ORIGINAL RESEARCH ARTICLE

Context and reasons of preference for use of traditional birth attendant care in Indonesia and Ethiopia

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Abstract

Despite progress achieved in improving maternal health in Indonesia and Ethiopia, both countries still have high maternal deaths. To address this key issue, the Indonesian and Ethiopian governments prioritise health facility childbirth and discourage the use of Traditional Birth Attendant (TBA) care. The study aims to explore context and reasons of preference to use TBA care in Indonesia and Ethiopia. Employing a qualitative approach, 110 semi-structured interviews (SSIs) and 7 focus group discussions (FGDs) in Cianjur and Southwest Sumba (Indonesia), as well as 44 SSIs and 14 FGDs in Sidama (Ethiopia) were conducted. Study participants included mothers, TBAs, community health providers, men within those communities and village leaders. The study found that preference for TBA care persists in the study sites within both countries. TBAs' cultural, psychological and geographical proximity, TBAs' wide-ranging and culturally deep-rooted services are important context and reasons of the preference for utilising TBA care. Improving health system cultural sensitiveness and strengthening partnership between formal health workers and TBAs have potential to enhance maternal health in both countries. *(Afr J Reprod Health 2025; 29 [6]: 40-57).*

Keywords: Childbirth; Culture; Ethiopia; Indonesia; Maternal health; Partnership; Pregnant women; TBA

Résumé

Malgré les progrès réalisés en matière de santé maternelle en Indonésie et en Éthiopie, ces deux pays enregistrent encore des taux élevés de mortalité maternelle. Pour remédier à ce problème majeur, les gouvernements indonésien et éthiopien privilégient les accouchements en établissement de santé et découragent le recours aux soins dispensés par des accoucheuses traditionnelles (AT). L'étude vise à explorer le contexte et les raisons de la préférence pour les soins dispensés par des AT en Indonésie et en Éthiopie. À l'aide d'une approche qualitative, 110 entretiens semi-structurés (ISS) et 7 discussions de groupe (GDF) ont été menés à Cianjur et dans le sud-ouest de Sumba (Indonésie), ainsi que 44 ISS et 14 GDF à Sidama (Éthiopie). Parmi les participants à l'étude figuraient des mères, des AT, des prestataires de santé communautaires, des hommes de ces communautés et des chefs de village. L'étude a révélé que la préférence pour les soins dispensés par des AT persiste dans les sites d'étude des deux pays. La proximité culturelle, psychologique et géographique des AT, ainsi que la diversité et l'ancrage culturel de leurs services constituent des facteurs importants de contexte et de raisons expliquant la préférence pour les soins dispensés par des AT. L'amélioration de la sensibilité culturelle du système de santé et le renforcement du partenariat entre les professionnels de santé et les accoucheuses traditionnelles pourraient améliorer la santé maternelle dans les deux pays. *(Afr J Reprod Health 2025; 29 [6]: 40-57).*

Mots-clés: Accouchement; Culture; Éthiopie; Indonésie ; Santé maternelle; Partenariat; Femmes enceintes; Accoucheuses traditionnelles

Introduction

Maternal ill-health including maternal death are critical public health issues in low- and middle-income (LMI) countries in Southeast Asia and sub-Saharan Africa, including Indonesia and Ethiopia. [1] Most global maternal deaths took place in these regions.[1] Though both Indonesia and Ethiopia have made progress in reducing maternal mortality rates (MMR), both countries still have high maternal death.[2-3]

Indonesia, a Muslim majority country in Southeast Asia with high geographic, socioeconomic and disease burden disparities across the archipelago had established various programs like community health centers (*Puskesmas*), the village midwife program, and community health outreach (*Posyandu*) to improve

maternal health and lower maternal deaths. However, despite Indonesia's position as a middle-income country with GDP per capita of 4919 USD, the country's MMR is still high compared to other countries in Southeast Asia. In 2022 Indonesia's MMR was 189/100 000 live births, the fourth highest in the region.[2]

Ethiopia, a Christian majority and a landlocked in the Horn of Africa, a low- income country with 1294 USD GDP per capita also faces wide socioeconomic and disease burden disparities across the state. Ethiopia had launched strategic programs such as the Health Extension Program (HEP) in 2004, deploying over 40 000 Health Extension Workers (HEWs) to provide essential health services to the community, with a strong focus on mothers and children. Nevertheless, in 2022 Ethiopia's MMR was 267 deaths per 100,000 live births, remains one of the highest in sub-Saharan Africa.[3]

In terms of governance, both Indonesia and Ethiopia have decentralised their health systems, transferring more decision-making power and resources to local governments. This change, initiated in 2001 in Indonesia and in 1991 in Ethiopia, aims to enhance social and health services to the people by allowing for better governance and local control.[4-5] Indonesian and Ethiopian health systems strongly encourage and emphasise the importance of institutional facility childbirth and the use of professional health workers services, thus discourage the utilisation of traditional birth attendant (TBA) care for delivery as the core of their efforts to improve maternal health.[6-8]

Several progresses related to maternal health indicators have been achieved in Indonesia and Ethiopia, such as the increased rates of childbirth at health facilities.[8,9] Between 2020 and 2022, facility-based deliveries rose from 15% to 31% in Ethiopia and from 69% to 87% in Indonesia.[2,3] However, various barriers including cultural-related challenges such as traditional beliefs, male-dominated decision-making related to the place of childbirth and preference for TBA care still hinder facility-based birthing in some areas in both countries.[6-11] Due to Indonesia's and Ethiopia's high maternal mortality rate, comparable policies and programs in supporting community health workers to improve maternal health as well as the existence of various barriers to health facility birthing, comparison between both countries has both significant academic and practical merit.

The various cultural challenges in tandem with geographical, logistical and financial barriers continue to make facility-based childbirth difficult for some women in Indonesia and Ethiopia.[7-11] Employing medical anthropology and phenomenology frameworks that address the importance and complexity of people's lived experience in responding to health-related issues and how cultural, historical and political factors shape people's actions[12,13], this article explores the context and reasons related to the preference of using TBA care during pregnancy and for childbirth in several areas in Indonesia and Ethiopia.

Methods

Qualitative methods and phenomenological approaches were employed to examine experiences and reasons of preference to utilise TBA care among pregnant mothers in the study sites in Indonesia and Ethiopia. A phenomenological approach is suitable to better understand human experiences, focusing on people's lived experience, perceptions, thoughts and practices.[12,13]

Study setting

This study was part of REACHOUT, an international research consortium focused on improving community health services' effectiveness and accessibility in rural and peri-urban areas of six countries in Asia and Africa, including Indonesia and Ethiopia. Specifically, this article was based on the fieldworks in Indonesia and Ethiopia aimed to explore factors influencing the performance of maternal health workers in rural and peri-urban regions in both countries in 2016-2017 and a follow-up study in 2024-2025.

Indonesia

Research took place in four villages in the Southwest Sumba district of East Nusatenggara province and four villages in Cianjur district of West Java province. The villages were chosen based on their distance from community health center (*Puskesmas*) and different levels of health

facility use. In 2023, the population of Southwest Sumba was 280 818, served by 15 *Puskesmas*, and Cianjur had 2 835 000 residents served by 47 *Puskesmas.*[14,15]

Ethiopia

The study covered six districts in Sidama Zone, Southern Ethiopia, selected for their diversity in maternal health outcomes and distance from the zonal capital, Hawassa. In 2023, Sidama Zone – with over 3.5 million people – is served by 2 public hospitals, 112 health centers, 9 clinics, and 533 health posts, each staffed by two health workers to cover about 6000 people. At the *kebele* (smallest administrative structure) level there are 553 health posts. Health posts are linked to their nearby health centers through a referral system.[16]

Data collection

Qualitative data was obtained through semi-structured interviews (SSIs) and focus group discussions (FGDs), using topic guides adapted from the REACHOUT framework. Local data collectors, all with undergraduate degrees and previous research experience, were trained over a week, conducted SSIs and FGDs, covering topics on the role of community health providers, barriers and enablers of facility deliveries, and pregnancy-related decision-making. SSIs lasted 45-60 minutes, and FGDs lasted 60-90 minutes. Study participants were compensated with meals or transport costs. Verbal consent was obtained, using the local language. Local data collectors negotiated and organised suitable timing and venues for SSIs and FGDs with the study participants, e.g. in the participants' home or office for SSIs and in village meeting space for FGDs. SSIs and FGDs were conducted using the local language familiar with the study participants and lasted between 45-60 minutes.

Study participants and sampling

Participants were selected using purposive sampling. Workshops with officers of district health and community health centers in Indonesia and Ethiopia provided valuable insights for selecting informants to participate in SSIs and FGDs. In Indonesia, 110 SSIs and 7 FGDs were conducted across 4 villages in Southwest Sumba and 4 villages in Cianjur, with participants including village midwives, community health volunteers, TBAs, mothers, men within the communities, village leaders and health officials. In Ethiopia, 44 SSIs and 14 FGDs were organised with purposively selected mothers, health professionals, HEWs, TBAs, men in the community and local *kebele* administrators. The various backgrounds of study participants allowed triangulation and more comprehensive perspectives related to the study aims.

Data analysis

All interviews and focus group discussions were recorded, transcribed, and translated into English. Research assistants and senior researchers checked the quality of translations. To facilitate credibility, transferability, dependability, and confirmability, a team of senior researchers evaluated data quality, reviewed the transcripts multiple times to find main themes and created a shared coding framework that enabled the provision of data validity, trustworthiness and triangulation. Extra codes were produced and added to reflect each country's specific context.

The coded transcripts were then analysed using Nvivo 10 software (license obtained). Following a thematic approach,[12] the data was organised into themes and sub-themes and then summarised into narratives. The summaries facilitated deeper understanding and linked the themes to address the study aims.

Ethical approval

The study was performed according to ethical standards as laid down in the 1964 Declaration of Helsinki and it was approved by the medical research ethics committee by no. (UOM/COM/MREC/21-22(53) in 25/4/2022). Before the start of data gathering, each participant was well-versed, either verbally or written in their consent, to participate in the study.

In Indonesia, ethical approval was obtained from Ethical Board Hasanuddin University in Makassar. In Ethiopia, approval was given by the South Nation and Peoples Region Health Bureau. Local

permissions were obtained from health offices in Cianjur and Southwest Sumba (Indonesia) and from regional health departments in Ethiopia. These approvals ensured the study followed ethical guidelines such as voluntary participation, anonymity and confidentiality.

Results

TBAs' cultural, psychological and geographical proximity

Despite government rules in Indonesia and Ethiopia restricting TBAs from assisting with childbirth, many women in the study sites in both countries still prefer TBA services. In Indonesia, women often choose TBA care due to trust built on their experience, age and ability to provide comfortable, home-based services that align with traditional practices. **In addition,** for many pregnant women in remote areas in both countries, TBAs are more accessible than midwives, especially when transportation to the health center is limited.

"The 'paraji' [TBAs] *have a stronger trust from the people. None can deny that they were already here since a long time ago. Many people in here view them as their mother or grandmother."* (SSI, Midwife Coordinator, Cianjur).

"I have known the 'mama dukun' [TBA] *since I was as kid. She helped my mother when she delivered her children, including myself. She* [TBA] *usually helps the labour in the pregnant woman's house, so it could be in our own room and with the room's door closed. She lets us wear our sarong [during delivery] which is a custom in here…Since 'mama dukun' live among us, transportation cost is not an issue."* (SSI, Mother, Southwest Sumba).

Ethiopian women in rural Sidama prefer TBAs for comparable reasons, viewing them as trusted community members who help during pregnancy and for childbirth care.

"They [TBAs] *have provided excellent care since my mother's and grandmother's generation. They are viewed as respected elders in this village. We know them very well and they know us. They help women to give birth at home…It is more practical for many of us because they* [TBA] *live not far from our house, they live in our village."* (FGD, Women, Sidama).

TBAs' wide-ranging and culturally deep-rooted services

Additional important reasons for choosing TBA care include their wide-ranging and culturally deep-rooted services including prayers for protection, herbal remedies, and massages, which are seen as comforting and beneficial, as emphasised by women in Cianjur and Southwest Sumba, Indonesia.

"'Paraji' [TBA] *look after us like her own daughter or their granddaughter. They usually send [Islamic] prayers for the safety of both the mother and the baby. 'Paraji' also provide valuable care like massage and 'jamu' [herbal medicine]."* (SSI, Mother, Cianjur).

"I suffered a lot when I was pregnant. I felt nauseous and lost my appetite. I was very anxious at the time because it was my first pregnancy. Thank God, after 'mama dukun' [TBA] *gave me a massage I felt much better and got my appetite again. I also felt calm since she always provides prayers from our Marapu culture* [local belief in Sumba]*"* (SSI, Mother, Southwest Sumba).

Differing to the study sites in Indonesia, TBAs in Sidama, Ethiopia did not provide such wide-ranging cares that for example included herbal medicine. Nevertheless, comparable reasons such as TBAs culturally deep-rooted care were also emphasised by women in this locality.

"They [TBAs] *have provided valuable care to the village people since long time ago, since my mother's and grandmother's generation. Their gentle hand, prayers and good words are very meaningful for us."* (FGD, Women, Sidama).

Collaboration between formal health workers and TBAs

There is certain degree of cooperation between formal health workers and TBAs in both countries. In Indonesian regions like Southwest Sumba and

Cianjur, village midwives, community health workers and TBAs work together to encourage women to attend antenatal care through health outreach programs (*Posyandu*) and to come to the health center for childbirth. In both localities, midwives acknowledge the TBAs' long-standing community trust, and in some cases, TBAs are allowed to assist at health centers providing a blend of traditional and modern care.

"The 'paraji' [TBAs] *are popular because they already serve the community much longer than us. So we made an agreement with them that midwives focus on delivery and they* [TBA] *can provide other things such as prayers, bathing the baby or providing herbal medicine. They also can help us to persuade pregnant mothers to give birth in the Puskesmas* [community health centre]. *I myself allow 'paraji' to accompany me in the* Puskesmas *while I assist the expectant to give birth. With this, all parties are happy."* (SSI, Village Midwife, Cianjur).

Similarly, partnership between midwives and TBAs was demonstrated in Southwest Sumba where the current policy aimed to increase health facility childbirth and discouraged delivery assisted by TBA.

"Now TBAs aren't allowed to help pregnant women to give birth. Before delivery if there is any pain or uneasiness in the women's pregnancy, it is TBA's role to encourage the expectant mother to go to Puskesmas for examination. As we suggest in the outreach program, the women should give birth at the health facility." (SSI, *Posyandu cadre*, Southwest Sumba).

Comparable collaboration was also found in the study site in Ethiopia where HEWs and TBAs try to work together to coordinate services for pregnant mothers in the community.

"*We work together to help pregnant mothers. Our roles are different but we try to combine our roles to support pregnant women. They [TBAs] provide more psychological support. They no longer assist delivery but their roles remain important. Some TBAs actively encourage expectant mothers to give birth at the health post."* (SSI, HEW, Sidama).

Challenges in formal health workers and TBAs collaboration

The partnership between formal health providers with TBAs are not without tensions. Challenges of collaborating occurred in cases where TBAs felt that their traditional roles were under threat.

"There were some tensions when we said that TBAs can no longer help for birthing, some of them were worried or offended. But gradually many TBAs agreed after we explained that they can still doing their roles like taking care of women and the babies. We also provide incentives for them if they refer the expectant to give birth at the Puskesmas." (SSI, Village Midwife, Southwest Sumba).

Compared to Indonesian experience, the partnership between HEWs and TBAs in Sidama, Ethiopia, seemed face more challenges due to TBAs' perceptions of being undervalued by formal health workers. Some TBAs stated that they encountered problems, since some HEWs were not respecting and supporting their work.

"I expect to work together with them [HEWs] but some are not kind to me... Some [HEWs] do not want to communicate with me. Some do not respect me but I continue to attend deliveries when I was invited by the people. I cannot refuse villagers' invitation." (SSI, TBA, Sidama).

Discussion

The study findings had outlined the complex dynamics that influence the preference for TBA care among pregnant mothers in the study sites in both Indonesia and Ethiopia. It had highlighted several key factors such as community reverence and close relationship with TBAs due to cultural alignment, geographical proximity, TBAs' traditional knowledge and wide-ranging services, which make them a trusted option for childbirth, particularly when formal healthcare options are limited or perceived as culturally inappropriate.

In Indonesia, TBAs hold a unique place in maternal care due to their integration of traditional practices and proximity to villagers' housing, which makes them convenient and trusted, especially in remote areas with limited transportation modes to

health facilities. These findings are in line with other studies in Indonesia which emphasise the view that TBAs' proximity, hands-on approach, including massages, prayers, herbal medicine and adherence to cultural practices, is highly valued.[17-19]

Comparably, Ethiopian communities in the study site exhibit a preference for TBA care based on cultural beliefs about home births and concerns over privacy in institutional settings that corroborate with other studies in sub-Saharan Africa.[20-22] In both Indonesian and Ethiopian contexts, TBAs fulfil not just a health-related role but no less importantly a cultural and social role that formal healthcare may not replicate as effectively.[17-22]

Additionally, the study findings raised the crucial issue and dynamics of collaboration between TBAs with formal health providers like midwives in Indonesia and HEWs in Ethiopia. While collaborative efforts exist, they are sometimes hindered by TBAs' perceptions of being undervalued by the formal healthcare system.[21-25] This suggests that improving maternal health outcomes may require more culturally sensitive approach that integrates TBAs as valuable partners, addressing the tensions in their collaboration with formal healthcare providers. [23--27]

The study advocates the importance of strengthening partnership between formal health workers and TBAs in Indonesia and Ethiopia. Encouraging a shared sense of purpose and trust between these care providers can assist in reducing tensions in their collaboration. Successful partnership with local agencies such as TBAs, who hold strong cultural influence, needs support from both national and local governments. Making health institutions more welcoming to traditional practices and traditional actors can encourage more women to give birth at health facility thus potentially improving maternal health outcomes. Working more closely with cultural and community leaders can further enhance community trust and support Indonesian and Ethiopian policy to increase facility-based childbirth, reduce pregnancy complications and maternal deaths. To achieve these goals, enhancing cultural competence, communication skills and supportive supervision of health professionals and close-to-community health workers – e.g. midwives, nurses doctors and village health volunteers – are essential.[23-27] In addition, the study findings indicate that effective maternal healthcare in the study sites in Indonesia and Ethiopia could be strengthened through policies that value the cultural role of TBAs while fostering respectful collaboration with formal healthcare systems. A mutual partnership between cultural actors, i.e. TBAs and community health workers particularly village midwives and village health volunteers, will potentially improve health facility childbirth and in turn may reduce maternal mortality rates in both countries.[28-36]

Conclusion

Despite differences in geographical location and culture, the study found several comparable context and phenomena in Indonesia and Ethiopia, i.e. preference for TBA care that still exists in both countries. Cultural, psychological and geographical proximity of TBAs are important contexts behind the preference of pregnant mothers to utilise TBA care. Moreover, the wide-ranging services and culturally deep-rooted cares provided by TBAs for women and expectant mothers in the study sites in both countries are reasons expressed by study participants to explain their reverence for TBA services.

Though Indonesian and Ethiopian national and sub-national governments encourage health facility childbirth and the use of professional health workers such as midwives' and doctors' services, preference for TBA cares persist and remain popular among some women in the study sites. Therefore, strengthening partnership between formal health workers such as village midwives and *Posyandu cadres* (village health volunteers) in Indonesia and HEWs in Ethiopia with TBAs could improve maternal health outcomes in both places. Furthermore, enhancing trust and partnership between formal health workers and TBAs is essential to improve maternal health programs, e.g. to support expectant to give birth at health facility by utilising TBAs encouragement and referral.

Study contributions and limitations

The study has contributed in providing more nuanced understanding of the context and reasons of preference to use TBA care during pregnancy and for childbirth in Indonesia and Ethiopia. As a qualitative study, it is noteworthy that although the findings highlight common themes from study participants, these results cannot be generalised to the wider populations in Indonesia and Ethiopia. Nevertheless, they do align with other studies that explored these topics and provide updated perspectives related to the reasons behind the preference to still utilise TBA care in Indonesia and Ethiopia as well as to improve insights associated with cultural barriers to health facility childbirth in both countries. Social desirability bias in which study participants may respond in a way they think is more acceptable to some extent could also have shaped their responses, though informants generally seemed comfortable expressing their views openly.

Competing interest

The author has no competing interests to declare that are relevant to the content of this article.

Author contributions

Sudirman Nasir, PhD, was part of REACHOUT Consortium team in preparing the study design. Dr Nasir supervised data collection and data analysis in Indonesia, drafted, edited and finalised the manuscript.

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