the alternative would have resulted in a woman delivering with no experienced birth attendant present.

Mary’s narratives illustrated that although women may be unable to openly oppose government policy mandating facility based deliveries, some women demonstrate resistance by avoiding formal health care services, and at times also avoiding the TBA, both in pregnancy and labour in order to deliver at home. Mary gave the example of when she assisted with a home birth where the woman had delayed
travelling to the clinic and delayed calling Mary for assistance until the woman was very close to delivery and there was insufficient time to reach the health clinic or call a midwife. This then required Mary to assist the woman to deliver at home. Mary also described how some young women have avoided antenatal care with her as they did not want their pregnancy reported to the health clinic. These findings were surprising as, although I had assumed that women would find ways to avoid institutional deliveries out of preference or economic necessity, I did not expect that they would also avoid the TBA. The implication of this is that women in Mary’s village are aware of Mary’s changing role and her increasing links and obligations to the formal health system. In turn, they are also avoiding Mary’s involvement as they know that she is obligated to facilitate their transfer to the puskesmas for delivery or to contact the village midwife. Thus the Revolusi KIA policy, which was designed to improve maternal health outcomes, in some cases has the perverse consequence of women accessing less health care overall.

Resistance to policy enforcing institutional births through avoidance strategies has also been documented in other research, such as in the remote Australian Aboriginal context. For many remote Aboriginal women, birth at a hospital is presented as the only option for a planned birth (Ireland, Belton & Saggers 2015). However, recent analysis of clinical practice models used to care for remote Aboriginal pregnant women, revealed that it is predominantly “power and not necessarily scientific evidence” that is being used to “sanction planned birth places” (Ireland, Belton & Saggers 2015, p. 6). As a result some remote Aboriginal women, who experience forced relocation to a regional centre for delivery, conceal their pregnancies and avoid antenatal care at local health clinics in an attempt to deliver at home in their community (Chamberlain et al. 2001, Ireland et al. 2011). Some Aboriginal women present to health care workers only once labour is well established and transfer to a hospital was no longer possible (Chamberlain et al. 2001, Felton-Busch 2009). Thus in this context also, the policy designed to ensure ‘safe birth’ and improve maternal health outcomes, actually resulted in some
women receiving little or no maternal health care especially during childbirth (Ireland et al. 2011).

It is evident that current maternal health policies, particularly the Revolusi KIA, have significantly changed Mary’s role as a TBA primarily through excluding her from providing delivery care to women in her village. Furthermore, this study found that Mary’s interaction with women in her village and how they utilise her services have also changed in view of Mary’s increased obligations to partner with formal health care services. Current health policies and programs have seen Mary increasingly being used as a link between the formal health system and the women in her village in attempts to increase institutional childbirth. I argue that Mary is increasingly viewed as part of the formal system and as seen in the above examples, this undermines her traditional role and relationship with women in her community. This research also provided examples of how current maternal health policy necessitated Mary navigate between policy requirements and health staff, and the desires of women in her village, often personally experiencing adverse consequences as a result. These findings resonate strongly with research in Cambodia which found that once biomedically trained and registered in the system, TBAs became torn between their responsibilities to the health service and their social and cultural obligations (Hoban 2002).

5.3 TBA role must continue

Despite changes to Mary’s TBA role, she continues to help women in her community, particularly those who are either unable or unwilling to use formal health care services. Furthermore, Mary continues to provide care where there are gaps in service provision by formal health care services, such as postnatal care. Mary repeatedly stated that the role of the TBA must continue in her community. The primary reasons she gave were the poor acceptability of formal health care
services; poor accessibility of health care services; and widespread health system
dysfunction influencing quality of care.

**Poor acceptability of health care services**

Throughout this study, Mary described her perception that although formal health
services are medically safe for women, they are emotionally unsafe. This attitude
forms part of Mary’s rationale for why TBAs must remain a part of maternal health
care in her community. Mary described scenarios where women delivering at health
clinics were subjected to treatment that caused them to be scared or ashamed.
Mary stated that at the *puskesmas* women’s dignity and privacy is not respected,
for example women are not provided a cloth or gown to cover their bodies when
delivering. Women are often left unattended for long periods of time during labour
without any emotional or psychological support. Ith, Dawson and Homer (2013)
conducted research in Cambodia and found that women who delivered in the public
health system, experienced care that disrespected their privacy, choices including
choice of birth companion, and even subjected them to physical and verbal abuse,
and shame. It is proposed that negative experiences such as these are a powerful
deterrent to women’s willingness to access health care (Ith, Dawson & Homer
2013).

When helping a woman at home Mary will stay with the woman, often for many
days, providing continual care and support throughout her whole labour. Mary’s
role is both comprehensive, spanning the continuum of care, and also holistic,
attending to physical safety in addition to emotional and psychological safety and
comfort. Continuity of care throughout pregnancy, delivery and the postnatal
period is a key strategy for improving maternal and neonatal health (Wang & Hong
2015). There is strong evidence from a Cochrane review that women who receive
continuity of care by midwives have less intervention in childbirth and improved
satisfaction (Cochrane Library 2015). Research has also shown that continuity of
care increases a woman’s sense of control throughout childbirth (Homer et al.
Mary described the importance of a woman feeling safe and comfortable in order to ensure a safe birth. Mary herself is not adverse to institutional deliveries, once escorting her own daughter to the hospital to deliver. However, she believes that birth at home can also be safe and that women often prefer her assistance as her care encompasses social, emotional and cultural safety in addition to physical safety. In summary, Mary’s experiences with formal health care services led to her attitude that although clinic birth may be medically or physically safe for women, it is often times psychologically and emotionally unsafe.

**Poor access to health care services**

In addition to the poor acceptability of health care services by many women, Mary identified a range of other physical and geographical barriers to accessing health care services. Poor road conditions, limited transportation options, and heavy rains all present barriers to women in the study village accessing the *puskesmas* for delivery. Furthermore, the nearest health facilities which can provide both basic and comprehensive emergency obstetric care services, are located on another island and requires a challenging journey in excess of two hours via truck, boat and car. Even if women were willing to make this journey, at certain times of the year travel is not possible due to weather conditions and the small boats available for transport. In these situations pregnant and labouring women become isolated on the island. The significant impact of geographical remoteness, isolation and seasonal difficulties on women reaching health care services was also found in recent NTT research conducted by Belton, Myers and Rambu Ngana (2014). Although not a significant theme in Mary’s narratives, Mary also discussed how some women are unable to access health care services for economic reasons, including paying for the expensive transportation to and from the clinic. In the study, Mary’s narratives explored a number of different issues that present significant challenges to women being able to access health care services. Thus, in addition to assisting women who are unwilling to access formal health care, Mary also continues to assist women who are unable to access health care and without
her assistance would deliver at home without an experienced or trained person attending them.

**Health system dysfunction and quality of care**

Even if women were both **willing** and **able** to access health care services, however, what quality of care would these services provide? This case study examining Mary’s experience and perceptions of the influence of policy on her TBA practice found a range of health system dysfunction issues that influenced access to quality formal health care. Mary outlined the general poor condition of the *puskesmas* including a lack of electricity and water, particularly in the dry season. Other NTT research also found health clinics that had a lack of water and power, damaged equipment and poorly stored medicine (Rambu Ngana, Meyers & Belton 2012). Mary reported that frequently there was a lack of obstetric trained health staff at the *puskesmas* and at times an absence of doctors on the island. As a result, TBAs are more readily and consistently available to assist women in childbirth than other health workers, a finding echoed in research by Titaley et al. (2010a). Even when health professionals were available however, they did not always have the required competencies or access to medical equipment to meet the need. For example, the example of the doctor who failed to examine a woman who was very close to delivery and yet insisted the woman travel 2 hours to the hospital on another island. In this scenario, Mary delivered the baby because the doctor was in another room writing a referral. It was the presence of Mary at the *puskesmas* and her willingness to engage with the formal health system that resulted in the woman being attended at delivery. Other research has also indicated issues with competency of village midwives (D’Ambruoso et al. 2009, Makowiechka et al. 2008), with Rokx et al. (2009) stating that the overall education of health professionals in Indonesia is poor. Sciortino and Tjong (2015) also argue that there are “chronic deficiencies in availability, performance, and accountability of health workers” across Indonesia (p. 52).
Additionally, Mary identified gaps in health services provided to women, particularly in the postnatal period where women received no post-natal health care services other than those provided by the TBA. We know that women are most at risk in the first and second days after delivery (Ronmans & Graham 2006), and that the evidence for postnatal care is strong, and yet women frequently return home as early as four hours after delivery with no further follow-up from the formal health system. The Indonesia Demographic and Health Survey 2012 found the 43 percent of women in NTT did not access postnatal care in the first two days following birth (BPS et al. 2013). Poor uptake of and difficulties accessing postnatal services has been documented in other Indonesian research (D’Ambruoso et al. 2009, Titaley et al. 2010b). Mary reported that women frequently call her on their way home after delivering at the health clinic and that she is the one to wash them, monitor their healing, watch for signs of infection, and teaches them to breastfeed and care for their infant. Thus, without the input of a TBA in this situation, women may not receive these core maternal health care services which would further place them at risk.

It is important to examine this health system dysfunction alongside the current NTT province Revolusi KIA policy, which Mary identified as the policy that has most significantly influenced her TBA practice over three decades. This policy states that all women must deliver at ‘equipped’ health facilities (Dinas Kesehatan NTT 2009), either a puskesmas PONED or rumah sakit PONEK (Dinas Kesehatan NTT 2009), in order to have a safe delivery and decrease maternal mortality. In addition to the primary health care services provided by a puskesmas, a puskesmas PONED also provides emergency obstetric care (Mize et al. 2010), such as management of postnatal haemorrhage, assisted vaginal delivery by vacuum extraction, and manual removal of placenta (see Table 2.1). However, whilst there are two puskesmas on the study island, neither puskesmas has PONED capacity (AIMPNH 2015a). Indeed, despite the implementation of the Revolusi KIA policy, which includes a commitment to increasing the number of puskesmas with PONED services, the percentage of puskesmas with PONED capacity in NTT actually decreased from 26%
in 2012 down to 22% in 2014 (AIPMNH 2015a). The district in which the research was conducted currently has three puskesmas PONED (AIPMNH 2015b), however all of these are located on another island from the island in this study and travel times to these clinics would exceed two hours.

There are a few critical issues to consider here. Firstly, Mary reported that women are ‘forced’ by the policy to deliver at the puskesmas despite their wish for a home birth. I argue that women have the right to choice and control over where they deliver and who assists them. Secondly, even if facility birth was desirable for women, the Revolusi KIA policy itself is not entirely implemented. The justification for ‘forcing’ women to deliver at a health facility is based on the premise that this is best for maternal health outcomes. In the study village, health professionals, including the village midwife, are informing women that they are required to deliver at the puskesmas located on the island. However, this puskesmas is not equipped to provide BEONC (AIPMNH 2015b), and birth at this clinic does not meet the Revolusi KIA policy of delivery at a puskesmas PONED. Thus, the findings suggest that both Mary and women are misled into delivering at the puskesmas on the island, firstly believing that it is required by policy and secondly that they will receive quality obstetric care services at the puskesmas. Women are losing the benefits of their desired home birth with a TBA that ensures their social, emotional and cultural safety, in order to experience a perceived medically and physically safer birth at the puskesmas. However, the personnel expertise and equipment for emergency obstetric care at the clinic is not available. Referral of women to puskesmas that are not equipped to deal with maternal emergencies is recognised as a significant issue across Indonesia (Mize et al. 2010).

The current Revolusi KIA policy promotes ‘safer’ birth through delivery at a facility with a ‘skilled birth attendant’. However, Graham, Bell and Bullough (2001) argue that skilled attendance at birth includes a partnership of skilled health professionals AND an “enabling environment of equipment, supplies, drugs and transport for
Delivering in an underequipped and under resourced health clinic or being assisted by a skilled birth attendant who does not have adequate support, will not in itself reduce maternal mortality. An example of this in the NTT province was two maternal deaths from postpartum haemorrhage that occurred in 2012. In this case study, although the two women attended the *puskesmas* for assistance, the *puskesmas* was not equipped to treat them and the women were unable to reach a hospital in time to save their lives (Druhan & Legendre 2013). Lessons learnt from Malaysia and Sri Lanka, indicate that increasing *utilisation* of maternal health care services must go hand in hand with improving access to *effective* services (Pathmanathan et al. 2003). It is a two pronged approach. One without the other is ineffectual. On paper the *Revolusi KIA* appears to give attention both to the utilisation and provision of maternal health care services. However, the study island demonstrates a focus on ensuring compliance with facility deliveries without the corresponding improved availability of competent skilled birth attendants or adequately equipped *puskesmas*.

**Increased dependence on an undependable system**

Mary continues to assist women in her village who are unwilling and unable to access health care, and also where adequate and quality formal health care services are not available. Mary continues to practice as a TBA in her village because she believes that without her input, women would not only receive inadequate care but may also be at risk of harm due to a lack of service provision. In their research in Java, Titaley et al. (2010a) also found that TBAs were essential to the provision of maternal health care particularly in the remote areas and in the provision of antenatal and postnatal care. When asked what maternal health care would look like without a TBA, Mary responded that TBAs are essential. Having no TBAs is not an option and, in Mary’s opinion, TBAs remain integral to maternal health and will continue to be so for the foreseeable future.
Despite the need for Mary and other TBAs to continue caring for women, and the notable gaps in the formal health system, all the current TBAs on the island are ageing and there are no new TBAs being trained or apprenticed for the future. Current policy means that the existing TBAs having less exposure to childbirth (with already low numbers of deliveries) and in turn may rapidly become deskillled. Therefore I argue that women in this district will become increasingly dependent on an undependable health system and for many women their only viable option for delivery care may be taken away in the near future. Research conducted in India, found that with the transition to institutional births brought about by policy changes, came a loss of self-reliance in the community because of the role redefinition and deskilling of TBAs (Sharma et al. 2013). Sharma et al. (2013) argued that if deskilling occurs without improvements in access to quality health care services, the only option for a birth attendant for some women in India will be gone. Research in Costa Rica also found that the increasing use of TBAs as a bridge to the biomedicalisation of childbirth, led to an erosion of the TBA role and less practicing TBAs overall (Jenkins 2003). This loss of TBAs was particularly problematic for the poor who have very limited alternative options for birthing care (Jenkins 2003), such as those women living in this study village.

5.4 Conclusion

This Masters of Public Health research project explored the impact of maternal health policies on the provision of informal maternal health care provided by a TBA at the village level. This case study found that with the introduction of the BDD program and the Revolusi KIA policy, the traditional role as a TBA significantly changed and continues to be redefined over time. The Revolusi KIA policy has largely excluded this TBA from providing delivery care at home and women are told that they are required to deliver at the puskemas or rumah sakit, which is located on another island. However, current policy mandating facility deliveries has resulted in some women avoiding formal health care services in an attempt to exert choice
and control over their births. These resistive strategies also included some women avoiding involving the TBA, as policy changes have increased obligations and links between the TBA and the formal health care system. As a result, the TBA’s interaction with women in her village and how they utilise her TBA services has changed. Consequently, policies designed to ensure ‘safe’ birth may have the unintended consequence of women accessing less health care overall.

Although global and Indonesian maternal health policies have redefined the TBA role over a number of years, Mary remains a core provider of maternal health care in her village. This remains so in many parts of the world today (Jenkins 2003, Kruske & Barclay 2004). Mary’s role in the provision of maternal health care is integral as there continue to be many barriers to women accessing formal health care services. These barriers include poor acceptability of services to women, difficulties accessing health care, and widespread health system dysfunction. The Revolusi KIA policy dictates that women must deliver at an equipped health facility. However, the puskesmas available to women on this island does not have BEONC capacity and thus does not meet the requirements of an ‘equipped’ health facility as defined in Revolusi KIA policy document. In these circumstances, the TBA continues to be safety net, providing assistance in pregnancy, childbirth and postnatally where women may otherwise receive little or no quality care. However, as current policies restrict the involvement of TBAs in delivery and TBA training has ceased, TBAs are at risk of becoming deskillled and ceasing to exist in the community. This is problematic as it will increase women’s dependence on a system that is currently undependable, and potentially remove the only option for experienced attendance at birth for many women. These findings demonstrate the importance of understanding the impact of policy at the local level and why policies need to be locally driven and tailored (Shankar et al. 2008). Health policies must be based on evidence demonstrating a link between the proposed policy and improved health outcomes (Banta 2003). For policies to be accepted and effective, however, evidence must also consider the context in which the policy will be implemented (Banta 2003).
5.5 Study implications and limitations

Although this is a small study, the findings contribute to the current knowledge on the role of the TBA and how maternal health policies are played out at the local level in NTT. Whilst the findings of this study are not intended to be generalisable and Mary’s personal story is unique, TBAs are very common in Indonesia and Mary’s story is similar in many ways to others in Eastern Indonesia. Having only one participant in this study allowed for a comprehensive and in-depth exploration of Mary’s experiences and perspectives. The seeking out of this particular story, including the traditional knowledge and behaviour around pregnancy and childbirth, is a form of preserving a heritage that is rapidly changing. It also gives a voice to the TBAs who despite their continued role in maternal health care often go unheard in the literature. Furthermore, there are few NTT specific maternal health research studies despite ongoing high maternal mortality rates in this province. Thus this research adds significantly to the available body of knowledge in this area. It is hoped that this knowledge can contribute to the evidence base for effective design and implementation of maternal health policies and programs at a local level.

The main limitation of this study and what made it particularly challenging, was that the research was both cross-cultural and involved completing research in a language that is not the researcher’s first language. Although cross-cultural research is common, it is also very complicated and open for misunderstandings (Liamputtong 2013). Also, this research was conducted in a linguistically diverse region and in many of the interviews up to four different languages were spoken, which added layers of extra complexity. The actual language of interviews influences the accuracy and interpretation of findings (Liamputtong 2013) and thus a number of strategies were utilised to mitigate this influence. For example the interviews were transcribed in the original language of the interviews and I
consulted with a local linguist and anthropologist regarding subtle nuances in the transcripts and translation (see Chapter 3 Methods for further detail). However, the potential impact of the cross-cultural and multi-lingual nature of the research on the findings is acknowledged.

**5.6 Recommendations**

**TBAs be part of the solution**

TBAs have historically shouldered the blame for a lack of progress in improving maternal mortality (Kruske & Barclay 2004) and many past and current policies, programs and literature, depict TBA practices as a threat to maternal and infant health (Jenkins 2003, p. 1894). TBAs are frequently viewed as part of the ‘problem’ that needs to be fixed. However, it is argued that “the provision of skilled attendants for all birthing women cannot occur in isolation from TBAs who in themselves are also highly skilled” (Kruske & Barclay 2004, p. 306). This study demonstrated that whilst maternal health policy and programs have changed the TBA role over time, Mary’s remains a core provider of maternal health care in her village. Many women continue to seek Mary’s assistance in pregnancy and delivery both out of preference and necessity. For some women, Mary remains their only option for an experienced birth attendant as there are many barriers to women accessing formal maternal health care. It is suggested that without Mary’s contribution to maternal health care, these women would be at risk of receiving less health care overall and be at risk of more adverse outcomes. Thus it is recommended that TBAs be acknowledged as part of the solution to tackling the complex issue of improving maternal mortality in Indonesia.

**Genuinely partner with TBAs**

If TBAs are part of the solution to improving maternal mortality, TBAs must genuinely be partnered with as valuable and respected providers of maternal health
care. True partnership with TBAs, instead of simply using them as a temporary bridge to accessing formal services, will result in better outcomes for women who have limited options available to them (Jenkins 2003). Titaley et al. (2010a) stated that partnership with TBAs is particularly essential in remote areas of Indonesia where health services are notoriously poor. This partnership must not simply be rhetoric but based on true respect and collaboration, supported at the policy level (Kruske & Barclay 2004). It is suggested that the TBA role must not simply be demarcated as a “subordinate position as referral agent, health monitor and educator” (Hoban 2002, p. 229) as many current partnership models suggest. Their role must be acknowledged as integral to current maternal health care provision, recognising their many skills, knowledge and experience.

If the end goal is increased skilled birth attendance, evidence has demonstrated that including a wide range of duties in the TBA role instead of just promotional tasks, increases skilled birth attendance in the long term (Byrne & Morgan 2011). In a context where the health system, facilities and human resources are under-resourced or inaccessible, Byrne and Morgan (2011) suggest that TBAs be integrated as contributors to maternal health care. They suggest that this should include TBAs “attending deliveries and supporting SBAs”, establishing “communication systems for triage and referral in emergencies”, development of “collaboration skills for SBAs for improved acceptance by TBAs and communities”, “inclusion at facilities for shared care and workloads”, and “definition of roles for decentralized TBA/SBA teams” (Byrne & Morgan 2011, p. 132). Samoa is another country which has recognised the ongoing need to partner with TBAs in the provision of quality maternal health care (Homer et al. 2012). Another example is the integration of local midwives with the formal system is in the remote Inuit setting of Canada. In this model of care, local midwives or traditional midwives are the lead caregivers and they work in conjunction with nurses and doctors at the local health centre, with local midwife training being a core focus (Van Wagner et al. 2007). This model supports and trains local midwives, allows for care to be provided in a culturally and socially safe manner whilst also ensuring the physical safety of
the woman and child. Choguya (2014) argues that although integration of TBAs with formal health care services may be difficult, partnering with TBAs is essential as TBAs are the best intervention tool for addressing maternal mortality.

*Focus on improving health system*

Examples of health system dysfunction were found in this study and also in other recent NTT research (for example, Belton, Myers & Rambu Ngana 2014 & Rambu Ngana, Myers & Belton 2012). In order to improve maternal health outcomes, the current system, facilities and staffing must first improve. A recent paper by the Australia Indonesia Partnership for Maternal and Neonatal Health argued that in order for improvements in maternal mortality to be made in NTT, increasing the number of puskesmas with the capacity to provide PONED services must be a priority (AIPMNH 2015a). Policy directing women to deliver at under resourced and inaccessible health facilities will not save lives. There needs to be an effective health system as “even the ability of the most skilled physician to save a life is limited if there is no blood or antibiotics, or if the facilities needed for a cesarean section are not available” (National Academy of Sciences 2013, p. 35).

*Take action on social and economic determinants of health*

It is widely acknowledged that health is more than the absence of disease and policies to improve health must also address social and economic determinants of health (Wilkinson & Marmot 2003). Successful strategies to reduce maternal mortality in Sri Lanka and Malaysia recognised the link between health and factors such as poverty, education, water and sanitation, and development (Pathmanathan et al. 2003). Efforts to improve maternal health in these countries also addressed malaria control, child health and family planning (Pathmanathan et al. 2003). It is suggested that in this study district, efforts to improve maternal health outcomes must also address, overall poverty, food security, water access, malaria control, the poor condition of roads, and improve access to transport including a ferry boat service.
More research

The process for incorporating TBAs as integral and valuable contributors to maternal health care provision in NTT could be further informed through a participatory action research project completed at the village level. Participatory action research is inquiry with others, not done on others (Altrichter 2002) and the control should lie with the participating group (Gribich 1999). This process would empower TBAs and others to explore the issue in their specific context, produce knowledge and take action (Tsey et al. 2002, p. 280) in order to improve maternal health outcomes for women in their community.
Photo: Plastic bottles and rope for growing seaweed, beach at study village

Source: Author’s personal collection 2015
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UNDP – see United Nations Development Programme

UNICEF – see United Nations Children’s Fund


WFP – see World Food Programme


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WHO – see World Health Organization


Appendix A

Information sheet (English and regional variety of Malay)

Information Sheet

Project title: The life narrative of a Traditional Birth Attendant set alongside the maternal health policy of Indonesia.

This Is For You To Keep

Purpose: This research aims to learn about how maternal health policies impact on the birthing care provided by a traditional birth attendant on a remote island in NTT. This research would document in detail the practice of this traditional birth attendant and provide insight into how health policies impact people at the village level. It is hoped this information would be beneficial when tailoring health services to the local context.

What would be expected of you? If you decide to participate in this study, it would involve meeting with the researcher on multiple occasions over a period of 2 to 3 months. It would involve a number of audio recorded interviews where the researcher would ask questions about your work, experiences, and thoughts regarding birthing care and health services in your village. It would also involve informal interactions and conversations with the researcher, from which fieldnotes would be taken. You will also be asked to comment on preliminary findings to check for accuracy.

You can say no if you do not wish to participate. You can withdraw from the study at any stage without negative consequence.

Confidentiality: The researcher will make every effort to ensure your anonymity and confidentiality is protected. Your name, location or language will not be used in any written documents or publications. All data collected will be kept in a locked bag or office and all electronic data password protected.

Concerns or complaints:

If you have any concerns or complaints regarding this study or the behaviour of any of the researchers, please contact the Executive Officer, Human Research Ethics Committee, Darwin, NT, Australia. Email: ethics@menzies.edu.au. Tel: (08) 8922 8196. Fax (08) 8927 5187.

Researcher Contact Details

Emma Crimes at Menzies School of Health Research, Charles Darwin University, Kupang. Email: emma.crimes@outlook.com. Tel: +62 82237525741.

Dr Suzanne Betton at Menzies School of Health Research, Charles Darwin University, Darwin. Email: suzanne.betton@menzies.edu.au. Tel: +61 8 89486215.

Frederika Rambu Ngana at Charles Darwin University, Darwin and Nusa Cendana University, Kupang. Email: ika_hamei@yahoo.co.id
Surat Informasi

Judul studi: Mau banding dukun banara di dea pung carita pangalaman deng kabijakan pamarenta RI soal mama deng ana dong pung sehat.

(Mama bole simpan ini Surat informasi)

Tujuan ini penelitian pung makud ko mau balajar dampak dari kabijakan pamarenta soal mama deng ana dong pung sehat, seng dukun banara pung palayana di desa di NTT. Ini studi mau catat deng taliti dukun banara pung palayana di desa. Ini studi ju mau liu karmana kabijakan pamarenta ada pangaru sampe di desa dalam ini hal dong, biar yang bae, ko yang sonde bae. Botong pung makud ko biar hasil dari ini studi bias kasi tunja jalan yang bae, ko biar palayan dukun banara dong di tingkat desa bisa jadi lebe bae lai.


Botong jaga identititas: ibu Emma mau juga bae-bae ko biar orang laen deng sonde usa tau Mama pung identitas, deng tuju ame informasi yang sonde pantei kasi deng tau. Mama pung nama, lokasi deng baha, ibu Emma sonde akan pake dalam tulunan macam-macam deng terbitan, dll. Samma data tulunan, ibu Emma akan konsi dalam tampu yang aman. Samma data di komputer akan pake konsi password ju.

Andekata ada kaluha, ko, rasa sonde enak:
Andekata ada kauhan, ko, rasa sonde enak soai ini studi, ko, kalo rasa ada kalauhan peneini yang sonde pantas, na, tolong hubungi: Executive Officer, Charles Darwin University, Human Research Ethics Committee, Darwin, NT, Australia. Email: ethics@menzies.edu.au. Telp: (08) 8922 8196. Fax (08) 8927 5187.

Cara hubung Peneliti:
Emma Grimes di Menzies School of Health Research, Charles Darwin University, Kupang, Email: emma.grimes@outlook.com. Telp: +62 82237925741.
Dr Suzanne Belton di Menzies School of Health Research, Charles Darwin University, Darwin, Email: suzanne.belton@menzies.edu.au. Telp: +61 8 89460215
Frederika Rambu Ngana di Charles Darwin University, Darwin, deng Nusa Cendana University, Kupang Email: jika_bembi@yahoo.co.id.
Appendix B

Interview Guide

Interview Topic Guide

The life narrative of a Traditional Birth Attendant set alongside the maternal health policies of Indonesia.

This ethnographic study will focus on the life narrative of a TBA and focus on her experiences and perspectives on the impact of maternal health policies on birthing care in her village.

Demographic and contextual data:

Demographic and contextual data will be collected such as age, education/years of school, how many years of TBA practice, place of last birth, how many births in the last year/in career, phone coverage on the island, transport distance and time to the nearest hospital and health clinic.

Themes:

Preparation for work as a TBA

Can you tell me the story of how you became to work as a TBA?

What word do you use to describe your work or role? (ie. biden, dukun bayi, other)

Can you tell me about how you learnt how to be a TBA?

What training did you receive and from who?

Work as a TBA

What is your purpose as a TBA?

What does your role involve? What activities do you do?

When do you see women? Pregnancy? Labour? Post partum period?

What women do you usually work with? Young? High parity? Married?

How do you get paid/reimbursed for your services?

Can you tell me a story about a birth that was very special to you?
Can you tell me a story about a birth that was difficult?

What strategies do you have for maternal emergencies? What do you see as a maternal emergency?

How do you currently interact with the formal health system? Do you partner with the village bidan (midwife) or health centre? If so, what does this look like? If not, why not? Can you tell me a story about this partnership?

Do you partner with the hospital? If so, what does this look like? If not, why not?

Where is the nearest health centre? Where is the nearest hospital? How does a woman in labour travel to either of these centres? Are there options for rumah tunggu (waiting house)?

Reflections on work as a TBA

How has your work changed from when you began to work as a TBA to now?

What do you know about current maternal health policies? How do you find out about these policies?

How have government policies changed your work?

What is your biggest concern regarding maternal and infant care in your village?

Further interview questions and topics will be considered and refined in collaboration with the research team and the interpreter upon commencement of the research.
Appendix C

Ethics approval from Menzies School of Health Research, Northern Territory, Australia

1st July 2014

Dr Suzanne Belton
Menzies School of Health Research
PO Box 41396
Casuarina NT 0811

Dear Dr. Belton,

HREC Reference Number: 2014.2218

Project Title: The life narrative of a Traditional Birth Attendant set alongside the maternal health policies of Indonesia

Thank you for letter dated 11/07/2014 and taking the time to respond to the issues of concern identified by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) at its meeting held on the 10/06/2014.

I am pleased to advise that the Chair of the HREC has granted full ethical approval of this research project. Please note that HREC approval applies only to research conducted after the date of this letter.

This approval will be ratified at the next meeting of the Human Research Ethics Committee.

Approved Project Timeline: 11/07/2014 - 31/07/2015

Approval is granted for a maximum period of twelve months. An annual progress report of final report is required on or before the 11/07/2015.

APPROVAL IS SUBJECT TO the following conditions being met:

1. The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.

2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) of any event that requires a modification or amendment to the protocol or other project documents and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the Menzies’ website, or by clicking here.

3. The Coordinating Principal Investigator will submit any necessary reports to the Coordinating Principal Investigator for the safety of research participants (e.g. protocol deviations, protocol violations) in accordance with the HREC’s policy and procedure. These guidelines can be found on the Menzies’ website, or by clicking here.

Sincerely,

[Signature]
4. The Coordinating Principal Investigator will report to the HREC annually and notify the HREC when the project is completed at all sites using the specified forms. Forms and instructions may be found on the Menzies' website, or by clicking here.

5. The Coordinating Principal Investigator will notify the HREC if the project is discontinued at a participating site before the expected completion date, and provide the reason(s) for discontinuation.

6. The Coordinating Principal Investigator will notify the HREC if any plans to extend the duration of the project past the approval period listed above will submit any associated required documentation. The preferred time and method of requesting an extension of ethics approval is during the annual progress report. However, an extension may be requested at any time.

7. The Coordinating Principal Investigator will notify the HREC of his or her inability to continue as Coordinating Principal Investigator, including the name of and contact information for a replacement.

8. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).

9. Researchers should immediately report anything which might affect continuing ethical acceptance of the project, including:
   - Adverse effects of the project on subjects and the steps taken to deal with these.
   - Other unforeseen events.
   - New information that may invalidate the ethical integrity of the study.
   - Proposed changes in the project.

10. Approval for a further twelve months, within the original proposal timeframe, will be granted upon receipt of an annual progress report if the HREC is satisfied that the conduct of the project has been consistent with the original protocol.

11. Confidentiality of research participants should be maintained at all times as required by law.

12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site information with full contact details.

13. The Patient Information Sheet must provide a brief outline of the research activity including: risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Administrators can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.

14. You must forward a copy of this letter to all investigators and to your institution (if applicable).
The letter constitutes ethical approval only. This project cannot proceed at any site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

Should you wish to discuss the above research project further, please contact the Ethics Administrators via email: ethics@menzies.edu.au or telephone: (08) 8922 7872 or (08) 8922 8705.

The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research wishes you every continued success in your research.

Yours sincerely,

[Signature]

Associate Professor Phil Giffard
Chair
Human Research Ethics Committee
of Northern Territory Department of Health
and Menzies School of Health Research
NHMRC Registration No. EC000153
http://www.menzies.edu.au/ssr/Research/Ethics_approval

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007). The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.
Appendix D

Extension of ethics approval from Menzies School of Health Research, Northern Territory, Australia

14 July 2016

Dr Suzanne Beton
Menzies School of Health Research
PO Box 41006
Cassowary NT 0811

Dear Dr Beton,

HREC Reference Number: 2014-2318

Project Title: The life narrative of a Traditional Birth Attendant set alongside the national health policies of Indonesia

The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) thanks you for taking the time to compile and return your annual progress report for the above project.

The report has been reviewed and noted. An extension to the project completion date from 31/07/2015 to 30/07/2016 has also been noted and approved. Continued ethical approval is granted for the above research project. This approval will be ratified at the next meeting of the HREC.

Please note that this approval applies only to research conducted after the date of this letter.

As a reminder, the approved project timeline is: 11/07/2014–31/07/2016. An annual progress report or final report is required on or before the 30/07/2016.

APPROVAL IS SUBJECT TO the following conditions being met:

1. The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.

2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) of any event that requires a modification or amendment to the protocol or other project documents and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the Menzies website or by clicking here.

3. The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants (e.g. protocol deviations, protocol violations) in accordance with the HREC’s policy and procedures. These guidelines can be found on the Menzies website or by clicking here.
4. The Coordinating Principal Investigator will report to the HREC annually and notify the HREC when the project is completed at all sites using the specified forms. Forms and instructions may be found on the Menzies’ website, or by clicking here.

5. The Coordinating Principal Investigator will notify the HREC if the project is discontinued at a participating site before the expected completion date, and provide the reasons for discontinuance.

6. The Coordinating Principal Investigator will notify the HREC of any plans to extend the duration of the project past the approval period listed above and will submit any associated recruited documentation. The procedure time and method of requesting an extension of ethical approval is during the annual progress report. However, an extension may be requested at any time.

7. The Coordinating Principal Investigator will notify the HREC of his or her inability to continue as Coordinating Principal Investigator, including the name of and contact information for a replacement.

8. The safety and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).

9. Researchers should immediately report anything which might affect continuing ethical acceptance of the project, including:
   - Adverse effects of the project on subjects and the steps taken to deal with these;
   - Other unforeseen events;
   - New information that may invalidate the ethical integrity of the study; and
   - Proposed changes in the project.

10. Approval for a further twelve months within the original proposed timeframe, will be granted upon receipt of an annual progress report if the HREC is satisfied that the conduct of the project has been consistent with the original protocol.

11. Confidentiality of research participants should be maintained at all times as required by law.

12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site in accordance with full contact details.

13. The Patient Information Sheet must provide a brief outline of the research activity including risks and benefits, withdrawal options, contact details of the researchers, and must also state that the Human Research Ethics Administrators can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.

14. You must forward a copy of this letter to all investigators and to your institution (if applicable).
This letter constitutes ethical approval only. This project cannot proceed at any site until separate research governance authorization has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site.

Should you wish to discuss the above research project further, please contact the Ethics Administrators via email ethics@menzies.edu.au or telephone (08) 8946 6857 or (041) 6945 8892.

The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research wishes you every continued success in your research.

Yours sincerely,

[Signature]

Dr Ronei O'Donnell
Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research
NHMRC Registration No. E008153
http://www.menzies.edu.au/page/Research/Ethics_approval

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007). The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.
Appendix E

Supporting letter from the Rector of Nusa Cendana University, East Nusa Tenggara Province, Indonesia (Original and English translation)
Number: 3530/UN15.1/PL/2014
Attachments: 1 folder
Regarding: Request for Research Permission

To: His Excellency the Governor of NTT
in this case the Head of KPTISP for the Province of NTT
in Kupang

With respect,
In regards to the plan for cooperative research activities between Nusa Cendana University with Charles Darwin University and Menzies School of Health Research, Darwin NT, Australia, from May 2014 through May 2015 in the province of NTT Province, we hereby request permission to carry out the aforementioned research.

A researcher from Undana, Frederika Rambu Ngana, S.Si, M.Eng, together with Dr. Suzanne Belton and Emma Grimes from Australia will carry out research aimed to understand the influence on the quality of maternal health and policy/ies relating to traditional health workers in West Timor.

We are confident that this research will benefit program(s) of improving maternal and child health in the Province of Nusa Tenggara Timur, and for increasing cooperation between Indonesia and Australia.

With this letter we attach the following documents in fulfillment of requirements for research permission:
1. Photocopy of passport
2. Photocopy of visa
3. Research plan
4. Curriculum Vitae
5. Letter of Recommendation from the Indonesian Consultate in Darwin, NT, Australia
6. Declaration of the willingness of the researcher to cooperate with a local associate in carrying out the research.
7. Declaration by the researcher to obey the laws and regulations in effect and respect local customs and traditions.
8. 3 passport photos measuring 4cm x 6cm
9. Letter of invitation from Nusa Cendana University
10. Research Proposal

Thus is our request, and for your attention and cooperation we express our thanks.

Kupang, 22 April 2014
Rector Nusa Cendana University

Copies to:
1. Charles Darwin University, Australia
2. Menzies School of Health Research, Darwin, NT, Australia
3. Head of the Office of Public Health Policy, Kupang

[NAITI Professional Translator, No. 4021]
Appendix F

Supporting letter from Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) (Original and English translation)

SURAT REKOMENDASI
ND: 036/AIPMNH/IV/2014

Tentang
RISET KEMITRAAN BIDAN DUKUN DI WILAYAH KERJA PROGRAM AUSTRALIA INDONESIA PARTNERSHIP FOR MATERNAL AND NEONATAL HEALTH (AIPMNH)

Saya yang bertanda tangan di bawah ini:
Nama : Dr. Louise Simpson
Tahapat : Program Direktur
Alamat : Kantor Dinas Kesehatan Provinsi NTT
          Jalan Palapa No. 22
          Lombok - Kupang

Dengan ini memberikan rekomendasi kepada:
Nama : Emma Simran
Pekerjaan : Volunteer S2
Alamat : Jl. Cendrawasih, Lombok - Kupang, NTT

Yang bersangkutan melakukan riset Kemitraan Bidan dan Dukun dalam wilayah Kerja Program AIPMNH di

Besar harapannya agar hasil riset ini bermanfaat bagi program di waktu yang akan datang.

Demikian surat rekomendasi ini dibuat untuk dipergunakan sebagi meistinya.

Hormat kami

[Signature]

Dr. Louise Simpson
Program Direktur

Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH)
Kantor Dinas Kesehatan Provinsi NTT, Jl. Palapa No. 22, Kupang, Kupang, NTT 08900
T (+62 380) 308010 F (+62 380) 605 090 Website www.aipmnh.org

AIPMNH is managed by GIZ on behalf of the Australian Department of Foreign Affairs and Trade
LETTER OF RECOMMENDATION
NO: 036/AIPMNH/IV/2014

Regarding
RESEARCH ON THE PARTNERSHIP BETWEEN
MIDWIVES AND TRADITIONAL BIRTHING ATTENDANTS
WITHIN THE WORK REGION OF THE
AUSTRALIA INDONESIA PARTNERSHIP FOR MATERNAL AND NEONATAL HEALTH
(AIPMNH) PROGRAM

I, the undersigned:
Name: Dr. Louise Simpson
Position: Program Director
Address: Office of the Department of Health, NTT Province
         Jalan Palapa No. 22
         Oebobo – Kupang

Do hereby give a recommendation to:
Name: Emma Grimes
Position: Master’s level Student
Address: Jl. Cendawan, Lasiana – Kupang, NTT

The one involved is carrying out research on the Partnership between Midwives and Traditional
Birthing Attendants within the work region of the Australia Indonesia Partnership for Maternal
and Neonatal Health (AIPMNH) Program.

It is our great hope that the results of this research will be of benefit for the program in the
future. Thus is this letter of recommendation made to be used as it ought.

With our respects,

Dr. Louise Simpson
Program Director

<signed>

[Given letterhead footer with addresses,
phone numbers, and website]
Appendix G

Research permission letter from East Nusa Tenggara Governor (Original and English translation)
East Nusa Tenggara Provincial Government
Office of One Door Integrated Permission Service
Julian Torata No. 10—Tel/Fax (0380) 833213
KUPANG — NTT — Kode Pos 85117

Kupang, 29 April 2014

Number: 070/1130/KPPTSP/2014
Priority: Normal
Attachments: —
Regarding: Research Permission

To:
His Honour the Bupati of Kupang

Investment Board and
Integrated Permission Service,
Kupang Regency, in DELAMASI

With reference to the letter from the Senior Research Fellow, Charles Darwin University, Number: —, dated 22 April 2014, regarding a Request to Carry Out Research, and after reviewing the plan/proposal of activities which was submitted, Research Permission can be granted to:

Name: EMMA GRIMES
Passport Number: M/219308
Address: C/-1/53 Yina Cres, Rosebery NT 0832
Profession: Student
Citizenship: Australian

To carry out research entitled:

"THE LIFE NARRATIVE OF ONE TRADITIONAL BIRTH ATTENDANT SET ALONGSIDE THE PUBLIC HEALTH POLICY OF INDONESIA"

Location: (stated in brackets)
Accompanied by: —
Duration of Research: 1 (one) year
Person with Responsibility: Senior Research Fellow Charles Darwin University

The researcher is obligated to respect/comply with regulations and codes of conduct in effect in the aforementioned region, as follows:

1. Prior to carrying out research activity, she must report her arrival to the Bupati of Kupang, in this case the Office of Public Health Policy for approval by showing this Letter of Permission.
2. Research which does not conform to its connected to the proposed title is not condoned.
3. She must obey the laws and statutes that are in effect, and appreciate the prevailing traditional laws and customs.
4. The researcher must report the results of her research to the Governor of East Nusa Tenggara Province, in this case the Office of One Door Integrated Permission Service at the provincial and regency levels. If the time period granted for this research comes to an end, while the research has not yet been completed, an extension of the research must be submitted to the agency of the requester [logo in the original frame].
5. This Letter of Permission will be withdrawn and declared invalid, if it turns out the holder of this Letter of Permission does not obey or show due appreciation for the stipulations specified above.

Thus this declaration made, and we thank you for your attention.

On behalf of GOVERNOR EAST NUSA TENGGARA
HEAD, KPPTSP, NTT PROVINCE
Dr. YOHAKIM KOTAN
Level 1 Advisor
NIP. 19620816 199302 1 001 [civ servant number]

Copies to:
1. Governor, East Nusa Tenggara in Kupang (as a report);
2. Vice Governor, East Nusa Tenggara in Kupang (as a report);
3. Provincial Secretary, East Nusa Tenggara in Kupang (as a report);
4. Head of the Body for National Unity and Politics, NTT Province in Kupang;
5. Head of the Office of Public Health Policy, Kupang Regency Government;
6. Rector, Nusa Cendana University in Kupang:

[NAATI Translator Level 3 No. 40121]
Appendix H

Research permission letter from district Mayor of study site (Original and English translation)

PEMERINTAH
BADAN PENANAMAN MODAL DAN PELAYANAN PERUINAN TERPADU (BPMP2T)

Nomor Lampiran Perihal

074/LU/13/BPMP2T/N1/2014
Izin Penelitian

Kepada

VIII.

Tempat.


Nama: EMMA MINNES
UM: M771508
Alamat: CF 1/53 verso Cross Springs NT 0692
Golongan: Australia

Untuk melakukan penelitian dengan judul:

"THE LIFE NARRATIVE OF ONE TRADITIONAL BIRTH ATTENDANT SET ALONGSIDE THE PUBLIC HEALTH OF INDONESIA."

Lokasi

Pengikut

Lamanya penelitian: 1 bulan TMT luar di diskusi
Penanggung jawab: Senior Research Fellow Charles Darwin University

Pemeta pendekatan mengintegrasikan peraturan daerah dan yang berkaitan dengan penelitian ini kepada Bupati Kupang.

Demikian surat ini dikeluarkan untuk dipersiapan sebagaimana mestinya untuk kebutuhan yang hak disampaikan sesuai kostr.

Tembusan:
1. (Sebagai laporan);
2. Rektor Universitas Nusa Cendana di Kupang;
3. Kepala Badan Kependudukan dan Uraian Pendapatan NTT di Kupang;
4. Kepala Kantor Pelayanan Pemberian Tanggung Satu Pintu (KPPS); Prov NTT di Kapen;
5. Kapala Kantor Kesbangpol dan
6. Yang berurusan lain (Aslu):

[Signature]

NIP: 197010131970101004

113
Government
Capital Investment & Services Agency
Integrated Permissions (BPMP2T)

08 August 2014

Number : 074/1023/BPMP2T/VIII/2014
Attachments : --
Regarding : Research Permission

To:
Hon. District Officer of

location

With reference to the letter from the Head of the Office of One Door Integrated Permission Services (KPPTSP) for the Province of East Nusa Tenggara Number 070/1130/KPPTSP/2014, dated 29 April 2014, regarding Research Permission, and after studying the plan of action / Proposal which was submitted, research permission can be granted to the university student:

Name : EMMA GRIMES
Passport Number (NIM) : M721508
Address : 1/1/53 Yirra Cres, Rosebery NT 0832
Citizenship : Australian

To carry out research entitled:

"THE LIFE NARRATIVE OF ONE TRADITIONAL BIRTH ATTENDANT SET ALONGSIDE THE PUBLIC HEALTH POLICY OF INDONESIA"

Location : location
Accompanied by : --
Duration of Research : 1 (one) year beginning from the issue of this letter
Person with Responsibility : Senior Research Fellow Charles Darwin University

The researcher is obligated to respect/comply with regulations and codes of conduct in effect in the aforementioned region and must report the results of her Research to the Bupati of Kupang (provincial level) or the latter's representative for the purpose of monitoring.

Thus is this Permission for Research issued to be used as needed, and we thank you for your good cooperation.

Head
<signed and stamped>
NIMROD C. NOKES, SH (law degree)
Level 1 Advisor
NIP. 19581115 197910 1004 [civil servant number]

Copies to:
1. Deputy Minister of Health
2. Rector, Nusa Cendana University in Kupang;
3. Head of the Office of Public Health Policy, East Nusa Tenggara Province in Kupang;
4. Head of the Office of One Door Integrated Permission Services (KPPTSP) for the NTT Province in Kupang;
5. Head of the Office of Public Health Policy, NTT Province;
6. The relevant parties (original)
7. Archives

[NAAIT Translator Level 3, No. 40121]
Appendix I

Consent form (English and regional variety of Malay)

Consent Form

This is a guide for verbal consent which will audio recorded and stored.

Project title: The life narrative of a Traditional Birth Attendant set alongside the maternal health policy of Indonesia.

This form asks you to participate in this study. If you provide consent you can still withdraw from the study at any time without negative consequences.

This Means You Can Say NO

I, ............................................................................................................................

If, ............................................................................................................................

Hereby consent to participate in a study designed by Ms Emma Grimas with Dr Suzanne Belton of Charles Darwin University in collaboration with Ms Frederika Rambu Ngana of Charles Darwin University and Universitas Nusa Cendana, Kupang.

Participant Statement:

I have read the Information Sheet and have had the chance to ask questions about participating in this study. Yes/ No

I understand that the purpose of the study is to learn about how maternal health policies impact on the birthing care provided by a traditional birth attendant. Yes/ No

I consent to giving an interview. Yes/ No

I consent to my voice being recorded on a tape recorder. Yes/ No

I consent to notes being taken during interviews and informal conversations. Yes/ No

I consent to the information that I provide in the interview being published in research reports, journals or in presentations. My name or voice will not be used to identify me in these interviews. Yes/ No

Although my name, language or location will not be published, I understand that the researcher cannot guarantee my confidentiality and people may know that I have participated in this research. Yes/ No
I understand that I can refuse to participate in this study without any negative consequences. I understand that I can withdraw from the study at any stage without negative consequences. If I withdraw consent, I understand that any collected data will be destroyed. Yes/No

I consent to participating in this study. Yes/No

Name of participant: ____________________________________________________________

Participant signature: ________________________________ Date:_____________________

Interpreter name: _____________________________________________________________

Interpreter signature: ________________________________ Date:_____________________

Witness name: ________________________________________________________________

Witness signature: ________________________________ Date:_____________________

Researcher Contact Details

Emma Grimes at Menzies School of Health Research, Charles Darwin University, Kupang, Email: emma.grimes@outlook.com, Tel: +62 82237525741.

Dr Suzanne Belton at Menzies School of Health Research, Charles Darwin University, Darwin, Email: suzanne.belton@menzies.edu.au, Tel: +61 8 89460115

Frederika Rambo Nganga at Charles Darwin University, Darwin, and Nuca Gondana University, Kupang Email: fre_hamet@yahoo.co.id.
Surat Kasi Ijin

(Botong mau rakám kalo Mama kasi ijin, ma ini formulir kasi tunju jalan sa)

Judiul studi: Mau banding dukan barana di desa pung carita pangalaman deng kabijakan pamarenta RI so'al mama deng ana dong pung sehat.

Botong mau minta Mama iko bantu botong dalam ini studi. Ma biar Mama satu ru sakarang, dari balakang masi bisa ondor diri, deng botong sonde kurang hati ju.

Dia pung arei, andia Mama BISA TOLAK kalo sonde mau bantu. Jang mau.
Ma KALO TARI MAE, deng mau iko bantu botong, tolong isi deng teken di bawu. Makasi.

Beta, andia: ..............................................................................................................................

yang tena di: ..............................................................................................................................

mau iko bantu Ibu Emma Geimes deng dia pung studi ni. Ibu studi tu, dia sunun deng dia pung Pambina, andia Dr Suzanne Betton dari Charles Darwin University, Ibu Frederika Ramla Soma dari Charles Darwin University deng Universitas Nusa Cendana, Kupung ju iko jadi Pambina 2.

Beta mangaku:
Beta su baca ini studi pung Surat informasi. Dong ju kasi bota waktu ko betanya-tanya so'al ini studi, deng beta pung parana dalam ini studi.
Batul/Sonde

Beta mangarti ini studi pung tujuan, andia deng mau balajar karmana kabi jakan pamarenta RI so'al mama deng ana dong pung sehat biza ada pangaru yang bae ko sonde bae, kasi sang dukan barana di desa deng pung palayan.
Batul/Sonde

Dong bole wawancara sang beta
Batul/Sonde

Dong bole rakám beta pung suara
Batul/Sonde

Dong bole tulis catatan waktu dong ada wawancara sang beta, deng kalo botong ada bacari-bacari biasa ju.

Batul/Sonde

Batul/Sonde


Beta mau iko bantu dalam ini studi.
Batul/Sonde
Mama yang iko bantu peng nama:............................................................................................................................

Teken/tandatangan (yg iko bantu): ..............................................................Tanggal:........................................................................

Nama Penerjemah isan:................................................................................................................................................

Teken/tandatangan (Penerjemah): ..............................................................Tanggal:........................................................................

Nama saksi: ..............................................................................................................................................................

Teken/tandatangan (saksi): ..............................................................Tanggal:........................................................................

Cara hubungi Peneliti:

Emma Grimes di Menzies School of Health Research, Charles Darwin University, Kupang. Email: emma.arinos@outlook.com, Telp: +61 82237525741.

Dr Suzanne Bellon di Menzies School of Health Research, Charles Darwin University, Darwin, Email: suzanne.bellon@menzies.edu.au, Telp: +61 8 89406213

Frederika Rambu Ngana di Charles Darwin University, Darwin, deng Nusa Cendana University, Kupang Email: ika_hamel@yahoo.co.id