

## Original Article

# Cultural Beliefs and Pregnancy Care among the Dayak Kenyah Community in East Kutai, Indonesia: An Ethnographic Study



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### ABSTRACT

**Background:** Maternal health during pregnancy, childbirth, and the postpartum period serves as one of the key indicators of community well-being. Various studies have emphasized that cultural practices exert a significant influence on maternal care across different communities. This study aims to explore and analyze cultural beliefs and pregnancy care among the Dayak Kenyah community in East Kutai, Indonesia.

**Methods:** This qualitative ethnographic study used purposive sampling with maximum variation. Data were gathered from 10 informants (6 pregnant women, 2 traditional leaders, 2 healthcare providers) through in-depth interviews and field notes. Analysis followed Braun and Clarke's thematic approach. The study adheres to SRQR reporting guidelines to ensure rigor.

**Results:** Five interpretive themes emerged: (1) Cultural Practices and Beliefs, involving dietary and behavioral taboos to protect against supernatural risks; (2) Traditional and Social Support, where traditional birth attendants (TBAs) provide physical and diagnostic assurance; (3) Integration with Formal Healthcare, highlighting midwives as cultural mediators; (4) Healthcare Quality Improvement, focusing on cultural competency to reduce stigma; and (5) Service Expectations, emphasizing a need for home-based care.

**Conclusion:** Maternal care among the Dayak Kenyah is a hybrid process where ancestral rituals and clinical services coexist. Success in improving outcomes depends on integrating traditional practices with formal systems through culturally sensitive approaches.

**Keywords:** Cultural Beliefs; Pregnancy Care; Ethnography; Indigenous Community; Maternal Health; Indonesia.

### Implications for Practice:

- Culturally sensitive maternal health services that integrate local beliefs, family involvement, and respectful negotiation of traditional practices have the potential to improve patient-centered care quality, trust in health providers, and utilization of formal maternal health services among indigenous communities
- The findings highlight the need for adaptive clinical guidelines that allow contextual flexibility, enabling health systems to align

### Implications for Practice:

- biomedical standards with local belief systems and traditional support structures without compromising maternal safety
- This study provides evidence to inform maternal health policy development and culturally responsive training programs for healthcare workers in resource-limited settings, supporting more inclusive, equitable, and effective primary healthcare delivery for indigenous populations

## Introduction

Maternal health during pregnancy, childbirth, and the postpartum period serves as one of the key indicators of community well-being. According to the World Health Organization (WHO, 2025), in 2020, approximately 287,000 women died from complications related to pregnancy and childbirth, with the majority of these cases occurring in developing countries, including Indonesia. Most of these deaths could have been prevented through appropriate healthcare interventions, which include understanding and respecting local cultural practices in maternal care.

Data from the ASEAN Statistical Yearbook (2022) reveal significant disparities in maternal mortality ratios (MMR) across ASEAN countries. Indonesia reported 305 deaths per 100,000 live births, making it the country with the highest MMR in the region. In contrast, Singapore and Malaysia recorded substantially lower figures, with 4.8 and 29.1 deaths per 100,000 live births, respectively, reflecting stronger maternal healthcare systems. The average MMR in ASEAN was reported at 202.8 per 100,000 live births. Several countries, including Cambodia (154), Myanmar (203), and Laos (196), also demonstrated relatively high maternal mortality levels. Meanwhile, Thailand and Vietnam reported 26.6 and 46.0 maternal deaths per 100,000 live births, respectively. These figures highlight that, despite progress in maternal and child healthcare services, several ASEAN countries, particularly Indonesia, continue to face major challenges in reducing maternal mortality (ASEAN, 2022).

Various studies have emphasized that cultural practices exert a significant influence on maternal care across different communities. Among the Ammatoa Kajang community, pregnancy is guided by the concept of *pamali*, which prescribes specific

dietary and behavioral taboos to ensure the safety of both mother and fetus (Astianti et al., 2023). A transcultural study in Ponorogo demonstrated that cultural practices are either maintained, negotiated, or restructured to align with modern healthcare systems (Furilta et al., 2020). Social and familial factors have also been found to shape maternal decision-making in Ghana, where husbands, extended family members, and traditional birth attendants play crucial roles (Barbi et al., 2021a). Similar practices were observed in Tanzania and Ethiopia, where traditions involving herbal medicine, religious rituals, and food taboos remain prevalent, though some carry health risks (Aynalem et al., 2023; Felisian et al., 2023). In Indonesia, studies of Javanese and Garut communities revealed the persistence of cultural rituals, such as the four-month and seven-month pregnancy ceremonies, along with pregnancy-related prohibitions that continue alongside biomedical care (Juariah, 2018; Kartini & Kusumadewi, 2022). More recent research confirmed that maternal decision-making patterns, both in rural and urban areas, remain strongly influenced by traditions and family authority (Maryuni et al., 2024a). An ethnographic study in Muna further illustrated that pregnant women often continue to rely on traditional healers and customary rules as primary references in maintaining pregnancy (Dwiyanita et al., 2024). Collectively, these findings underscore that culture remains a critical determinant in maternal care, although its forms and practices vary across communities.

According to demographic data from Busang Sub-district in 2025, the Dayak ethnic group constitutes the majority of the population, with 3,726 individuals out of a total population of 5,922, accounting for approximately 62.9%. The Bugis represent the second-largest group with 952

individuals (16.1%), followed by the Kutai with 909 individuals (15.3%), and the Javanese with 134 individuals (2.3%). Other ethnic groups, such as the Banjar, Balinese, Batak, Chinese, and others, represent relatively smaller proportions of the population. The dominance of the Dayak, particularly the Kenyah sub-ethnic group, indicates that cultural values and customary practices remain deeply embedded in the social fabric of the community. These traditions significantly influence daily life, including maternal health practices and childbirth rituals ([Busang, 2024](#)).

The Dayak Kenyah, one of the sub-ethnic groups of the Dayak people residing in East Kalimantan, maintain various cultural practices related to maternal care during pregnancy, childbirth, and the postpartum period. During pregnancy, Dayak Kenyah women observe a series of rituals and taboos aimed at safeguarding maternal and fetal health. For instance, restrictions on the consumption of certain foods are believed to influence the well-being of the fetus. In addition, pregnant women are advised to avoid strenuous physical activities and to maintain emotional balance. These practices reflect the community's belief in the importance of preserving harmony between the expectant mother and her surrounding environment ([Harsanto & Sampurno, 2019](#)).

In Indonesia, maternal mortality remains a critical public health challenge. According to the 2022 Indonesia Demographic and Health Survey (IDHS), the Maternal Mortality Ratio (MMR) was recorded at 305 deaths per 100,000 live births, underscoring the urgent need for improved maternal healthcare services, particularly in regions where cultural practices significantly shape pregnancy care patterns (BPS, 2022).

In East Kalimantan, maternal mortality is a matter of serious concern. Data from the Provincial Health Office of East Kalimantan

(2023) reported 83 maternal deaths, exceeding the target of 70. The province continues to face relatively high maternal mortality rates despite ongoing efforts to strengthen healthcare services. In 2023, the highest number of maternal deaths occurred in Samarinda City (19 cases), followed by Kutai Kartanegara District (14 cases) and East Kutai District (13 cases). By contrast, Mahakam Ulu District reported zero maternal deaths, while the remaining 37 cases were distributed across other districts and municipalities such as Paser, West Kutai, Berau, North Penajam Paser, Balikpapan, and Bontang. The leading causes of maternal deaths were haemorrhage (28.02%) and eclampsia (18.22%) ([Dinas Kesehatan Provinsi Kalimantan Timur, 2023](#)). Regarding the place of death, 74% of maternal deaths occurred in hospitals, 9% occurred en route to health facilities, and 11% occurred at home ([Aviva et al., 2025](#)).

A preliminary study conducted in the working area of Busang Community Health Center revealed that out of 116 recorded deliveries, 7 mothers (6%) were still assisted by traditional birth attendants. All of these cases involved women from the Dayak Kenyah community, who continue to maintain inherited cultural practices during childbirth. In contrast, the majority of deliveries were attended by professional healthcare providers. Among 118 registered pregnant women, 106 (89.8%) had completed four antenatal care visits (K4), indicating relatively good access to healthcare services in the region. These findings suggest that while formal healthcare services are available and utilized by most of the community, a portion of Dayak Kenyah's mothers continue to prefer cultural approaches in childbirth. This reflects a unique challenge, namely the tension between biomedical healthcare services and local cultural beliefs, which

remain highly influential in maternal decision-making (Busang, 2024).

Moreover, this study draws on a cultural health belief framework situated within maternal health ethnography. From this perspective, pregnancy care is understood as a socially produced practice shaped by symbolic meanings, moral obligations, kinship structures, and customary authority (Davis-Floyd & Sargent, 2023; Jetten et al., 2012). Cultural beliefs, such as pregnancy taboos, ritual practices, and reliance on traditional birth attendants, shape women's interpretations of bodily risk, responsibility, and protection, which in turn inform maternal care behaviors (Bernard, 2017; Das, 2015; McElroy, 2018). Rather than positioning culture and biomedicine as oppositional domains, this framework conceptualizes maternal healthcare as a negotiated practice, wherein women actively navigate and reconcile indigenous knowledge systems with biomedical expectations (Coffie, 2025; Gurr, 2014). This approach allows for a nuanced analysis of how cultural logics shape maternal health decision-making in the Dayak Kenyah context.

Despite the growing body of literature on cultural dimensions of maternal health, a significant research gap remains regarding the interactive and negotiated processes between indigenous cultural belief systems and formal maternal healthcare. Existing studies generally acknowledge that culture influences health behavior; however, there is limited empirical understanding of how indigenous women simultaneously navigate and reconcile traditional beliefs and biomedical expectations within their maternal care trajectories. In the context of East Kalimantan, little is known about the decision-making processes that enable women to comply with modern antenatal care protocols, as reflected in high K4 coverage, while choosing traditional birth

attendants for childbirth. The ways in which spiritual beliefs, ancestral taboos, and the authority of customary leaders intersect with or challenge formal maternal healthcare interventions remain largely undocumented. The Dayak Kenyah context, therefore necessitates qualitative exploration, as quantitative indicators alone are insufficient to capture the subjective meanings, social pressures, and intra-family power relations that shape maternal health behaviors. A qualitative approach is essential to elucidate the cultural logic underpinning these practices, including lived experiences and the symbolic significance of rituals, which cannot be adequately identified through statistical analysis alone. Without such contextual understanding, maternal healthcare initiatives risk overlooking culturally embedded factors that influence community engagement and service utilization. So, based on the explanation above, this study is to explore and analyze cultural beliefs and pregnancy care among the Dayak Kenyah community in East Kutai, Indonesia.

## Methods

### Study Design

This study uses a qualitative ethnographic design based on the interpretive tradition of Clifford Geertz. Drawing on Geertz's concept of thick description, the study seeks to interpret the cultural meanings that shape pregnancy care practices, while recognizing health behaviors as socially embedded rather than individually determined (Dadze-Arthur, 2017; Geertz, 2017). As Spradley (2016) argues, ethnography enables researchers to document how cultural knowledge is organized, learned, and enacted in daily life—an essential consideration when examining pregnancy-related dietary taboos, ritual practices, and decision-making processes involving families and

customary leaders. In addition, ethnography is particularly appropriate for exploring beliefs and practices surrounding pregnancy care because such beliefs are deeply embedded in cultural norms, kinship structures, and customary authority systems (Anggreni & Km, 2022; Dwiyana et al., 2024). The geographical isolation and sociocultural history of the community play a vital role in shaping health outcomes. Limited access to urban centers often strengthens the influence of customary leaders, making it essential to study these practices within their specific physical and social environment.

Unlike research designs that rely solely on interviews or surveys, interpretive ethnography allows for prolonged engagement and informant observation within the community, capturing the dynamic interplay between stated beliefs and actual practices. This is critical for understanding how traditional pregnancy care beliefs interact with biomedical healthcare expectations in real-world contexts. Moreover, the community's geographical isolation and sociocultural history amplify the influence of customary leaders and collective decision-making, further underscoring the suitability of ethnography for studying pregnancy care within its specific social and physical environment. To enhance rigor and transparency, this study follows the Standards for Reporting Qualitative Research (SRQR), ensuring systematic documentation of methodological decisions and analytic processes.

### Research Team and Reflexivity

This study was conducted by a multidisciplinary research team led by a Senior Lecturer specializing in maternal health and qualitative research methodologies. The lead researcher has extensive experience in socio-cultural research and ethnographic approaches,

particularly within maternal and community health contexts. The research was supported by a midwifery student whose academic training and research interests aligned closely with the objectives of this study, contributing to data organization and active field engagement. In addition, the research process was guided by a supervisory team of senior lecturers with expertise in Management and promotion health, and thematic analysis. This combination of clinical midwifery expertise and social science scholarship strengthened the study's methodological rigor and analytical depth.

With regard to positionality and cultural proximity, the lead researcher possessed relevant cultural and contextual knowledge that facilitated sensitivity to local norms and practices, while maintaining a reflexive awareness of their role as a researcher. Prior to data collection, the research team had no personal or professional relationships with the community or the informants. This absence of prior engagement was maintained to reduce power imbalances and to support the generation of authentic narratives grounded in the informant's lived experiences. In line with ethnographic conventions, all individuals contributing data in this study are referred to consistently as informants, reflecting their position as knowledgeable agents and experts of their own cultural and social realities.

Recognizing that researchers' backgrounds, assumptions, and disciplinary training may influence data collection and interpretation, reflexivity was deliberately embedded throughout the research process. Several strategies were employed to manage potential bias and enhance the trustworthiness of the findings.

1. First, the lead researcher maintained detailed field notes and a reflexive journal throughout fieldwork. These

records documented observational details, methodological decisions, personal reflections, and emotional responses, enabling ongoing critical examination of how the researcher's positionality might shape interactions with informants and emerging interpretations.

2. Second, regular peer debriefing sessions were conducted with academic supervisors and members of the research team. These discussions provided an external and critical perspective on the data collection process and analytical decisions, ensuring that interpretations were firmly grounded in the empirical data rather than individual assumptions.
3. Finally, periodic team discussions facilitated collaborative reflection on emerging themes and challenged taken-for-granted interpretations. This

collective reflexive process contributed to minimizing individual subjectivity and enhanced the credibility and confirmability of the final analysis.

### Participants

This study employed an explicit purposive sampling strategy with maximum variation to capture a broad spectrum of perspectives regarding maternal and childbirth practices. To ensure access to influential community figures, this was supplemented by snowball sampling, where initial informants (traditional leaders) assisted in identifying further informants deeply embedded in local childbirth traditions. To ensure data quality and relevance, specific criteria were established for each informant group in **Table 1**.

**Table 1.** Criteria of Informants

Informant Group	Inclusion Criteria	Exclusion Criteria
Pregnant Women	(1) Second or third trimester; (2) Member of the Dayak Kenyah community; (3) Resident of the study area.	(1) High-risk health conditions (e.g., preeclampsia, severe anemia); (2) Significant communication or psychological difficulties.
Traditional Leaders	(1) Recognized community figure; (2) Actively engaged in childbirth-related cultural practices.	(1) Lack of direct involvement in pregnancy or delivery traditions; (2) non-Dayak Kenyah affiliation.
Healthcare Providers	(1) Direct experience in maternal care within the study area; (2) Minimum 1 year of service.	(1) Administrative staff without direct clinical interaction with maternal patients.

Study informants were purposively selected to represent key perspectives relevant to maternal health within the Dayak Kenyah community. Based on **Table 1**, three informant groups were included: pregnant women, traditional leaders, and healthcare providers. Pregnant women were eligible if they were in their second or third trimester, identified as members of the Dayak Kenyah community, and resided in the study area, while those with high-risk

health conditions or significant communication difficulties were excluded. Traditional leaders were included based on community recognition and active involvement in childbirth-related cultural practices, whereas individuals without direct engagement in pregnancy or delivery traditions were excluded. Healthcare providers were selected based on their direct experience in maternal care within the study area and a minimum of one year



of service, with administrative staff excluded due to a lack of direct clinical interaction with maternal patients.

Informants were recruited with the assistance of community health workers and local leaders. A total of 12 individuals were approached; however, 2 declined to participate due to time constraints, resulting in a final sample of 10 informants (6 pregnant women, 2 traditional leaders, and 4 healthcare providers). Prior to data collection, all informants received a comprehensive explanation of the study's aims, procedures, and their right to withdraw. Informed consent was obtained from all informants. No financial compensation was provided for participation to avoid coercion; however, small tokens of appreciation (e.g., basic food items or health kits) were provided in accordance with local customs. Recruitment continued until data saturation was achieved. This number was deemed sufficient as the final interviews yielded no new codes or themes, confirming that the depth of information reached a point of redundancy ([Tuti Meihartati et al., 2022](#))

### Data Collection

The study took place in the Busang District, Kutai Timur Regency, East Kalimantan, Indonesia, a region where the Dayak Kenyah community maintains traditional maternal care practices. Data collection was conducted over a two-month period, from October 1 to November 30, 2024. The primary method employed was in-depth, face-to-face interviews, complemented by field notes to capture contextual and non-verbal observations.

Interviews were held in private settings, either the informants' homes or the Busang Health Center, to ensure confidentiality and comfort.

- Mode: Individual, face-to-face sessions.

- Duration: Each session lasted between 20 and 40 minutes, with an average duration of approximately 30 minutes.
- Recording: All sessions were recorded using a phone as a digital voice recorder (with informant consent).

In other hand, data collection was guided by a semi-structured interview guide featuring open-ended questions designed to explore cultural pregnancy beliefs. Sample questions included:

*"How do you maintain your health during pregnancy (e.g., in terms of diet, physical activities, or practices to avoid)?"*

*"What traditional rituals or prohibitions do you follow during the prenatal period?"*

Moreover, to ensure the integrity of the findings, the following steps were taken:

- Verification: Audio recordings were transcribed verbatim and cross-checked against field notes for accuracy.
- Member Checking: Informants were given the opportunity to review their transcripts and validate the findings, ensuring the data accurately represented their perspectives.
- Data Saturation: Recruitment continued until data saturation was reached. This was identified when three consecutive interviews yielded no new codes, themes, or insights, indicating that the information gathered was comprehensive.

### Data Analysis

Data were analysed using a hybrid approach combining Spradley's ethnographic analysis to capture cultural context ([Spradley, 2016](#)) and [Braun & Clarke \(2024\)](#) six-phase thematic analysis to identify and refine patterns within the transcripts. The analysis was managed and organized using NVivo 12 software. The

thematic analysis followed a systematic six-phase progression:

1. Familiarization: Transcripts were read and re-read while noting initial ideas.
2. Generating Initial Codes: Systematic coding of the entire data set was conducted to identify relevant features.
3. Searching for Themes: Codes were collated into potential themes.
4. Reviewing Themes: Themes were checked against the coded extracts and the entire data set.
5. Defining and Naming Themes: Ongoing analysis refined the specifics of each theme.
6. Producing the Report: Selection of vivid examples and final analysis relating back to the research questions.

To enhance analytical rigor and credibility, inter-researcher validation was incorporated throughout the coding and theme development process. Initial coding was conducted independently by four members of the research team. The researchers then met regularly to compare coding decisions, discuss interpretive differences, and collaboratively refine code definitions and theme boundaries. This process functioned as investigator triangulation, helping to minimize individual researcher bias and strengthen the trustworthiness of the analysis. Where discrepancies arose, iterative discussion and reflexive dialogue were used to reach consensus, ensuring that the final thematic structure represented a shared and robust interpretation of the data.

### **Trustworthiness and Rigor**

To ensure the integrity of this qualitative ethnographic study, specific validation strategies were integrated throughout the research process. These measures were designed to enhance the study's credibility, dependability, confirmability, and transferability, and credibility ensures that the research

findings represent a “true” picture of the phenomenon. Triangulation of data sources was applied by cross-checking data through the engagement of multiple informant groups, including pregnant women, healthcare workers, and traditional leaders, and by using diverse methods such as in-depth interviews and informant observation. Member checking was conducted at the conclusion of each interview, where key points were summarized and verified with informants to ensure that the researcher’s interpretations accurately reflected their lived experiences. Peer debriefing was also implemented, in which the research process and emerging themes were regularly discussed with academic peers and colleagues to challenge potential biases and refine the analysis.

In addition, these strategies ensured that the study remained consistent and that the findings were shaped by the informants rather than by researcher bias. Audit trail documentation was maintained by the researchers documenting every methodological decision, data collection step, and analytical turn, allowing the research process to be traced and verified by outside observers. Reflective journaling was also conducted, in which the researcher utilized a reflexive journal to document personal assumptions and emotional responses, ensuring that the findings remained strictly grounded in the informants’ narratives. Standardized procedures were implemented by maintaining consistent data collection through the use of a standardized interview guide, thereby ensuring a stable foundation for comparison across different contexts.

Furthermore, to assist other researchers in determining the applicability of these findings to different settings, extensive use of direct informant quotations was employed throughout the findings, which preserved the original “voice” of the informants and provided the nuanced

evidence necessary for readers to assess the transferability of the results.

### **Ethical Consideration**

This study has been reviewed and ethically approved by the Health Research Ethics Committee of Institut Teknologi Kesehatan dan Sains Wiyata Husada Samarinda. The ethical exemption approval is documented under approval number No. 20/ITKES-WHS/KEPK/EC/2025, valid from July 03, 2025, to July 03, 2026. While the ethical clearance provides the academic framework, the study has secured specific administrative and community-level permissions to ensure cultural sensitivity and local cooperation. Administrative approval was granted by Puskesmas Busang under approval number No. B-400.7.22.1/1308/PKM-BSG and by the Long Lees Village Office under approval number No. B.800.1.4.1/585/DS.LL-BSG. Community leadership authorization was also formally obtained from Jalung, the Head of Rantau Sentosa Village, under approval number No. B-400.7.4.5/249/DS.RS-BSG. As this research involves the Dayak Kenyah Indigenous community, these village-level approvals serve as the primary gateway for community entry and cultural recognition.

To protect the privacy of the informants, several procedures were implemented. Anonymization was applied by replacing all personal identifiers, such as names and specific addresses, with unique alphanumeric codes during the data transcription and analysis phases. Secure storage was also maintained, where physical records, including field notes and

signed consent forms, were kept in a locked cabinet accessible only to the researcher, while digital data were stored on an encrypted, password-protected device. In accordance with institutional policy, data retention procedures were established whereby all data will be destroyed after a period of five years following the completion of the study to ensure long-term privacy.

The researchers employed a written informed consent process before any data collection began. Informants were first provided with an Information Sheet, translated into local dialects if necessary, explaining the study's purpose, the voluntary nature of participation, and the right to withdraw at any time without penalty. Informants who agreed to join the study then signed a formal Informed Consent Form. For informants with limited literacy, the form was read aloud in the presence of a witness, and a thumbprint was accepted as a formal mark of consent.

### **Results**

The study involved 12 informants comprising six pregnant women, four healthcare workers (midwives and nurses), and two customary leaders. The pregnant women ranged in age from 20 to 36 years, while healthcare workers had between 5 and 15 years of professional experience. All informants resided in Busang District, East Kutai Regency, and represented diverse educational and occupational backgrounds. This variation provided rich perspectives on maternal care practices, reflecting both traditional cultural beliefs and biomedical approaches to pregnancy (**Table 2**).

**Table 2.** Characteristics of Research Participants

No.	Participant Code	Role	Age	Gender	Ethnicity	Occupation	Education
1	P1	Pregnant Woman	34	Female	Dayak Kenyah	Housewife	Senior High School.
2	P2	Pregnant Woman	32	Female	Dayak Kenyah	Housewife	Junior High School.
3	P3	Pregnant Woman	26	Female	Dayak Kenyah	Housewife	Senior High School.
4	P4	Pregnant Woman	27	Female	Dayak Kenyah	Contract Employee (TK2D)	Bachelor's Degree
5	P5	Pregnant Woman	36	Female	Dayak Kenyah	Housewife	Bachelor's Degree
6	P6	Pregnant Woman	29	Female	Dayak Kenyah	Housewife	Senior High School.
7	P7	Healthcare Worker	35	Female	Batak	Midwife	Diploma III Midwifery
8	P8	Healthcare Worker	35	Female	Batak	Midwife	Diploma III Midwifery
9	P9	Healthcare Worker	35	Female	Dayak Kayan	Midwife	Diploma III Midwifery
10	P10	Healthcare Worker	35	Female	Batak	Midwife	Diploma III Midwifery
11	P11	Customary Leader	73	Female	Dayak Kenyah	Farmer	Elementary Sch.
12	P12	Customary Leader	83	Male	Dayak Kenyah	Farmer	Elementary Sch.

*Theme 1: Cultural Practices and Beliefs in Pregnancy*

Cultural beliefs constituted the primary framework through which pregnancy was understood and managed in the Dayak Kenyah community. Informants described a structured system of dietary regulations, behavioral restrictions, and spiritual practices aimed at safeguarding maternal and fetal well-being from both physical and supernatural threats.

*“Yes, there are several foods that are usually forbidden for us pregnant women, such as katuk leaves, pumpkin leaves, and ludo, as they can cause miscarriage. Also, snakehead fish (ikan aruan) or fish with many bones, because they can cause birth defects in the baby. On the other hand, there are recommended foods, such as consuming more rice and tubers, scaleless fish, and boiled red ginger to warm the body.”*

*(Informant 6, 26-year-old mother)*

*“...certain foods are recommended, including increased consumption of rice and tubers, scaleless fish, and boiled red ginger to provide warmth to the body.”*

*(Informant 12, 83-year-old- Customary Leader)*

These practices reflect an embodied cultural logic in which food functions not merely as nutrition but as a moral and protective agent during pregnancy.

*Theme 2: Traditional and Social Support Systems*

Pregnancy care was embedded within a communal support structure involving family members and traditional birth attendants, emphasizing collective responsibility rather than individual autonomy.

*“My husband helps me at home, and my family continuously gives advice about*



*what I am allowed and not allowed to do during pregnancy.” (Informant 1, 34-year-old mother)*

*In several cases, familial support also translated into restrictions on physical labor, reflecting protective norms aimed at reducing perceived risks to the pregnancy.*

*“My family and husband strongly support me during this pregnancy. They also forbid me from working, including doing household chores.” (Informant 6, 29-year-old mother)*

These narratives indicate that family involvement functions simultaneously as emotional support and behavioral regulation, reinforcing cultural expectations of rest and protection while shaping women’s autonomy during pregnancy.

### *Theme 3: Integration with Formal Healthcare*

Rather than operating in isolation, formal healthcare services were increasingly negotiated in relation to existing traditional systems.

*“The traditional birth attendant would care for postpartum mothers for one week.” (Informant 11, 83-year-old-Customary Leader)*

*“The traditional birth attendant helped to adjust my baby’s position and lift my baby because I urinated frequently; according to the traditional belief, this indicated that the baby’s position had descended.” (Informant 6, 29-year-old mother)*

*“During pregnancy, we also consulted the traditional birth attendant to determine the position of the fetus.” (Informant 5, 36-year-old mother)*

### *Theme 4: Healthcare Quality Improvement*

Improving maternal healthcare quality was framed not solely in technical terms but also through social and cultural dimensions.

*“We strive to build mutual trust with pregnant women and traditional birth attendants through collaboration and mutual respect, with a shared goal of ensuring the safety of both mother and baby.” (Informant 8, 35-year-old Healthcare Worker)*

*“I frequently attend antenatal check-ups with a midwife, as it is safer for monitoring the condition of the pregnancy.” (Informant 3, 26-year-old mother)*

### *Theme 5: Expectations Regarding Health Services*

Informants articulated clear expectations for maternal healthcare services that combine clinical safety with respectful and culturally attuned interactions.

*“I hope that maternal healthcare services for pregnant women in our village can be provided more frequently, that midwives can conduct regular home visits, and that they can collaborate with local traditional birth attendants.” (Informant 1, 34-year-old mother)*

*“I hope that midwives can understand and respect local beliefs so that community members feel comfortable and are not afraid to seek healthcare services.” (Informant 2, 32-year-old mother)*

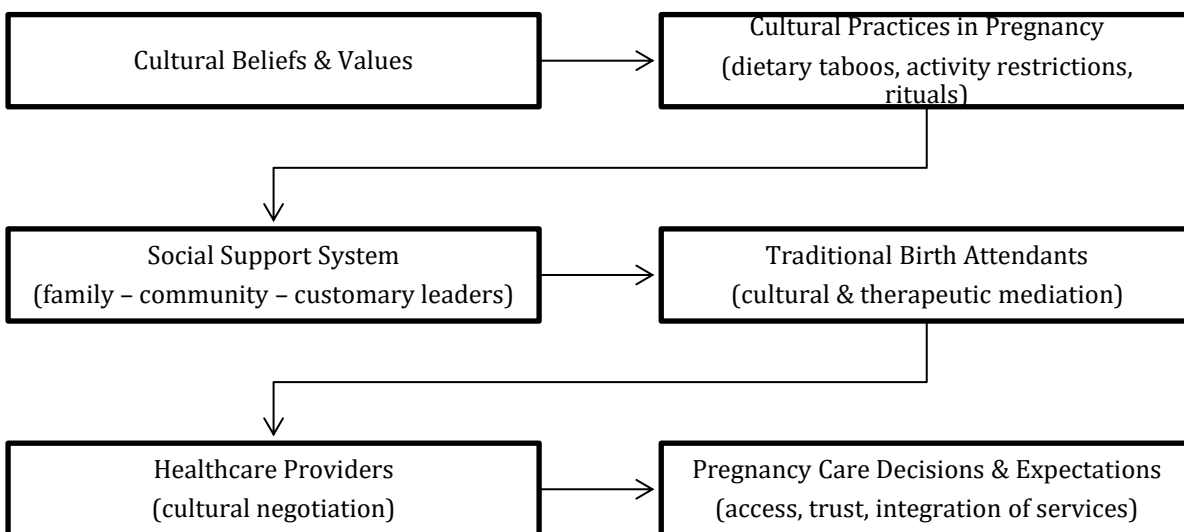
*“If possible, antenatal examinations should be conducted at home for mothers who live far from the posyandu.” (Informant 4, 27-year-old mother)*

**Table 3.** Coding Tree of Maternal Cultural Practices and Healthcare Interaction

Main Theme	Subthemes / Categories	Initial Codes
Cultural Practices & Beliefs in Pregnancy	1.1 Dietary Taboos & Recommendations	Food prohibitions, miscarriage risk, fetal deformity, and warming foods.
	1.2 Behavioral & Activity Restrictions	Dusk restrictions, secrecy of pregnancy (evil eye/spirit protection).
	1.3 Spiritual Connection	Ancestral messages (dreams), ritual protection ( <i>jemulang</i> ).
Traditional & Social Support Systems	2.1 Family-Based Care	Intergenerational knowledge, domestic help from elders.
	2.2 Birth Attendant ( <i>Dukun</i> )	Fetal positioning, traditional massage, and herbal medicine ( <i>jamu</i> ).
Integration with Formal Healthcare	3.1 Role of Medical Staff	Midwife support, clinical safety, and nutritional education.
	3.2 Collaborative Care Models	Mutual trust, cross-sector collaboration ( <i>Dukun</i> & <i>Bidan</i> ).
Healthcare Quality Improvement	4.1 Cultural Competency	Respect for local beliefs, reduction of fear/stigma.
	4.2 Accessibility	Home-based care, overcoming geographic barriers.
Expectations regarding services	Hospitality	Midwife support, clinical safety, and nutritional education.

Based on **Table 3**, the analysis revealed five interrelated themes shaping maternal care in the Dayak Kenyah community: (1) Cultural Practices & Beliefs in Pregnancy, (2) Traditional & Social Support Systems, (3) Integration with Formal Healthcare, (4) Healthcare Quality Improvement, and (5) Expectations regarding services. Cultural practices, both prohibitions and recommendations, formed the foundation of maternal behavior, reinforced by social and familial support. Traditional birth

attendants bridged ancestral knowledge and biomedical care, while healthcare workers contributed professional expertise. Informants emphasized the need for stronger collaboration and mutual respect between both systems of care. Together, these findings highlight a hybrid model of maternal health in which cultural traditions and formal healthcare coexist, offering a holistic approach to supporting pregnant women in indigenous communities (**Figure 1**).



**Figure 1.** Conceptual Workflow

## Discussion

The general overview of this study indicates that the majority of informants were of Dayak Kenyah ethnicity, a group recognized for its strong traditions and cultural values that regulate various aspects of life, including maternal health. This composition is consistent with demographic data from Busang District in 2025, which reports that the Dayak community constitutes 62.9% of the population ([Busang District in Figures 2025, 2025](#)). Such demographic conditions influence maternal care practices, as decisions concerning maternal health are typically guided by customary norms and local beliefs. This is consistent with Koentjaraningrat (2002), who emphasized that culture serves as a behavioral framework and a basis for decision-making within society.

Pregnant informants in this study were between the ages of 26 and 36 years, which falls within the range of healthy reproductive age as defined by the World Health Organization (WHO, 2024). Consequently, the risk of medical complications is comparatively lower than in pregnancies occurring before the age of 20 or after the age of 35. However, educational attainment among informants varied, ranging from elementary school to undergraduate level. This variation significantly affects the ability to comprehend health information. [Maryuni et al. \(2024b\)](#) affirmed that educational level influences the acceptance and adaptation of modern health practices, although cultural factors remain dominant in communities with strong customary ties.

The majority of pregnant informants were housewives, indicating greater availability to follow family and customary leaders' advice regarding taboos and recommendations during pregnancy. This finding aligns with [Dwiyana et al. \(2024\)](#), who observed that housewives tend to

adhere more strictly to traditional practices due to their involvement in socio-cultural community activities.

Four healthcare providers were present in the study area, of whom only one belonged to the Dayak Kenyah ethnic group. Their presence played a critical role in bridging medical knowledge with customary practices. Two customary leaders involved in the study acted as custodians of traditional values, reinforcing the application of cultural norms among pregnant women ([Harsanto & Sampurno, 2019](#)). Overall, this informant profile reflects conditions well-suited for examining interactions between formal healthcare services and cultural practices.

In other hand, this study employed thematic analysis based on [Braun & Clarke \(2006\)](#), involving familiarization with data, initial coding, theme development, review, and reporting. This approach enabled the identification of patterns of meaning related to the role of culture in pregnancy care within the Dayak Kenyah community. The analysis demonstrated that culture functions as a framework shaping decision-making, regulating behavior through taboos and recommendations, providing social support, channeling care through traditional birth attendants, and influencing relationships with healthcare providers.

Based on the findings, cultural practices during pregnancy remain deeply embedded in the Dayak Kenyah community. Dietary taboos were widely reported, including prohibitions against consuming pumpkin shoots, katuk leaves, ludo, and certain types of fish believed to cause miscarriage, preterm delivery, or congenital abnormalities. This knowledge is transmitted intergenerationally through parents, family members, and customary leaders. Comparable practices have been documented in other cultural contexts. [Diana et al. \(2018\)](#) identified similar food taboos in the Madurese community, while

[Aynalem et al.](#) (2023) reported dietary restrictions among pregnant women in Ethiopia.

In addition to dietary restrictions, informants described activity-related taboos, such as avoiding walking at dusk, entering forests, splitting firewood, and husbands sitting in doorways. These practices are perceived as protective measures against physical or supernatural risks, consistent with findings from Java ([Kartini & Kusumadewi](#), 2022) and Garut ([Juariah](#), 2018). Spiritual beliefs also remain integral. Dreams were interpreted as ancestral messages, and rituals such as burning jemulang tree bark were believed to ward off malevolent spirits. Similar spiritual practices have been reported in Tanzania ([Felisian et al.](#), 2023) and Ghana ([Barbi et al.](#), 2021b). In contrast to prohibitions, certain foods, such as rice, tubers, scale-free fish, and boiled red ginger, were encouraged to maintain strength and stamina, as also reported by [Diana et al.](#) (2018). Overall, cultural practices encompass dietary taboos, activity restrictions, spiritual beliefs, and dietary recommendations, functioning as protective mechanisms for maternal and fetal well-being.

In addition, traditional and social support systems constitute critical determinants in enhancing maternal health outcomes. Within this framework, family-based care functions as a psychosocial support instrument that significantly bolsters the self-efficacy of primiparous mothers and facilitates lactation success through mechanisms of domestic assistance and intergenerational knowledge transfer ([Pertwi et al.](#), 2021; [Roy](#), 2024). The presence of traditional birth attendants (TBAs) remains relevant within public health structures as providers of complementary services; these include fetal repositioning techniques, oxytocin massage therapy to stimulate uterine involution, and

the application of herbal pharmacopoeia (*jamu*) to accelerate postpartum recovery ([Agustina & Fitrianti](#), 2020; [Elingsetyo Sanubari et al.](#), 2022; [Muhsanatia & Sulastrri](#), 2024; [Trisnawati et al.](#), 2025). Reorienting the role of traditional practitioners as collaborative partners to healthcare professionals aligns with global recommendations that emphasize the integration of cultural values to foster positive and holistic maternal experiences for postpartum women ([Ellyzabeth Sukmawati & Titi Alfiani](#), 2025; [Ernawati](#), 2024)

Moreover, traditional birth attendants (TBAs) remain central to pregnancy, childbirth, and postpartum care in many communities, particularly in low- and middle-income countries. Their practices commonly include traditional physical examinations, abdominal and postpartum massage, the use of herbal remedies, and continuous emotional and social support for mothers before and after delivery. Importantly, these traditional practices often coexist with biomedical maternity services, forming a pluralistic healthcare system in which women navigate both cultural and clinical forms of care ([Kim et al.](#), 2020; [Patil et al.](#), 2024). Previous studies indicate that TBAs are frequently trusted figures due to their cultural knowledge, accessibility, and holistic approach to maternal well-being, especially in settings where formal health services may be geographically, economically, or culturally limited ([Bohren et al.](#), 2020; [Dawkins et al.](#), 2021)

Furthermore, healthcare providers, particularly midwives, play a pivotal role in antenatal care through the provision of routine health assessments, maternal health education, and continuous monitoring of maternal and fetal conditions. In many community-based settings, midwives are perceived by pregnant women as trusted sources of safety,

professional competence, and reliable health information. Beyond their clinical responsibilities, midwives also function as cultural mediators by building trust with community members and collaborating with traditional birth attendants. This collaborative approach facilitates the integration of biomedical services with local beliefs and practices, thereby enhancing the cultural acceptability and utilization of maternal healthcare services ([Musie et al., 2024](#); [Wollie et al., 2025](#)). Such partnerships have been shown to improve maternal health outcomes by fostering respectful maternity care and strengthening referral pathways between traditional and formal health systems ([Aidoo, 2025](#); [Asefa et al., 2020](#)).

Lastly, informants expressed expectations for improved access to healthcare services, particularly through regular home visits, in response to geographical barriers and limited transportation infrastructure. Home-based care was perceived as a practical and culturally appropriate strategy to ensure continuity of antenatal and postnatal care in remote settings. Informants also emphasized the importance of sustained collaboration between healthcare providers and traditional birth attendants, highlighting the need for cultural competence among formal health practitioners. Respect for local beliefs and practices was viewed as essential for fostering trust and increasing community acceptance of biomedical healthcare services. These expectations align with findings from previous studies indicating that culturally sensitive, community-based maternal healthcare models, especially those integrating home visits and traditional practitioners, can enhance service utilization, improve maternal experiences, and strengthen referral systems in geographically constrained contexts ([Christianah Omolola Diyaolu,](#)

[2025](#); [Gordon et al., 2025](#); [Ssegujja et al., 2025](#))

So, pregnancy care is shaped by cultural mechanisms that frame pregnancy as a social and cultural process rather than solely a biomedical condition, influencing how bodily changes, risks, and appropriate care are understood within the community. Shared belief systems and traditional knowledge, maintained by family members and traditional birth attendants, guide interpretations of pregnancy experiences and foster trust through cultural familiarity and social proximity. Care-seeking decisions are embedded in kinship networks, where emotional support and collective norms shape preferences for home-based, traditional, or combined forms of care. Local meanings of safety often emphasize cultural appropriateness and continuity of tradition alongside clinical considerations, leading many women to integrate traditional and biomedical services. Through ongoing negotiation and collaboration between these systems, cultural mechanisms ultimately shape the acceptability, utilization, and effectiveness of pregnancy care.

### **Implications and limitations**

The findings of this study highlight the important role of cultural values and traditional practices in shaping maternal health behaviors within the Dayak Kenyah community. Understanding these cultural dynamics can help healthcare providers design more effective, respectful, and culturally sensitive maternal care programs. Collaboration between healthcare workers and traditional leaders can strengthen trust and improve service delivery in indigenous areas. Therefore, the study provides meaningful implications for public health policy, particularly in promoting culturally responsive healthcare interventions that respect local wisdom while ensuring maternal and child safety.

Despite its contributions, this study has several limitations. The qualitative ethnographic design focused on in-depth cultural understanding without quantitative analysis, so the findings cannot be generalized to a larger population. Some interviews were relatively brief, and the head of the customary council could not be directly interviewed, limiting representation. The researcher also faced personal and linguistic challenges and an imbalance in informant categories. Nonetheless, these limitations do not reduce the value of the study, which offers an authentic and context-rich understanding of cultural influences on pregnancy care and serves as a basis for future research and culturally appropriate health policies.

### Relevance to Practice

The findings of this study can be directly applied to improve culturally sensitive maternal care within indigenous communities. Healthcare professionals, particularly midwives and nurses, can incorporate local cultural values and traditional beliefs into health education, counseling, and antenatal care to enhance trust and patient engagement. Integrating traditional leaders and birth attendants in maternal health programs allows for culturally respectful collaboration that aligns modern medical practices with community traditions. Institutions and policymakers should develop training programs for healthcare workers on local customs, taboos, and communication styles to ensure respectful and effective service delivery. By adopting these culturally informed approaches, maternal health initiatives can become more inclusive, accepted, and effective in reducing risks and improving outcomes for mothers and infants in culturally diverse settings.

### Conclusion

This study aimed to explore cultural beliefs and pregnancy care practices among the Dayak Kenyah community in Busang District, Kutai Timur, and found that maternal behaviors and healthcare decisions are strongly shaped by dietary taboos, activity restrictions, spiritual rituals, and community norms. These findings underscore the significance of culture as a central framework through which pregnancy is understood and managed, influencing how women navigate both traditional practices and formal healthcare services. The key implication is that future maternal health efforts should prioritize culturally sensitive approaches that acknowledge and work with local beliefs rather than dismissing them. Integrating traditional practices with formal healthcare systems is therefore essential to enhance service utilization, strengthen trust between healthcare providers and communities, and improve maternal and neonatal outcomes in indigenous settings.

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### CrediT Authorship Contributions Statement

**Tuti Meihartati:** Conceptualization, methodology design, data analysis, literature review, supervision and critical revision of the manuscript.

**Ringgit:** Conceptualization, data collection, validation of findings and manuscript drafting.

**Sumiati:** Supervision, field coordination, community engagement, and validation of findings.

**Aries Abiyoga:** Supervision, field coordination, community engagement, and validation of findings, critical revision of the manuscript

## Conflicts of Interest

The authors declare no conflict of interest related to this study.

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