According BPS data, 21 per cents of birth deliveries are still assisted by traditional birth attendants. This condition emerge any problems, as long as the delivery process does not have any complications.


Photo: WRI doc.

In public health facilities, discriminations to women still continued. When a pregnant woman has a pregnancy check or reproductive consultation, questions given to them are always related to the existence of her husband. This situation also applies to medical problems related to women reproduction. Women are assumed to have weaker condition (due to physical condition during pregnancy) has caused them to be neglected in any decision making which related to medical treatments.

What have we done so far?

"The development of health facilities is based on humanity, equality, utilization, protection, respect rights and duties, justice, gender and non-discriminative and religious norms"(Health Law No. 36 in 2009).

Decreasing MMR is not merely a matter of health, also covering policy matters. This condition is closely connected to comprehension on power relation within men and women relation. Indonesia has Health Act No. 36 in 2009 which stated that health reproduction service is only provided to married women. Yet, as stated in Chapter 72 'health' terminology used is referring to 'legally' married couple. Chapter 72, point A stated "ha-ving a reproductive and sexual life that is healthy, safe, and without coercion and/ or violence with the legalized partner."

The Health Act does not guarantee women's health which related to pregnancy happened without marriage. This situation contributes higher susceptibility for MMR. Similar condition is also experienced in budget allocation for health. In the past five years, from 2005 to 2009, national health budget did not have any significant increase. The National State Budget had a massive increase from IDR 226 trillion in 2005 to IDR 1,032 trillion in 2009, but at the same time, budget allocation for health sectors was decreased from 3.1 per cents in 2005 to 1.8 per cents in 2009.[11]

Should the health budget allocation is still ranging on 1-2 per cents, then having significant decrease for MMR in Indonesia will be very difficult to achieve.

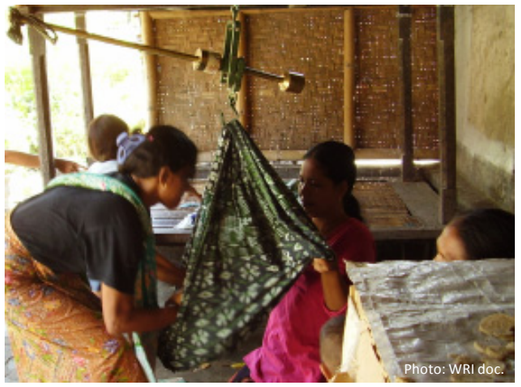
Photo: WRI doc.

[11] Summary of SMERU Research Institute "Strategi Akselerasi Pencapaian Target MDGs 2015".

Jalan Kalibata Utara II No. 78, Jakarta 12740 - INDONESIA
Tel. (62-21) 7918.7149, 798.7345 Fax. (62-21) 798.7345
Email. office@wri.or.id Website. www.wri.or.id

WOMEN RESEARCH INSTITUTE

Poverty, The Main Cause of Maternal Mortality

"The progress of women's health is a challenge to human history. Therefore, there is urgent need to address it with the utmost seriousness"[1]

(Endang Rahayu Sedyaningsih, Minister of Health of Republic of Indonesia)

Maternal mortality rate (MMR) in Indonesia still becomes an argument. Nevertheless, Bappenas takes the high maternal mortality rate as the most challenging problem in Indonesian health sector.[2] This fact is in accordance to assessment findings of Women Research Institute (WRI).

The calculation of MMR was based on international comparison method established by UNICEF, and shows that the MMR for Indonesia which reported for 2000-2007 periods was 310, while the adjusted data for 2005 was 420.[3] *Kompas* (23/1/2010) quoted various data which sourced from UNFPA, in which stated that MMR in was still in 420/100.000 per living birth level; akin to MMR in 2005 stated by UNICEF.[4]

[1] Speech delivered on behalf Minister of Health of Republic of Indonesia at the annual of IFPMA reception on the 63rd World Health Assembly.
[2] Badan Perencanaan Pembangunan Nasional (Bappenas - Ministry for National Development Planning/National Development Planning Agency), Summary Report Millennium Development Goals, Indonesia 2007, p. 8.
[3] www.unicef.org: Indonesia: Statistics: Women.
[4] *Kompas*, "Angka Kematian Ibu Dapat Diturunkan; Edisi Kesehatan Ibu dan Anak", January 23, 2010, p. 36.

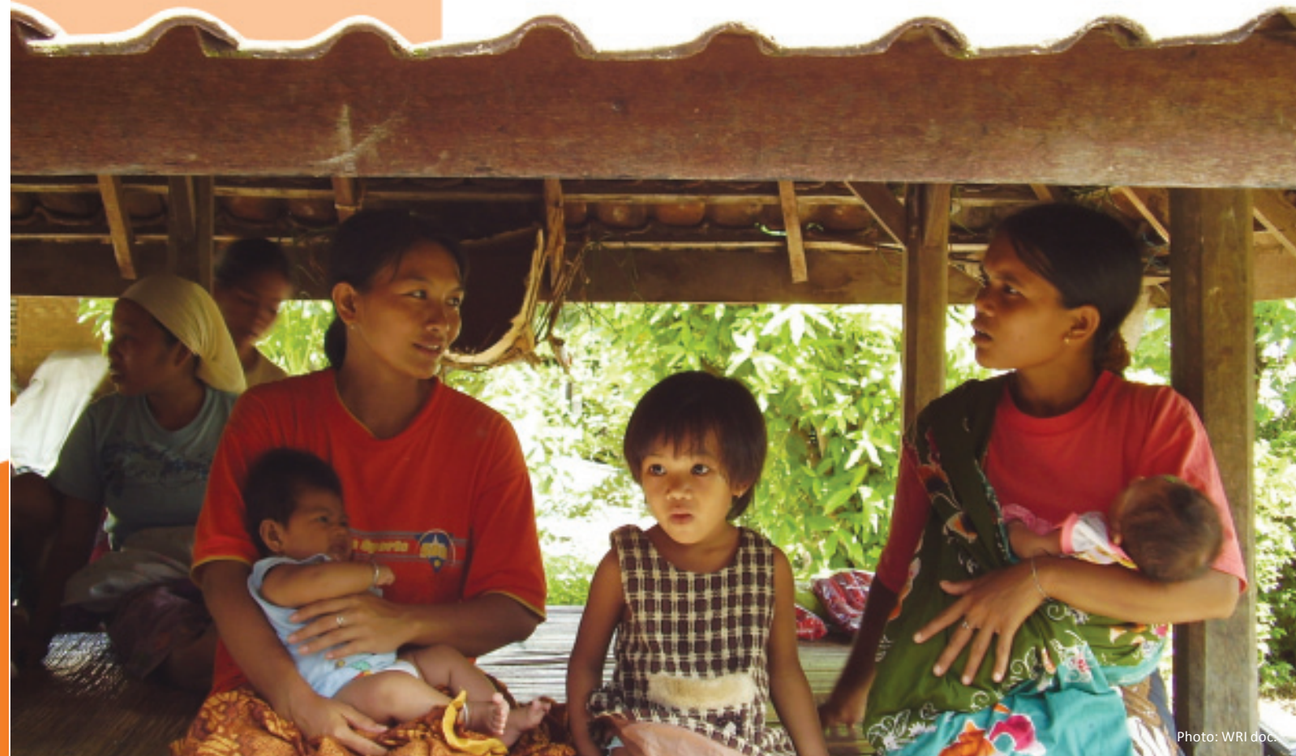
Photo: WRI doc.

Indonesian MMRs which published by those international organizations were far higher compared to data published by Bappenas for 2007[5] and 2009.[6] Bappenas stated that MMR in Indonesia had decreased from 390 per 100.000 living birth in 1994 to 307 in 2000-2003, and to 228 in 2008. Although national calculation rate showed decreasing trend, Bappenas implied that it will be difficult for Indonesia to achieve Millennium Development Goals (MDGs) target in decreasing MMR to 125 in 2015. In its publications, Bappenas hinted that Indonesian MMR in 2015 would be around 163. Indonesia was left behind Malaysia and Thailand with 30 and 24 as their MMR, respectively, and closer to Vietnam (150), Philippines (230) and Myanmar (380).[7]

This situation was caused by complex and varied background, from the high level of poverty, gender-biased and insensitive policies towards the poor, unfriendly nature, to the insufficient infrastructures provided.

MMR data varies in every region. The discrepancy started from two to 98 per cents. Not to mention the fact that there were several locations with higher level of difficulty in accessing health facilities and medical officers. Data from Susenas (national census program) in 2001 showed that there were only 46 per cents of all birth processes assisted by village midwives. Distribution of midwives availability in Indonesia is also far from sufficient. According Indonesian Midwives Association, currently there are only 80.000 midwives to serve 240 millions of population in Indonesia. On top of that, midwives availability in the village is decreasing from 62,812 in 2000, to 39,906 in 2003. Indonesian Health Profile in 2000 recorded that around 80 per cents of Indonesians were inhabited in 69,061 villages and there were 22,906 villages which have no village midwives.[8]

[5] Badan Perencanaan Pembangunan Nasional (Bappenas - Ministry for National Development Planning/National Development Planning Agency), Summary Report Millennium Development Goals, Indonesia 2007.

[6] Directorate of Sectoral Development Evaluation, Bappenas, Status Ringkas: Millennium Development Goals, Indonesia 2009.

[7] *Kompas*, "Angka Kematian Ibu Dapat Diturunkan; Edisi Kesehatan Ibu dan Anak", January 23, 2010, p. 36.

[8] Executive summary of SMERU Research Institute "Strategi Akselerasi Pencapaian Target MDGs 2015".

Research undergone by WRI found that the main problem was not the quantity of midwives, but the insufficient distribution of midwives within targeted areas, particularly in peri-urban areas.

The geographical condition where pregnant women lived was also emerging problem in accessing health facilities. WRI assessment which was held in seven districts and municipalities: South Lampung, Lebak, Indramayu, Surakarta, Jembrana, Central Lombok, and West Sumba, found three key factors of delays which caused maternal mortality:

1. Delays in identifying danger sign and decision making
2. Delays reaching health facilities
3. Delays accessing service in the health facilities

What caused all of the aforementioned delays was due to the lack of knowledge. Women's access to knowledge, even knowledge related to their reproductivehealth is still dominated by men. Patriarchal religious values also played significant role in preserving the reproductive health knowledge. Contraception issues were still debated in the community. Moreover, contraception health technologies were still gender-biased. Varieties of contraceptive devices were still intended to be used by women (IUD, pills, and implants). Almost all contraceptive

Photo: WRI doc.


Photo: WRI doc.

devices, except IUD, were used as controls toward women's hormones.

Man as decision maker in the family

Beliefs that man is the head of the family and has privilege in making every single decision, still becomes a dominant beliefs in the community. Women's capability in domestic areas is 'considered' as an unproductive work, a condition which caused have no whatsoever rights in making decisions related to family financial condition. This condition is also applied unconsciously as double standard in poor women community. This condition of poverty has close relation to cultural values that does not provide enough space for women's participation.

Problems to access Health Facilities, including basic health service

The following is a general description on giving birth expenses. In health facilities like Puskesmas, although though there is a Regent's decree which stated that there should be no health service expenses charged for mother and children, 49 per cents of the population are still pay around IDR 300,000.[9] While the average income for Indonesians, according to BPS, in August 2010, was around IDR 1,373,753 per annum. Hence, if the average birth expense is IDR 300,000, then 25 per cents of the average income should be extorted from the family budget. The expenses paid are not covering transportation fee to health facility and other medicines needed before and after the labor. What about regions which do not have free laboring expenses policy?

Infrastructure problems, such as insufficient main road installation and limit the access to health facilities for pregnant women, are contributors for high MMR because many health facilities are available the sub-district capital and not covering remote villages yet. Difficulties to reach health facilities creates expensive transportation fee. In remote areas or villages, access to health facilities could only be reached by using *ojek* (rented taxi motorbike while road condition is not good. At the same time, this condition charged more additional fees to get health service. The *ojek* costs around IDR 5,000 to IDR 30,000, and the community in the remote villages need to pay it to arrive in the health facility. The expensed paid almost matched the daily wage for working in the rice field for woman labors.[10]

The community has solid belief to traditional birth attendants and many myths on pregnancy, pregnant women and birthing process add more problems in socializing reproduction health. The birthing process is still considered as a normal process that can be undergone naturally by all women. These barriers caused women in the village prefer to choose traditional birth attendants as a better option.

[9] Findings from WRI research (2009) in Jembrana, Tabanan Bali.

[10] *Ibid.*

Table
Percentage of Infants Born in the Last Birth Attendants

Doctor	Midwife	Medical Personnel	*Dukun*	Family
15,3 %	61,2 %	1 %	21,3 %	1,2 %

Source: BPS Publications Booklet August, 2010