

Behind the Slow Road to Progress: Addressing Myriad Causes of the Persistence of Relatively High Maternal Mortality in Brebes Regency after the Post EMAS Program

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Abstract. The purpose of this article is to discuss the restricting factors which hinder the Brebes regency's goal of reducing maternal and new born mortality, especially in the aspects of communication strategy which has been applied by the local district government. The location of the research was Bulakamba sub-district which has applied the system of "*desa siaga madya*" (mid-size alert village) but unfortunately has the highest maternal mortality in Brebes regency. Through analyzing data which have been collected by making observation, doing interviews, conducting focus group discussion and studying documents using an interactive data analysis technique, the results show that there are some complex obstacles which hinder the success of the program. Although the local government has attempted to produce health regulations as an intervention, to improve the quality of the health services and to develop special communication strategy, the rate of maternal mortality is still relatively high in this sub-district. However, the cultural change as the impact of modernization and cultural mobility, especially in the coastal area of the regency could not be blamed as one of the myriad causes of the persistence. It still needs a special address from the government to intervene, especially to prepare the society to face the modern life with all of its complexities.

1. Introduction

Early research on the post implementation of EMAS (Enhancing Maternal and New Born Survival) program in Brebes has shown that this program has subsequently not been able to bring down the rate of maternal and new born mortality as the target planned. In 2015, the highest rate of maternal mortality in Central Java was in Brebes with 47 cases although compared to the 2014 rate, it was a 45% reduction rate. In 2016, Brebes maternal and new-born mortality was still in a crucially high state, with five cases each month[1]. The number of the cases has caused dissatisfaction among health practitioners in the regency and led to curiosity towards the hindering factors of the still relatively high maternal mortality. One case worth questioning has been that the highest maternal mortality rate predicate was actually given to a sub-district which was considered to be highly knowledgeable about maternal health.

Ending preventable maternal mortality is an internationally accepted goal with the target of global average of less than 70 per 100,000 live births by 2030. USAID has developed the Vision for Action for Ending Preventable Maternal mortality applying integrated, comprehensive, and holistic approach with putting on equity and respect for women and context specifics supported with "strong guiding principles



and good governance. [2][3] The target plan was to reduce 75% of Maternal Mortality Ratio (MMR) by 2015. However, until September 2015 of the time of the end of the era of Millennium Development Goals (MDGs), the global decline of MMR was only 44%. [4] Every country has different pathways to reduce maternal mortality. Challenges include poverty, geographic features limiting access to health services, cultural norms and/or weak health systems.

In Indonesia, the hindering factors are relatively complex. It is often not a medical condition, such as suffering hemorrhaging, eclampsia, sepsis or unsafe abortion identified globally as the main causes.[5] The Women Research Institute has identified that a lack of access to adequate reproductive health facilities is often the main cause of the persistence of Maternal Mortality Rate in Indonesia. Poverty is the main reason why pregnant women do not try to get help although they are categorized as being in high risk. Most of them deliver their baby at home assisted by untrained traditional birth assistant (*dukun bayi*). Findings show that childbirths attended by untrained traditional birth assistance also encounter other problems such as the lack of clean water, electricity for lighting, sterile space and equipment, and necessary medicines which could be risky for the health of the mother. However, many pregnant women refuse to get service from doctors or midwives although they acknowledge that they have better medical expertise because the cost of traditional midwives is more affordable and their services are from the pre-natal and delivery process until the post-delivery care to the infant and the family. Another hindering factor is the geographical condition, such as the considerable distance between the community health center to the regional public hospitals compounded by poor road infrastructure and a lack of public transportation. The other cause is the myths which are relatively still strong in the society such as traditional midwives having supernatural powers who could give them a comfortable feeling and is still reinforced with the strong belief that delivering a baby is natural for women. Cultural norms also prescribes women's lack of access to their body: women could not make their own decision about where they will deliver the baby and who will assist them in the process of delivery.[6]

In 1996 Indonesia developed a program to promote safe motherhood called *Gerakan Sayang Ibu* (Love Mom Movement). Some strategies developed are creating a program of the Making Pregnancy Safer Movement and making an effective partnership through a cooperative cross-sector program. In 2006 the government made a policy through Ministry of Health to develop a program of *Desa Siaga* (Village Alert System) to encourage the local government to provide early assistance to keep out the three delays. However, WRI found out that some districts did not have enough political will to allocate funds for health programs which in consequence the GSI program did not show an expected success to reach the target of MMR reduction.[5] In 2012 Indonesia has developed EMAS program with the support of USAID. EMAS is a five-year program with the goal to contribute to an overall 25% reduction in maternal and neonatal mortality. It works through the collaboration of five institutions, Jhpiego as the lead partner, Lembaga Kesehatan Budi Kemuliaan Muhammadiyah, Save the Children and RTI International. EMAS Program interventions involve emergency maternal and new-born care at hospitals, district referral systems, maternal and new-born care at health centres (*puskesmas*) and local government and civil society accountability in which all interventions interact synergistically between community, civil society, health facilities, and district health system. 300 districts and cities in six provinces in Indonesia acquired the EMAS program and Brebes regency is one of them.[7] Although EMAS has reported that the program has successfully reduced the MMR in Indonesia, some regencies still have high MMR including Brebes.

In 1987 in concern with the high rate of maternal mortality the program of Safe Motherhood Initiatives was brought about to call for local, national and international level to design actions with mutual agreement aiming at improving women health status and women's access to health services during pregnancy and the quality of medical care for treating complications during pregnancy and delivery. There were many interventions proposed and they were the subject of the debates among health practitioners and policy makers. However, they had one agreement that the interval between the assault of the obstetric complications and the provision of the timely obstetric care was the potential causes of

maternal deaths. [8] Meanwhile, an in depth analysis of multifactorial causes is pointed to demographic, behavioural, nutritional, and health services related factors.[9] The post-2015 Sustainable Development agendas have broaden to include health, gender equality, and sexual and reproductive health and rights to cover the limitations of MDGs which has too focus only on agenda of reducing maternal mortality rate and do not consider the interdependence between health and human right. The unachieved target of MDGs in related to MMR reduction is due to the action of the government in providing grossly underfunding health rather than making long standing commitment. The paradigm supported by World Bank is Universal Health Coverage (UHC) as the health goal which means that the poorest and the most marginalised people should have access to healthcare. However, the implementation of UHC also raises an issue of financing.[10]

Maternal mortality has become a focus of attention in research and policy, especially since it is the goal of number 5 in MDGs. Various researches have been done in looking at the causes of the relatively persistence of the MMR especially in many developing countries and the impact of interventions.[11] Various policies and strategies have also been developed and implemented to reduce the MMR, such as Every Newborn: cash transfer and voucher scheme in South Asia or An Action Plan to End Preventable Death (ENAP) and Strategies toward ending Preventable Maternal Mortality (EPMM).[3][8][12] Some have reported their success through “the combination of a right-to-health approach with learning and capacity building, community networking, popular mobilization and legal action” and intervention standards.[11][13] However, most researches still reported that the enormous number of maternal death in developing countries stayed the same as 100 years ago and direct obstetrics are the main causes of maternal mortality.[3][14]

This paper provides an overview of the implementation of EMAS and the implication of the program in Brebes regency with interests in the sub-district located in the coastal area of Brebes which is reported having the highest number of maternal mortality cases in 2016. It reviews especially the implementation challenges and limitations based on currently available data. This study in some way is an attempt to identify other unexpected factors behind the slow progress of the target planned. Points to develop in this paper are addressed to urban issues, as most previous studies have more focused on rural setting categorized as the poor without considering the deprivation or urban areas as an impact of globalization.[15]

2. Material and Methods

This article uses a qualitative approach which considers people’s attitudes, norms, and values as data of this research. The location of the research was Brebes regency, especially the Bulakamba sub-district. The data were obtained from FGD with pregnant women and community leaders which were conducted separately, participants’ observation, documentation survey and in depth interviews with governmental staffs of community health centers of the subdistrict and the regency of Brebes. Verbal and non-verbal behaviors were also used to understand cultural norms, patterns, values, etc. In depth interview, in the form of personal communication was also employed to some participants when non-verbal behaviors indicated conflicting information or needed further clarification. The data collection employed triangulation to avoid the limitations of a single method, to help create the reliability and validity of the data. All data were then managed carefully.

3. Results and Discussion

3.1. The Coastal Culture of Brebes Regency

Brebes regency is located in the north-western part of Central Java province. It comprises 17 sub-districts which spread from the mountainous area of the mount Slamet to the coastal area of the north-western part

of Central Java. Majority of Brebes people speak in Javanese language with a special accent which shows the intersection of Javanese and Sundanese accent and culture. With the population of about 1.7 million people (2016), Brebes' economy is supported by several occupations, with the main focus on agriculture and fisheries. This fact is supported by the high rainfall, up to 18,94 mm per month and a tropical climate. Brebes regency has about 37,7% wetland area, consisting of rice fields and swamps, supporting up to 70% of the population.

Concentrated fisheries and agriculture areas are mainly in Bulakamba sub-district. Bulakamba, one of the most densely populated sub-district in Brebes regency, is located west of the capital of Brebes regency, and is 3 km above the sea level. It borders the Java Sea in the north, Larangan and Ketanggungan sub-district in the south, Tanjung and Kersana sub-district in the west, and Wanasari sub-district in the east. Bulakamba sub-district uses 7411 Ha of land for agricultural needs (wet lands), and the remaining 2882 Ha are non-wet lands. Aside from the vast wet lands, three rivers flow through Bulakamba sub-district, which are Pakijangan River, Bangsri River, and Kluwut River. These rivers are what supports Bulakamba as an agricultural sub-district. However, some villages are located on the coastal area with fisheries as the main income of the people. Some people work as a fisherman and others which are mostly female work on the traditional fish processing. Information from reliable person informally acquired mentions that some young people work as sailors however this occupation is not specifically reported in *Brebes dalam Angka* (Brebes in Number).

As reported in 2015 Brebes in Number, there are 5 government and private hospitals. To provide the health service of the community as well as to ease the community to access the service, there are 38 main community health centers and 60 supporting community health centers available in every sub-district. Some sub-districts, such as ones located in remote areas or covering wider area with more dense population, it is even more than one community health centers, such as in Bulakamba sub-district. In relation to provide services of women reproductive health, the community health center in Bulakamba has provided some basic emergence of obstetric and neonatal services.

3.2. *Behind the Slow Road to Progress*

Maladies that cause maternal mortality such as haemorrhage, sepsis, hypertensive disorders, illegal abortions, and obstructed labour can be treated successfully as long as there is no delay of seeking care, reaching care and receiving care to public health specialists. However, other result from in depth analysis to the multifactorial causes of MMR points to other factors, such as socio-demographic, cultural, and communal factors, beside health service related factors. As various studies have reported, the persistence of the relatively high maternal mortality rate (wherever) is caused by various factors such as poverty, limited access to educational and economic opportunities, gender-based stereotypes and discrimination and harmful traditional practices such as early marriage.

Finding on the research on the persistence of Brebes MMR has shown that Brebes has designed various intervention with EMAS support to reduce the number of maternal mortality. In line with Safe Motherhood Initiatives, Brebes has also developed interventions and strategic drivers to reduce maternal mortality and shorten the three delays. The setting of Brebes which spreads from the mountainous to coastal area with the centre of the local government and the regional public hospital in between is potential for causing delay to reach and receive care because of geographical constraints. It is still possibly compounded with socioeconomic conditions and the financial environment that obstruct access to money and information as well as cost of services. Although it is sometimes not considered by the community of the remote areas or the low income people because of their low esteem, the scope and organization of medical services and the quality of care are still questionable, especially in the eyes of the health practitioners of the regency. 2015 research on the implementation of EMAS in Brebes, for example has identified that the referral exchange system is still problematic despite the policy produced to improve

communication among health centres and regional public hospital in order to stabilize, refer, and prepare for emergency referrals.

In conversations with some pregnant women and their mothers, separately conducted, they acknowledge the professional ability of the midwives on their knowledge, skills, and competence in assisting delivery. They also acknowledge that good facilities of health centre is important for pregnancy checks and delivery process. However, when questions on who has checked their pregnancy and who will help their delivery, reluctantly they answer that they still go to the traditional birth assistance (*dukun bayi*). Reasons are mentioned that *dukun bayi* does not only provide pregnancy check and delivery process, but also in looking after other pregnancy disturbing conditions, such as giving massage and making herbal potion for creating fresh feeling. In some way, the function of *dukun bayi* is to replace the position of a mother in looking after the pregnant women, who are still relatively young (in their 20s). *Dukun bayi* could satisfy their need for attention and care that unfortunately could not be provided by midwives. *Dukun bayi* could also serve any time as needed. Aside pregnancy related care, *dukun bayi* also looks after the baby after the delivery. Because of the complete service of *dukun bayi* and also the flexibility of the payment of the service, some pregnant women or their mother prefers to get service from *dukun bayi*. Such conditions produce difficulties in monitoring the condition of the pregnancy. Brebes regency has produced regulation to stop this practice by giving penalty to the *dukun bayi* with some of money established as a fine for helping the process of delivery, however, it does not work. Women who get services from *dukun bayi* report that they deliver the baby on the way to the health centre. It can be said that they cover the practice of *dukun bayi* because they consider the importance of the service. As the target of reducing the number of maternal death is more important rather than the implementation of the regulation, the community of health centre of the sub-district Bulakamba facilitates monthly regular meeting between *dukun bayi* and health practitioners to disseminate various informations on pregnancy health especially to detect the high risk pregnancy that needs serious attention and care from health centre. Health communicators of the sub-districts also work hand in hand with *ustadz*, Islamic preachers to insert some informations of the importance of maternal health on their preaching.

The contrastive geographical setting produces also unique cultural differences between the two areas. Some sub-districts are located on the mountainous area which are geographically remote and the culture of the sub-districts is very communal. Meanwhile, some are located on the coastal area which is close to the highway connecting Central Java to West Java and the characteristics of the people is more closely to urban in attitude and values. The complex characteristics of the community encourage the regency of Brebes to develop programs with some considerations of the local wisdom of the sub-districts. Thus, the socio-cultural milieu, such as values, beliefs, and attitudes of the community can be considered in designing and producing interventions.

Finding also shows that Brebes has been successful in enabling and mobilizing individuals and communities though the establishment of *Forum Masyarakat Madani*, a civic forum which becomes the medium between the EMAS program and the community. This forum works with community organizations, sometimes door to door, to educate the community, all women and families, to have adequate knowledge about maternal health. This forum also has a role to communicate the need of quality health care which includes access to services, goods, and information. As a medium between the government and community, this forum could develop a dialogue between the government and community and it can result in changes of procedures and policy from the feedbacks given by the community. In some way, this forum has successfully reduced the MMR to zero cases such as in the sub-district of Sirampog, despite the geographical barriers that are the winding and steep roads and considerably far between the location of the community health centres of the sub-district to the regional public hospitals. The problems of the traditional practice of early marriage, and also the community myth that early pregnancy should be kept out of public have also been tackled through the strategic communication developed by the civic forum. Their intervention is to escort the pregnant women from

the early pregnancy to the delivery process through educating the whole member of the family on the importance of the quality of services and health care which are only provided by the community health centre. Even, the develop “*kelas ayah*” group of fathers to educate them about all issues related to stage of pregnancy and also informations on new born which should be recognized by father.

This research also identifies the different attitude of the pregnant women related to finding information on pregnancy health. The characteristics of the community on the coastal area have somehow been infused with some aspects of modernization and it influences the perspectives of the pregnant women on the importance of maternal health and health facilities. Some of them say that they go to specialist for their pregnancy check and plan to have the delivery on private hospital. Some of them go to community health centre for regular check as suggested by the person they trust. Some of them use internet to get various information on reproductive health while others still rely on their relative’s suggestion. It can be said the pregnant women in the coastal area of Brebes are diverse on their individuality and perspective on pregnancy. This phenomenon shows the urban advantage of the women in accessing the reproductive health information.[15] Looking at the literacy of the pregnant women on reproductive health information and the characteristics of the individuals in finding informations, the local government of Brebes does not provide EMAS support to reduce the number of maternal mortality. Thus, the community health centers on Bulakamba do not create *Forum Masyarakat Madani* as a mediator between the government and the community. It is ironical that the highest rate of maternal death is reported from Bulakamba.

Finding also shows that sub-districts in Bulakamba have complex problems. Despite high risk pregnancy because of too old and too young for pregnancy, some of them have low income and no healthcare. Although pregnancy health check could be performed in community health centre for free, they could not get further obstetric treatment from regional public hospital until they can show their healthcare card. Unfortunately, healthcare in Indonesia is not free. Individual should pay certain amount of money every month to get health cover which unfortunately is still not affordable for some low income people. Cases on neonatal death are also high in Bulakamba. Data show that low income makes some women reluctantly check their pregnancy health and pay attention to the development of the fetus. That is why, anaemia and poor nutrition are the main causes of maternal and neonatal death. Still in line with previous research conducted in Africa, Asia and Latin America in 2010 assessing the “urban advantage” in maternal health care, this research also identifies the unequal access of the urban poor to the health services and barriers to access in different contexts which suggest to do more interventions from both the central and local government.[15]

Low income could encourage individuals to be migrant workers. In Bulakamba, informal information accepted that some individuals work as sailor on foreign ships who are in some way experience cultural mobility. By working as a sailor on foreign ships, somehow they could improve their financial condition. However, they also bring back some unexpected perspectives and attitudes which are still morally unacceptable for the community. The biggest issues raised by the staff of the community health centre in Bulakamba as the unexpected impact brought to home by migrant workers are sexual permissiveness and homosexuality which are still morally and religiously unacceptable in Indonesia. Issue needs to tackle seriously by the local government is the number of people with HIV that shows an increase in recent years. Also, some women unfortunately become pregnant because of sexual permissiveness practice, which is shameful not only for the women but also for the community. Meanwhile, cultural norm, elsewhere in Indonesia is still relatively strong which produces such a question as related to the existence of the husband when a pregnant woman checks her maternal health in public health facilities. In a culture which is to require the participation of the husband during the pregnancy checks, a single woman attending community health centre for a reproductive check could raise many questions that can be disturbing. It is not surprising if a woman who finds herself pregnant without a husband prefer to hide her pregnancy rather than accepting disturbing questions and comments from the people around. Also, there

is an issue of who will take responsibility for the baby. It is plausible that these women want to terminate their pregnancy with any meant. Unfortunately, abortion is illegal by law, religion and culture. Five cases of maternal mortality are caused by the unintended pregnancy and the reluctance of the pregnant women to have their pregnant health checks. Rumours spread around that these women purposively abandon their pregnancy by not having pregnancy health checks which lead to the unhandled obstetric complication. Some of these pregnant women unfortunately are economically weak and uninformed on the knowledge of woman reproduction. In such cases, the position of the staffs of the community health centre and the head of the community is dilemmatic. Giving information on access to modern contraceptive, for example is still considered as controversial issue because some people still understand it as supporting to sexual permissiveness. It creates barriers for both the staffs of community health centre and the head of the community as the local leader to manage on how to educate the community on sexual health and access to modern contraceptive. Meanwhile, modernization has also eroded the community's emotional connection to their local leader which further reduces the degree of interaction between the leaders and the community members. As people become more individualized, the power of the local leader to interfere when unacceptable behaviours are noted gradually diminishes. Despite various interventions addressing to both clinical and social problems, cultural issues need to have more attentions, especially to factors accompanying modernization.

4. Conclusion

In an attempt to reduce the number of maternal mortality cases, the regency of Brebes has conducted various intervention efforts with the support of EMAS program. Looking at the intervention programs developed by the local government of Brebes hand in hand with the community from many sub-districts, it shows that the programs are the implementation of Safe Motherhood Initiatives. However, the development of the program is still narrowed on reducing the MMR only although all of the implementations have shown the collaboration between donors, health system, health policy, and civil society. MDGs has been over and post-2015 is the era of SDG which promotes universal access to quality health services. Although on the level of sub-districts, the local government hand in hand with the community have escorted pregnant women from early pregnancy to safe delivery, when it comes to obstetric complication which needs referral to regional public hospital, there is still an issue who will finance the medical treatment. The problem of the regency of Brebes and also elsewhere in Indonesia is poverty. Unfortunately, many low income families still do not have health insurance which leads to the lack access to health care. Other unexpected issue which makes the slow progress of reducing the number of maternal death is the case of unintended pregnancy resulted from the life style change of the community. What happen to the coastal area of Brebes is a common issue in Indonesia as a transition of the society from communal into modern as an impact of modernization. Special strategy needs to design to meet the complexity of the society while still putting on the first on achieving the target of reducing MMR to 75%. Thus, further research needs to conduct to look at the cultural issues which become the hindering factors of the slow progress to reduce the maternal mortality rate, such as through ethnographic studies to certain communities.

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