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ADDRESSING GENDER INEQUALITY TO IMPROVE MATERNAL HEALTH IN INDONESIA: A NARRATIVE LITERATURE REVIEW

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ABSTRACT

Introduction: High maternal mortality ratio (MMR) remains a pressing public health issue in Indonesia. Despite many studies have been conducted to identify the associated factors from medical and socio-cultural perspectives, fewer studies and discussion appeared to focus on another social dimension such as gender norms, which is not explored deeply in the context of Indonesia.

Aims: This paper aimed to discuss how gender inequality affects maternal health in Indonesia and practical strategies needed to address gender inequality in improving maternal health outcomes in Indonesia.

Methods: This was a narrative literature review, based on several types of documents: research article, literature review, systematic review, books, and reports from institutions. Those would be reviewed and adjusted with the context of Indonesia in terms of how gender inequality affects maternal health, followed by the synthesis of argumentative ideas related to the practical strategies needed to address this issue.

Results: The well-maintained patriarchal system and gender norms in Indonesia leads to gender inequality as one of the social factors contributing to maternal health outcomes. Gender inequality works to influence maternal health outcomes through structural and individual level factors, in which, influence women's power and ability in the decision-making process and impact on women's demand for maternal health service utilization. In addition, implemented maternal health programmes have not fully addressed gender inequality in Indonesia so far.

Conclusion: To address gender inequality in order to improve maternal health, some strategies are suggested, such as women empowerment, men engagement to be supportive, and strengthening the protection of women's reproductive rights.

Keywords: gender inequality, maternal health, maternal mortality ratio, patriarchy, Indonesia

INTRODUCTION

Global and National Situation of Maternal Health

Poor maternal health condition remains a public health concern across the world. World Health Organization (WHO) estimated that there are 830 women die every day related to the delivery or pregnancy-related causes [1]. The maternal mortality ratio (MMR) in the world showed the declining by 44% during the last two decades from 385 per 100,000 live births in 1990 to 216 maternal deaths per 100,000 live births in 2015 [2]. Even though the global trend of MMR is declining in recent years, the current situation shows that the wide disparities of maternal health remain occurring between high-income and low-income

countries. Dramatically, 99% of the global maternal deaths in 2015 occurred in developing countries [3]. The highest MMR was the countries in Sub-Sahara Africa region at 546 deaths per 100,000 live births, followed by Southern Asia with MMR of 176 deaths per 100,000 live births, whereas the MMR in developed regions accounted for 12 per 100,000 live births only [4]. Both of Sub-Sahara Africa and Southern Asia regions contributed to the high MMR in the world, accounting for 66% and 22% of global maternal deaths, respectively [2].

Indonesia as a developing country still has not moved forward to decrease the MMR since the target of Millenium Development Goals (MDGs) point 5A of MMR reduction by 75% between 1990 and 2015 was unachievable. The report published by Ministry of Health (MoH) Indonesia showed that at initial achievement, the MMR declined gradually from 390 to 228 per 100,000 live births during 1990 to 2007. Unexpectedly, it rose sharply to reach 359 per 100,000 live births in 2012 and remained high, at 305 per 100,000 live births in 2015. It indicates that the last MMR in 2015 was three times higher than the target of 102 maternal deaths per 100,000 live births which must be achieved by the end of MDGs [5], indicating Indonesia failed to meet the target of MMR reduction. In 2015, Indonesia took the second place for high MMR in Southeast Asian region after Lao PDR in the first place of 357 per 100,000 live births, whilst Philippines, Myanmar, and Cambodia were in third, fourth, fifth with 221, 180, 170 per 100,000 live births, respectively [6]. Therefore, maternal health is still an urgent public health problem in Indonesia which needs to be addressed earnestly.

Medical and Socio-Economic Determinants of Maternal Health

WHO defines that “*maternal deaths is the death of a woman whilst 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*” [7]. This definition allows some literature to determine the causes of maternal death in two main groups, as direct and indirect causes [8–10]. Direct causes such as embolism, hemorrhage, hypertension, unsafe abortion, and other direct causes contributed to 73% of global maternal deaths whereas 27% of maternal deaths were associated with indirect causes such as HIV infection, DM, anemia, etc. [9]. In spite of those medical causes seem to determine the maternal deaths significantly, other factors such as socio-economic factors should be paid attention since these factors are the trigger to drive women into a risky situation where the medical causes will occur later.

Socio-economic factors as non-medical factors have contributed to many maternal deaths in developing countries [11]. The poor socio-economic condition remains as the barrier of the women to access the maternal health services including ante-natal care (ANC), natal (attended delivery), and post-natal care. The poverty is the main factor which creates the situation where the maternal health services are inaccessible and unaffordable for the women, particularly those in rural and poor areas [12]. In addition, the low educational level, food taboos, and other cultural practices also drive the worse condition of maternal health [13]. Similarly, several studies conducted in some areas in Indonesia found that various conditions of socio-economic factors increased the likelihood of maternal mortality such as unemployment status of the women [14], women’s low educational level [15], and low-income of the family [16]. Moreover, the food taboos for pregnant and post-partum women is still existing in some rural areas in Indonesia, leading to the poor maternal health condition [17].

Although many studies focus to reveal the social-economic factors related to the maternal health, another social dimension such as the gender norm is not explored deeply in the context of maternal health in

Indonesia. As one of the non-medical causes of maternal mortality, gender norms have been identified as a socially-constructed barrier for improved maternal health outcomes. Even though none studies are found to report how many percentages of gender inequality solely contributes to maternal health in Indonesia or in international contexts, previous studies confirmed that gender inequality was associated with maternal health [18,19]. Given the gender norms situation in Indonesia, the patriarchal system is still maintained in most rural areas by internalizing this idea into the structure of society, cultural beliefs, and values, resulting in the unequal position between men and women in the union [20]. Moreover, the gender inequality leads the lack both of economic opportunities and autonomy among the women which indirectly affects to their sexual and reproductive health and rights including the maternal health [12]. Since the limited discussion focusing on the topic of gender inequality in the context of maternal health in Indonesia, this paper tries to answer two main questions: 1) how does gender inequality affect maternal health in Indonesia? 2) what are practical strategies needed to address the gender inequality in improving maternal health in Indonesia?

METHODS

This paper was narrative literature review. The sources were retrieved from the several types of documents, such as original research article, literature review, systematic review, books, and national and international reports from authorized institutions that discussed either “gender inequality” or “maternal health”. Those would be analysed to define the relationship between gender inequality and maternal health and adjusted with the situation in Indonesia, and then followed by the synthesis of argumentative ideas related to the practical strategies needed to address the gender inequality in improving maternal health in Indonesia.

RESULTS AND DISCUSSION

How Does Gender Inequality Affect Maternal Health in Indonesia?

The enactment of the patriarchal system in Indonesia results in the idea of masculinity which differentiates the roles of men and women in the society. Unfortunately, the society expects the men to have more power and position rather than the women in almost all aspects, such as in education, politic, and economy which leads the discrimination against women to have the same access as the men [20]. Even though the gender perception in Indonesia has been started to change since the fall of the Soeharto’s era, the conservative people remain to assume and state the women’s role strongly that the women are houseworker and related to reproductive responsibility [21].

In the context of maternal health, gender inequality plays a significant role to affect the health-seeking behaviour and health care utilization among the women, including the access to the ante-natal care (ANC), natal (attended delivery), and post-natal care [22]. Therefore, the gender inequality influences the women’s demand for health care services at almost all socio-economic levels. The following explanations describe how gender inequality influences maternal health in Indonesia at structural level factors and individual level factors [12].

a. Structural Factors

Structural factors comprise of social norm, culture, and value in the society. Since the patriarchal system and idea of masculinity are strongly existing in Indonesia, those define the women’s roles and duties in order to be an ideal wife in the union. Interestingly, the duty of the wife was recognised since a long time ago, listed explicitly in Indonesia Marriage Law No. 1/1974 which stated that “*the women in the union is the housewife*” (article 30 paragraph 3) and “*the wife has to do housework properly*” (article 34

paragraph 2). In addition, as the religious country, the religion's values coming from Islam and also other religions in Indonesia position men or husband as the household leader and active in social domain [23]. Moreover, in the Javanese society culture, there is a phrase that says "*swarga nunut, neraka katut*", which means the wife always follow her husband; if the husband is happy, the wife will be happy as well and the otherwise [23]. Therefore, these structural factors that contain gender-biased belief lead the situation where the wife is dependent and must obey to their husband and accept the husband's rights to determine their social life [20].

These structural factors obviously affect maternal health through disempowering women in the decision-making process related to their own health. As the "nature" of women shaped by the society, they might be unable to negotiate their spouse since the society does not expect the women to argue their husband [23]. Despite the women concern about their health, the structural factors indirectly blind them from recognising their reproductive rights [24]. Therefore, related to maternal health care utilization, the wife will follow their husband's decision regarding "*what the maternal health care service that will be used*", "*where the health care service that will be accessed*", and "*when the right time to access that health care service*", without asking "*why I should access this service at proposed place and time*".

In the Indonesian rural area where the delivery process can be provided by a traditional birth attendant, the decision from the husband can determine the choices of delivery services, between skilled health personnel or traditional birth attendant [25]. In addition, in more developed areas, even though the service from trained health providers is accessible, the husband's decision regarding the timing of the wife to access the health care services results in the different maternal health outcome. A study conducted by Wulandari et al. found that the husband was the dominant to make a decision regarding the timing of referring his wife from primary to the secondary healthcare facility [26]. Therefore, the decision made by the husband is crucial which can lead the worse outcome of maternal health if the wife's real needs of maternal health services are not taken into account.

b. Individual Factors

Individual factors are more specifically related to the women's factors such as their lack opportunity for education and economy [12]. Those create the imbalance power in the household that affect women's ability to make the decision, to hold individual autonomy, to have control of vital resources, and it also increases their chance to be a victim of domestic violence. The individual factors can be the strong determinants of the gender inequality magnitude in household level and influence the accessibility of maternal health services.

Lack opportunity to participate in labour force makes the wife is not considered as the main income source of the family, even though they provide free domestic labour [27]. As a non-productive member in the family, the wife has no income or cannot accumulate the asset which can be used to access to maternal health services that require the cost of transportation, medical services, and medicine. Despite the decision to use maternal health care services comes from the wife, it can not be translated into the action unless the economic support from their husband [28]. A study conducted in Banyumas District, Central Java found that an unemployment woman or a housewife was more likely to die related to pregnancy causes [14]. Being housewife will be strongly dependent on the husband so that they do not have an income to access health care services and fulfil their own real needs during pregnancy, delivery, or 42 days after delivery.

The low power because of economic dependency affects to less women's involvement in the decision-making process in the household, even it is related to their own body and health [29]. The previous study conducted by Sugiyarto about maternal health inequality in West Java showed that women's involvement in the decision-making of health care treatment was significantly associated with the incidence of maternal deaths [15]. Indeed, either active or passive women's participation in the decision-making process will derive the different outcome. The inability of women to express and negotiate their needs leads the women-impartial decision resulted by the husband which fails to recognise women's need. Furthermore, it also makes the women lost the autonomy of their body. In addition, as perceived that the women bear the reproductive responsibility, the husband will not much aware of women's reproductive rights because those are not men's concerns, leading to poorer maternal health condition.

Regarding the lower position in marital relationship, women are also vulnerable to intimate partner violence (IPV) committed by husband which is also common during her maternal period [30]. It was estimated to occur 4-8% of pregnancies which is higher than the incidence of two medical causes of maternal deaths, such as preeclampsia and gestational diabetes [31,32]. The IPV commonly occurs to the women who are less educated and economically dependent on their husband [33]. The evidence from Malaysia showed that the wife who earned the lower income was more likely to be the survivor of domestic violence perpetrated by her husband [34]. The women as the victim of IPV are more likely to suffer chronic disease and depression that contributes to increase the risk of preterm birth [30,35]. In a lot of cases, the women's dependency to their husband prevents them to leave their abusive relationship. Unfortunately, the patriarchy in Indonesia makes the authoritarian behaviour of husband can be accepted by the family members, even it involves physical violence [36]. Therefore, those unfavourable conditions will affect the worse maternal health and increase the vulnerable situation of maternal death.

The structural and individual factors as explained before show how the gender inequality affects the maternal health through influencing the women's demand for maternal health services. The inability of women to make a decision and take an action to utilize maternal health services are the roots of the three critical delays which contribute to the maternal death, such as 1) the failure to look for the prompt health services in time, 2) the delay to come to the healthcare facility, and 3) the delay in obtaining health services at the facility [12]. Therefore, it is essential to figure out the practical strategies in addressing gender inequality to enhance maternal health in Indonesia. Furthermore, this paper will explore "*what the strategies that have been done*" and "*what the potential strategies that should be done*" to fill the gaps in addressing this issue.

What are The Practical Strategies Needed to Address Gender Inequality in Improving Maternal Health in Indonesia?

Since the maternal health has been a focus on MDGs started in 1990, Indonesia government has been launching some programmes as the efforts to improve maternal health and reduce maternal morbidity and mortality. There are some maternal health programmes that have been implemented in Indonesia such as Safe Motherhood Initiative, *Gerakan Sayang Ibu* (Mother Friendly Movement), Making Pregnancy Safer, and Expanding Maternal and Neonatal Survival (EMAS) [5]. The following is the brief explanation of those programmes.

1. Safe Motherhood Initiative

Safe Motherhood Initiative programme aimed to ensure that all of the pregnant women would obtain the adequate health care during the delivery and postpartum [5]. The programme was launched in 1990 to respond the high MMR of 390 per 100,000 live births and the target was to reduce the MMR by half until 2000 [37]. This programme concerned to provide family planning services as a way to prevent unwanted pregnancy which can lead maternal death because of abortion. In addition, the provision of the adequate obstetrical health services was recognised as the efforts to prevent the maternal death from the women with the pregnancy complication. Moreover, the roles of traditional birth attendants had been taken into account by training them in order to provide a hygiene and safe delivery.



Figure 1. Timeline of Maternal Health Programmes in Indonesia

2. Gerakan Sayang Ibu (Mother Friendly Movement)

Gerakan Sayang Ibu (GSI) was started in 1996 which continued the previous programme in accelerating the declining of maternal mortality. One of the main components of the programme implementation was to assign a large number of midwives into rural areas across Indonesia which aimed to provide the accessible services related to maternal and child health [5]. This programme tried to involve the active participation from the community as a way to enhance their knowledge and awareness in making integrated efforts to prevent maternal mortality, such as to conduct the savings collection for delivery, map the pregnant women, do the blood donation, and provide local ambulance [38].

As a part of GSI, the approach of *Suami SIAGA* (Alert Husband) was made known nationally in 1998 to encourage shared responsibility to the husband about the wife's pregnancy [39]. The term of "SIAGA" is an abbreviation which stands for '*SIap*' (ready for the danger situation), '*Antar*' (take and accompany the wife to the health care facility), and '*jaGA*' (guard the wife) [40]. The campaign of *Suami SIAGA* aimed to involve the husband's participation actively in the birth preparedness and preventing the maternal death.

The husband is expected to be aware and alert to their wife's need during the maternal period through encouraging and accompanying their partner to seek for ANC, delivery care, and also post-natal care. In addition, the husband should prepare for the emergency situation such as obstetrical complications so that they have to work with the community to develop an adequate transportation system to respond the emergency situation [41]. Furthermore, this concept has been expanded by involving more community's participation through introducing the integrative notions such as *Bidan SIAGA* (Alert Midwife), *Warga SIAGA* (Alert Citizen), and *Desa SIAGA* (Alert Village) [39].

3. Making Pregnancy Safer

Making Pregnancy Safer was released in 2000 to promote three key messages including 1) every delivery service is assisted by the trained health provider, 2) the adequate management for obstetrical neonatal complications, 3) every woman in reproductive age can access to unwanted pregnancy prevention services and the post-abortion care [42]. According to this programme, the proportion of childbirths assisted by the skilled birth attendants has increased from 25% in the 1990s to 76% in 2006

[43]. The strategies for programme implementation were increasing the coverage of maternal and child health services, developing the collaboration with the other sectors to maximize the resources in planning and implementation, empowering women and her family by enhancing their knowledge about healthy behavior and maternal health care utilization, and involving the community's participation to ensure the availability and the utilization of maternal and child health services [44].

4. Expanding Maternal and Neonatal Survival (EMAS)

Expanding Maternal and Neonatal Survival (EMAS) was five-year programme effectively started in 2012 which focused on improving the complication detection and management at the public health centres, making an adequate referral systems of the complicated cases from the public health centres to the hospital, and improving the quality and management for complicated cases in referral hospitals [45]. EMAS was only implemented in some provinces with the high maternal and neonatal mortality in Indonesia through improving the quality of obstetrical and neonatal services in at least 150 hospitals and 300 public health centres [5].

According to those maternal health programmes that have been implemented in Indonesia, most of them focused on adequate maternal health services by providing the skilled health providers to assist the delivery, improving the quality obstetrical complication services, and strengthening the referral system between public health centres and hospitals. In the context of addressing gender inequality, only the *Suami SIAGA* as the part of GSI implementation period tried to reduce the gender inequality in household level. It calls the husband's active participation in birth preparedness in order to make the husband be responsible for his wife's pregnancy. However, it does not guarantee the wife's involvement in decision-making process since the women have less power in the household. A study about the *Suami SIAGA* in Indonesia showed that there was no difference of women's empowerment defined as the participation in making the decision regarding their own health between those who with the husband as the *Suami SIAGA* or not [40]. Therefore, what have been done by the previous maternal health programmes have not fully reduced the power imbalance between women and men in the household and wider society.

Beyond the programmes focusing on maternal health, there is a programme namely MAMPU (*Maju Perempuan Indonesia untuk Penanggulangan Kemiskinan*= Empowering Indonesian Women for Poverty Reduction) as the partnership programme between Australian and Indonesia which has been implemented since 2013. This programme is implemented by civil society organizations (CSOs) as MAMPU partners and Indonesian government which aims to enhance the well-being of poor women in Indonesia where the addressing gender inequality and women empowerment are the concerns [46]. It is a concrete approach to address the gender inequality to improve maternal health in Indonesia since this programme has targeted themes related to this issue such as improving women's access to social protection programme; jobs and removing the discrimination in the workplace, better maternal health and nutrition, and reducing the violence against women [46]. Therefore, regarding the effort of this programme to strengthen women position in the society and their access to health services, it potentially reduces gender inequality and results in better maternal health.

The following is the strategies that can be applied to address gender inequality in improving maternal health in Indonesia.

1. Women Empowerment

The women empowerment is the critical point because it is the first step to address gender inequality before involving the men to be supportive of women as the next phase. The women should be empowered since prior the married by giving the opportunity of education. More educated women are more likely to participate in labour force so that they can earn income for themselves. Consequently, they are less economically dependent on their husband and minimize power imbalance in the union. Moreover, more educated, more knowledgeable they are. During the decision-making process at the household level, they will have more capability and power to negotiate their husband to make informed decision regarding their own health and body [47]. Since they are independent to their husband, it makes the health services including maternal health services be accessible and affordable for them. It is supported by the study conducted in Indonesia that the ownership of assets as the indicator of power relations within the couples would lead the women to be more likely to access ANC and have the delivery in the hospital or private clinic [48].

The MAMPU programme can be a concrete example of women empowerment to reduce gender inequality and increase their opportunity to access the basic services, including maternal health services. Therefore, the implementation of MAMPU programme should be widespread, particularly among those in poor and rural areas. Nowadays, MAMPU programme is being implemented in 27 provinces and it should be expanded in some provinces in Sulawesi, Kalimantan and Papua islands that have not taken into account in advance [46]. Moreover, as what MAMPU programme did, the collaboration with local stakeholders and NGOs is a substantial approach to conduct some activities, for instance, maternal-income generating activity in order to improve women position and facilitate their access to maternal health services.

2. Engagement Men to Be Supportive

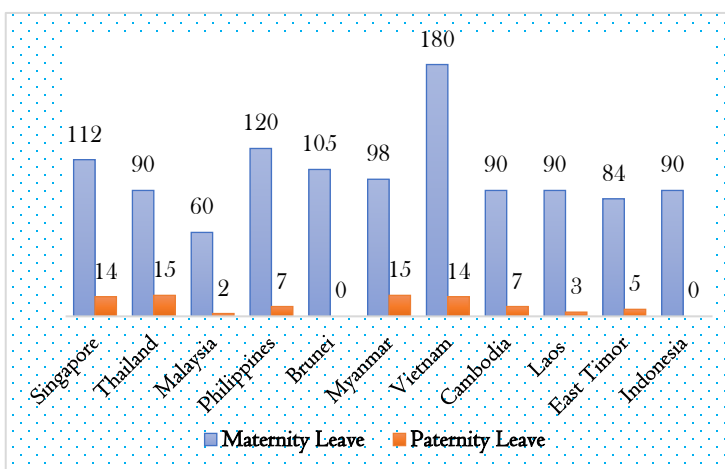


Figure 2. The Length in Days of Paid Maternity and Paternity Leave in Southeast Asian Countries 2017

The next step after empowering women is to engage the men to be supportive of women's decision and take responsibility for maternal conditions. The *Suami SIAGA* as explained before is the first innovation from the Indonesian government to involve men in birth and pregnancy complication preparedness. Currently, in the escalation process of the socio-economic status among most of the people in Indonesia, the husband might not fully take care of their wife's pregnancy because their strict work time whereas the wife who works can have the maternity leave in order to take care themselves. Therefore, the

campaign of *Suami SIAGA* since 1998 should be adjusted to the current condition by translating into employment regulation of paternity leave. It can stimulate the shared responsibility of the wife's pregnancy to the husband and change the assumption in the household and wider society that the pregnancy is not only wife's business, but also the husband's responsibility.

According to the Indonesia Employment Law No. 13/2003 article 82, the employee women deserve to gain maternity leave for 3 months which consists of 1.5 months before and after delivery. However, the paternity leave is not considered as married male worker's rights under this law. Comparing with developing and developed countries in the Southeast Asian region [49–59], Brunei is similar to Indonesia that has not considered paternity leave under their labour or employment regulation. Interestingly, East Timor as the youngest country in Asia was successful to recognise the men employee's rights and responsibility of taking care their wife and child by enacting 5 days of paid paternity leave. Therefore, the Indonesian government should follow nearby countries to regulate paternity leave in order to address gender inequality in the household and change the value of the society that the husband has the same responsibility regarding childbirth.

3. Strengthening the Protection of Women's Reproductive Rights

The Indonesian government should pay attention to the enforcement of women's reproductive right protection. Reproductive right from the International Conference on Population and Development (ICPD) in 1994 was defined as *“the right to decide freely and responsibly the number, spacing, and timing of their children, and to have the information and means to do so; the decision should be made free from discrimination, coercion, and violence”* [60]. Therefore, the timing of marriage is also included implicitly as the part of the women's reproductive rights. However, the current situations in Indonesia showed that the patriarchal system makes more discrimination against women and drives the gender inequality, for instance, the enactment of different minimum age of marriage among men and women in Indonesia.

The minimum age of marriage is regulated in Indonesia Marriage Law No. 1/1974 article 7 paragraph 1 which stated that *“the marriage is permitted with a condition where the man ages 19 years old and the woman ages 16 years old”*. Since the minimum age of marriage for women is lower than 18 years, it contradicts with Indonesian Child Protection Law No. 35/2014. Consequently, it will remain the child marriage among the women in the society which increase their risk of maternal morbidity and mortality because of violence, abuse, and exploitation [61]. The lost of educational and economic opportunities are the consequences of child marriage which affect the gender inequality and power imbalance in the household. Therefore, the Indonesia government has to revise the minimum age of marriage which should be at least 18 years old by considering the child protection law and must be equal between male and female. Revising this law by enactment the same minimum age of marriage between male and female can stimulate the value changing of gender perception in the community where the women should be positioned as equal as men.

CONCLUSIONS AND RECOMMENDATIONS

Maternal health remains the public health concern in Indonesia because the MMR reduction target during the MDGs implementation was not achieved. Since the patriarchal system is maintained in Indonesia, gender inequality is one of the social factors which contributes to maternal health outcomes. It plays important roles at structural factors and individual factors which influence women's power and ability in the decision-making process in the household and impact to women's demand for maternal health services. Therefore, addressing gender inequality is essential to improve maternal health in Indonesia. Regarding maternal health programmes that have been done in Indonesia such as Safe Motherhood Initiative, *Gerakan Sayang Ibu* (Mother Friendly Movement), Making Pregnancy Safer, and Expanding Maternal and Neonatal Survival (EMAS), those have not fully addressed gender inequality in Indonesia. However, the current implemented programme, namely MAMPU targets the gender inequality and women empowerment as a substantial approach to improve women's welfare. As the result, this paper recommends some applicable strategies to address gender inequality to improve maternal health in Indonesia, such as women empowerment, engagement men to be supportive, and strengthening the protection of women's reproductive rights.

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