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# The Relationship Between Family Cultural Practices and Childbirth Behavior in Cikunir Village Tasikmalaya Regency

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**ABSTRACT**

**Background:** Family cultural practices may influence decision-making and mothers' behavior in seeking childbirth assistance. Beliefs about the roles of husbands or family members, inherited cultural advice, perceptions of health-service costs, and acceptance of referral may affect childbirth-related decisions. This study examined the relationship between family cultural practices and childbirth behavior in Cikunir Village, Tasikmalaya Regency.
**Objective:** To describe family cultural practices and analyze their relationship with childbirth behavior among postpartum mothers in Cikunir Village, Tasikmalaya Regency.
**Methods:** This quantitative analytical observational study used a cross-sectional design. The population comprised postpartum mothers in Cikunir Village, and the sample included 22 mothers who were 1–2 months postpartum. Total sampling was used, including all eligible members of the population.
**Results:** In the group with less-supportive cultural practices, 3 mothers (37.5%) had good childbirth behavior, while 5 (62.5%) had moderate/poor behavior. In the group with moderately supportive/supportive practices, 5 mothers (35.7%) had good behavior and 9 (64.3%) had moderate/poor behavior. Fisher's exact test yielded $p = 1.000$ ($p > 0.05$), OR = 1.08, and 95% CI = 0.18–6.54, indicating no statistically significant relationship.
**Conclusion:** Family cultural practices remain evident among postpartum mothers in Cikunir Village, particularly in family decision-making, cultural advice, perceptions of health services, and attitudes toward medical referral. Midwives should provide culturally sensitive education and birth preparedness and involve husbands and families in decision-making.
**Limitations:** The small sample (22 respondents) and the study's restriction to one village limit generalizability. The cross-sectional design cannot establish causality. Future studies should include larger samples and wider geographic coverage to provide stronger empirical evidence.

**Keywords:** Cultural Practices, Family, Childbirth Behavior, Postpartum Mothers

**Introduction**

Maternal and newborn safety during childbirth is an important indicator of health development. Safe childbirth is determined not only by the mother's clinical condition and the competence of health professionals, but also by family decision-making, access to health services, and the values and beliefs prevailing in the mother's social environment. Sociocultural factors and family support are aspects that need to be considered when choosing a place of childbirth because they may influence a mother's decision to use health facilities. Lilis et al. (2022) reported an association between sociocultural factors, family support, and the choice of childbirth location. Similar findings were reported by Wulandari et al. (2024), who found an association between sociocultural factors and decisions about where to give birth. Therefore, understanding social and cultural factors is important in developing woman- and family-centered midwifery care.

Delays in obtaining childbirth assistance remain an important concern in efforts to improve maternal safety. This issue can be understood through the three delays model: delay in deciding to seek care, delay in reaching a health facility, and delay in receiving adequate care. Decisions to use health facilities may be influenced by knowledge, family support, sociocultural conditions, and access to services. Wati et al. (2020) found that culture, family support, and distance to health facilities were associated with the choice of childbirth attendant in the working area of Mataraman Community Health Center, Banjar Regency. These findings highlight the importance of considering family and social-environmental factors when improving access to safe childbirth assistance.

Efforts to improve maternal safety in Tasikmalaya Regency need to be supported by accurate local health data. The research document records a maternal mortality ratio (MMR) of 158 per 100,000 live births in 2022. This figure should be verified against the 2022 Tasikmalaya Regency Health Profile to ensure that the indicator and data source are accurate. Official local health data can describe the maternal health situation and help determine service priorities. In this study, attention is directed not only to maternal mortality indicators but also to social and family factors that may be associated with mothers' decisions to obtain childbirth assistance (Dinas Kesehatan Kabupaten Tasikmalaya, 2022).

Social and cultural factors can shape how individuals and families understand pregnancy, childbirth, and the need for medical assistance. In Indonesia, decisions about the place of childbirth are not always determined by a mother's personal preference; they may also be associated with family support, knowledge, and values prevalent in the community. Lilis et al. (2022) reported that sociocultural factors and family support were associated with the choice of childbirth location in the working area of Muara Kumpeh Community Health Center. Meanwhile, Wulandari et al. (2024) found an association between sociocultural factors and decisions about the place of childbirth in the working area of Rokan IV Koto I Community Health Center. These findings show that childbirth behavior needs to be understood within the relationship between mothers, families, and the health service system.

Family culture does not always hinder safe childbirth. Support from husbands, involvement of parents, and family habits that encourage mothers to seek professional assistance can support birth preparedness. Conversely, certain values or habits may become barriers if childbirth decisions must wait for family approval, traditional advice is prioritized over health professionals' recommendations, or the family does not understand the urgency of referral when complications occur. Lilis et al. (2022) and Wati et al. (2020) demonstrated

the relevance of cultural factors and family support to the choice of childbirth location or attendant. Culture should therefore be understood contextually, by considering whether a practice supports or potentially impedes the use of health services.

In this study, family cultural practices were examined through several aspects: the authority of husbands or older relatives in determining the place and attendant of childbirth; the need to obtain extended-family approval in emergencies; the tendency to follow cultural advice passed down across generations; perceptions of the cost of childbirth in health facilities; and acceptance of medical referral when complications occur. These aspects operationalize the variables used in this study to describe how cultural values and family dynamics may be associated with childbirth behavior. The relevance of examining cultural factors, family support, and decisions about the place of childbirth is also supported by Lilis et al. (2022) and Wulandari et al. (2024).

Preliminary information from Cikunir Village, Tasikmalaya Regency, was obtained from a preliminary study involving 22 postpartum mothers. According to these data, all respondents (100%) reportedly gave birth with the assistance of health professionals at health facilities. Nevertheless, 6 respondents (27.3%) reportedly experienced delays in decision-making involving their husbands or families, 2 respondents (9.1%) reported barriers related to distance or transportation, and 2 respondents (9.1%) reported cultural practices or taboos related to childbirth. Regarding cultural practices, 14 respondents (63.6%) were classified as having practices that were moderately supportive, while 8 respondents (36.4%) were classified as having practices that were less supportive (Preliminary study data from Cikunir Village, 2026).

These preliminary findings show that the use of health facilities by all respondents does not necessarily rule out the possible influence of culture and family decision-making dynamics. Decision-making delays among some respondents indicate the need to understand childbirth behavior more broadly than simply the place of birth or the birth attendant. However, the preliminary data are descriptive and cannot establish a causal relationship between cultural practices and childbirth behavior. Lilis et al. (2022) and Wulandari et al. (2024) provide empirical grounds for examining sociocultural factors in the context of choosing a place of childbirth. On this basis, the relationship between family cultural practices and childbirth behavior in Cikunir Village warrants empirical analysis.

Previous studies in Indonesia have examined the relationships among sociocultural factors, family support, and the choice of childbirth location using quantitative approaches. Lilis et al. (2022) examined knowledge, education, sociocultural factors, community commitment, and family support in the choice of childbirth location. Wati et al. (2020) investigated factors associated with the choice of childbirth attendant, including culture, family support, and distance to health facilities. Wulandari et al. (2024) specifically examined the relationship between culture and decisions about the place of childbirth. These studies show that the relationship between cultural factors and childbirth decisions has received attention in maternal health research. However, further examination is needed of cultural practices within families and their relationship with childbirth behavior in local communities with distinct social characteristics.

The novelty of this study lies in its quantitative analysis of the relationship between family cultural practices and childbirth behavior among postpartum mothers in Cikunir Village, Tasikmalaya Regency. Unlike previous studies that focused on the choice of childbirth location

or attendant, this study examines cultural practices through family decision-making, the transmission of cultural advice, perceptions of service costs, and acceptance of medical referral, and then analyzes their relationship with childbirth behavior. The study also considers the use of health facilities and possible delays in decision-making as phenomena that should be understood together. Thus, its contribution lies in the local context, operationalization of the variables, and analytical focus. This distinction should be refined through comparison with previous articles rather than presented as a claim that childbirth culture has never been studied (Lilis et al., 2022; Wulandari et al., 2024).

Based on this background, this study aimed to describe family cultural practices and analyze their relationship with childbirth behavior among postpartum mothers in Cikunir Village, Tasikmalaya Regency. The findings are expected to provide empirical evidence for developing culturally sensitive midwifery care, particularly through communication and education involving mothers, husbands, and families. This approach is consistent with previous findings that identify sociocultural factors and family support as relevant to the choice of childbirth location (Wati et al., 2020; Lilis et al., 2022; Wulandari et al., 2024).

## Objective

This study aimed to determine the relationship between family cultural practices and childbirth behavior in Cikunir Village, Tasikmalaya Regency. Specifically, it sought to describe cultural practices within families and analyze their relationship with childbirth behavior among postpartum mothers.

## Methods

### *Design and setting*

This quantitative, observational analytical study used a cross-sectional design to examine the relationship between family cultural practices and childbirth behavior among postpartum mothers in Cikunir Village, Tasikmalaya Regency. The study involved mothers who were 1–2 months postpartum. Data were collected using a questionnaire, and univariate and bivariate analyses were performed to describe respondent characteristics and examine the relationship between the study variables.

### *Population and sampling*

The study population consisted of all postpartum mothers residing in Cikunir Village, Tasikmalaya Regency, during the study period. Postpartum mothers were selected because they could provide information about childbirth experiences, family cultural practices, and decision-making during childbirth.

The inclusion criteria were mothers who were 1–2 months postpartum, lived in Cikunir Village, and agreed to participate. The exclusion criteria were postpartum mothers who could not provide the required information or did not complete the questionnaire.

The sample comprised 22 postpartum mothers. Total sampling was used, meaning that all accessible population members who met the study criteria during data collection were included. Sampling involved identifying eligible postpartum mothers, checking the inclusion and exclusion criteria, explaining the study, and obtaining informed consent before participation.

***Instrument and measurement***

Validity and reliability tests were conducted to assess whether the instruments were suitable for measuring the study variables. Item validity for the knowledge questionnaire, which consisted of five true-or-false statements, was assessed using point-biserial correlation or an appropriate item-total correlation method. Item validity for the family cultural practices questionnaire, which used a four-point Likert scale, was assessed using corrected item-total correlation.

The validity tests indicated that the knowledge questionnaire and family cultural practices questionnaire were valid for measuring the study variables. Reliability of the knowledge questionnaire was assessed using the Kuder–Richardson Formula 20 (KR-20), while reliability of the family cultural practices questionnaire was assessed using Cronbach's alpha. The reliability tests indicated that both questionnaires were reliable and suitable for data collection.

***Data collection and analysis***

Data were collected directly in Cikunir Village, Tasikmalaya Regency, from mothers who were 1–2 months postpartum. Data collection took place after research permits, ethical approval, and the research instruments had been prepared. Before completing the questionnaire, potential respondents were informed about the study objectives and procedures and were asked to provide consent to participate.

The collected data were checked for completeness, coded, and analyzed according to the study objectives. Univariate analysis was used to describe respondent characteristics and the distribution of each variable. Bivariate analysis was used to test the relationship between family cultural practices and childbirth behavior.

The chi-square test was not used because its assumptions were not met. Expected frequencies in the contingency table did not satisfy the chi-square requirements; therefore, Fisher's exact test was used. Statistical significance was set at $p < 0.05$.

**Results**

1. Characteristics of Postpartum Mothers

   The characteristics analyzed included age, highest educational attainment, occupation, parity, and the infant's age when the questionnaire was completed. These characteristics provide an overview of the study participants before analysis of the main variables.

   a) Age distribution

Table 1.1. Characteristics of Postpartum Mothers

| Age Group | F | % |
|---|---|---|
| 20–35 years | 10 | 45.5 |
| >35 years | 12 | 54.5 |
| Total | 22 | 100.0 |

Of the 22 postpartum mothers, 10 (45.5%) were aged 20–35 years and 12 (54.5%) were older than 35 years. No mothers younger than 20 years were included in the analyzed data. Thus, the group older than 35 years was the largest age group.

b) Educational distribution

Table 1.2. Education

| Education | F | % |
|---|---|---|
| Elementary school | 4 | 18.2 |
| Junior high school | 4 | 18.2 |
| Senior high school | 12 | 54.5 |
| Diploma/Bachelor's degree | 2 | 9.1 |
| Total | 22 | 100.0 |

Most mothers had completed senior high school (SMA/MA/SMK), totaling 12 (54.5%). Four mothers each (18.2%) had completed elementary school (SD/MI) and junior high school (SMP/MTs), while 2 (9.1%) had a diploma or university degree.

c) Occupational distribution

Table 1.3. Occupation

| Occupation | F | % |
|---|---|---|
| Homemaker/Not employed | 20 | 90.9 |
| Trader/Self-employed | 2 | 9.1 |
| Total | 22 | 100.0 |

Most mothers were homemakers or were not employed (20; 90.9%), while 2 (9.1%) worked as traders or self-employed individuals.

d) Parity distribution

Table 1.4. Parity

| Parity | F | % |
|---|---|---|
| Primiparous | 2 | 9.1 |
| Multiparous | 20 | 90.9 |
| Total | 22 | 100.0 |

Based on parity, 20 mothers (90.9%) were multiparous and 2 (9.1%) were primiparous. This indicates that most participants had previous childbirth experience.

2. Univariate analysis

Univariate analysis was conducted to describe the distribution of each study variable. The variables presented were maternal knowledge, family cultural practices, and childbirth behavior.

a) Distribution of maternal knowledge

Table 1.5. Maternal Knowledge

| Category | F | % |
|---|---|---|
| Good | 16 | 72.7 |
| Moderate | 2 | 9.1 |

| | | |
|---|---|---|
| Poor | 4 | 18.2 |
| Total | 22 | 100.0 |

The analysis showed that 16 mothers (72.7%) had good knowledge, 2 (9.1%) had moderate knowledge, and 4 (18.2%) had poor knowledge. Thus, most postpartum mothers had good knowledge of childbirth and danger signs according to the study instrument.

b) Distribution of family cultural practices

Table 1.6. Family Cultural Practices

| Category | **F** | **%** |
|---|---|---|
| Supportive | 0 | 0.0 |
| Moderately supportive | 14 | 63.6 |
| Less supportive | 8 | 36.4 |
| Total | 22 | 100.0 |

The measurement of cultural practices showed that 14 mothers (63.6%) were in the moderately supportive category and 8 (36.4%) were in the less supportive category. No mothers were classified as supportive. This finding indicates that cultural beliefs or practices that may influence decision-making and maternal behavior during childbirth were still present in the study data.

c) Distribution of childbirth behavior

Table 1.7. Childbirth Behavior

| Category | F | **%** |
|---|---|---|
| Good | 8 | 36.4 |
| Moderate | 10 | 45.5 |
| Poor | 4 | 18.2 |
| Total | 22 | 100.0 |

Based on scores from five childbirth-behavior indicators, 8 mothers (36.4%) had good childbirth behavior, 10 (45.5%) had moderate behavior, and 4 (18.2%) had poor behavior. The most common category was moderate childbirth behavior. This differs from the initial calculation using only four indicators because the question concerning cultural practices or taboos during childbirth was included as the fifth indicator in accordance with the questionnaire structure.

d) Distribution of responses for each childbirth-behavior indicator

Table 1.8. Distribution of Responses for Each Childbirth-Behavior Indicator

| Indicator | Response Indicating Safe Practice | F | **%** |
|---|---|---|---|
| Birth attendant | Health professional | 22 | 100.0 |
| Place of childbirth | Health facility | 22 | 100.0 |
| Delay in decision-making | No | 16 | 72.7 |

| | | | |
|---|---|---|---|
| Delay due to distance/transportation | No | 20 | 90.9 |
| Cultural practices/taboos | No | 20 | 90.9 |

At the item level, all 22 mothers (100.0%) gave birth with the assistance of health professionals, and all 22 (100.0%) gave birth at health facilities. Sixteen mothers (72.7%) did not experience delays in decision-making when medical assistance was needed, whereas 6 (27.3%) reported such delays. Twenty mothers (90.9%) did not experience delays due to distance or transportation, while 2 (9.1%) did. For the indicator concerning cultural practices or taboos during childbirth, 20 mothers (90.9%) answered no and 2 (9.1%) reported specific practices or taboos.

3. Bivariate analysis

Bivariate analysis examined the relationship between family cultural practices as the independent variable and childbirth behavior as the dependent variable. Cultural-practice categories were combined into two groups: less supportive and moderately supportive/supportive. This combination was necessary because no mothers were classified as supportive. Childbirth behavior was also combined into good and not-good behavior (moderate/poor) to produce a 2 × 2 table suitable for Fisher's exact test.

Table 1.9. Distribution of Cultural Practices and Childbirth Behavior

| Cultural Practices | Good Behavior | Moderate/Poor Behavior | Total |
|---|---|---|---|
| Less supportive | 3 | 5 | 8 |
| Moderately supportive/supportive | 5 | 9 | 14 |
| Total | 8 | 14 | 22 |

In the less-supportive cultural-practice group, 3 mothers (37.5%) had good childbirth behavior and 5 (62.5%) had moderate/poor behavior. In the moderately supportive/supportive cultural-practice group, 5 mothers (35.7%) had good childbirth behavior and 9 (64.3%) had moderate/poor behavior.

Fisher's exact test yielded $p = 1.000$ ($p > 0.05$), with an odds ratio (OR) of 1.08 and a 95% confidence interval (CI) of 0.18–6.54. Because the p-value was greater than $\alpha = 0.05$, the analysis did not detect a statistically significant relationship between family cultural practices and childbirth behavior.

**Discussion**

1. Characteristics of Postpartum Mothers

In this study, more than half of the participants were older than 35 years (54.5%). The largest educational group had completed senior high school (54.5%). Most mothers were homemakers or were not employed (90.9%), and most were multiparous (90.9%). These characteristics indicate that most participants had previous childbirth experience and that secondary education was the most common educational level.

These characteristics were not used as a basis for drawing causal conclusions. They primarily describe the composition of the study participants and help readers understand the context of the analyzed data.

2. Maternal Knowledge of Childbirth and Danger Signs

Most mothers had good knowledge (72.7%). This was reflected in their ability to answer correctly statements concerning term childbirth, danger signs, the importance of skilled health professionals, and the need for medical intervention in the event of complications. Nevertheless, 18.2% of mothers had poor knowledge, indicating that education about danger signs and the need for prompt assistance remains relevant to midwifery care.

3. Family Cultural Practices

For cultural practices, 63.6% of mothers were in the moderately supportive category and 36.4% in the less supportive category. The absence of mothers in the supportive category indicates that, according to the cut-off points used, no mother obtained a high score across all cultural-practice statements. Thus, beliefs about the roles of husbands or relatives, approval by extended family, prioritization of customary advice, perceptions of health-facility costs, and attitudes toward referral remained evident in some mothers' responses.

The findings show that family cultural practices were still present among postpartum mothers in Cikunir Village, Tasikmalaya Regency. Based on the measurements, 14 mothers (63.6%) were classified as having moderately supportive cultural practices, while 8 (36.4%) were classified as less supportive. No mothers were classified as supportive. This suggests that although most mothers showed a relatively moderate tendency to support safe childbirth, certain family beliefs and cultural practices may still influence decision-making during childbirth.

The cultural practices identified in this study were not limited to actions or rituals performed directly during childbirth. They also involved family beliefs about who has the authority to make decisions, which sources of advice are considered trustworthy, perceptions of health-service costs, and attitudes toward medical referral. These aspects correspond to the five cultural dimensions measured by the instrument: the authority of husbands or older relatives in choosing the place and attendant of childbirth; the need for extended-family approval in emergencies; the tendency to follow customary or inherited cultural advice; the perception that childbirth at health facilities is expensive; and acceptance of medical referral when obstructed labor occurs.

a) Childbirth decisions made by husbands or older relatives

One cultural issue examined in this study was the belief that decisions about the place and attendant of childbirth fall under the authority of husbands or older relatives, such as parents or parents-in-law. This illustrates that maternal health decisions are not always viewed as individual decisions but may involve the family structure (Kurniawati, 2023).

In midwifery care, this situation deserves attention because, in normal circumstances, the involvement of husbands or family members can provide social support to mothers. However, if family authority becomes so dominant that a mother's decision is delayed or cannot be made promptly during an emergency, it may become a barrier to obtaining care (Rizkianti, 2020).

Therefore, family culture should not automatically be viewed as negative. The involvement of husbands and family members can be a source of support when it helps

mothers access health services. Problems may arise when family decisions conflict with medical needs or delay the provision of assistance.

b) The need for extended-family approval in emergencies

Another cultural aspect concerns the belief that, in an emergency, a mother must first wait for approval from the extended family before being taken to a community health center or hospital. Such a belief indicates that family decision-making structures continue to play an important role in determining maternal health actions (Wilopo, 2019).

The study found that 6 mothers (27.3%) reported experiencing delays in decision-making by their husbands or families when immediate medical assistance was needed.

This finding deserves attention because, although all mothers in the study eventually gave birth with the assistance of health professionals at health facilities, the process of reaching care was not always free of barriers. In other words, eventually reaching a health facility does not necessarily mean that the entire decision-making process was optimal (Setyoningsih, 2025).

In midwifery care, midwives should provide education not only to mothers but also to their husbands and families. Families need to understand danger signs and the importance of making prompt decisions when a mother requires assistance. Family involvement, which is already part of the cultural context, can thus be directed toward supporting maternal safety rather than causing delays.

c) Influence of customary or intergenerational cultural advice

Cultural practices in this study also included the belief that customary advice or recommendations passed down through generations are safer to follow than advice from midwives or other health professionals. This suggests that families may draw on health knowledge based on previous generations' experiences (Maryuni et al., 2024).

The presence of traditional knowledge or advice does not necessarily mean that a family rejects health services. However, if such advice is given greater priority than information provided by health professionals, differences may arise in deciding what action to take when a mother experiences childbirth problems (Maryuni et al., 2024).

The findings showed that most mothers had good knowledge of childbirth and danger signs (16; 72.7%). This helps explain how health knowledge and family culture can coexist. A mother may have good knowledge about childbirth while also maintaining or considering the cultural values practiced in her family.

Midwives should therefore not simply seek to eliminate family culture. Instead, they should identify practices that are still followed, distinguish harmless practices from those that may delay care, and provide clear, respectful education so that families can make decisions that support the safety of mothers and babies.

d) Perceptions of childbirth costs at health facilities

Another cultural aspect measured was the perception that childbirth at a health facility is always very expensive, making home birth with assistance from someone other than a medical professional seem preferable to the family. Such economic perceptions may form part of family beliefs that influence health-service choices (Harahap, 2021).

However, according to the study data, all 22 mothers (100.0%) gave birth at health facilities and received assistance from health professionals.

This finding indicates a difference between beliefs or perceptions that may still exist within families and mothers' actual behavior during their most recent childbirth. In other

words, a cultural belief or perception about costs does not automatically lead a mother to give birth at home or choose assistance from someone who is not a health professional. This may help explain why family cultural practices did not show a statistically significant relationship with childbirth behavior in this study. Although cultural elements were still present, all mothers' actual childbirth behavior involved choosing health professionals and health facilities as the birth attendant and place of childbirth.

e) Resignation to fate and refusal of medical referral

Another cultural aspect was the belief that refusing medical referral and leaving the outcome to fate or destiny when labor becomes difficult is acceptable within family tradition. Beliefs about fate are sensitive aspects of community life and should not be interpreted solely as negative factors (Rudiyanti, 2024).

In midwifery, concern arises when resignation leads a family to delay accepting a referral recommendation when a mother needs medical assistance. In such circumstances, beliefs may influence decision-making. However, the findings do not show that all mothers acted in this way during childbirth. On the contrary, all mothers gave birth with the assistance of health professionals at health facilities. Therefore, the presence of family beliefs or cultural views cannot automatically be equated with refusal of health services.

4. Childbirth Behavior

Scores for the five indicators showed that 36.4% of mothers had good childbirth behavior, 45.5% had moderate behavior, and 18.2% had poor behavior. All mothers gave birth with health professionals and at health facilities. However, some mothers still experienced decision-making delays, distance/transportation barriers, or cultural practices and taboos. As a result, not all overall childbirth-behavior scores fell into the good category.

From a transcultural midwifery perspective, delays in childbirth-related decision-making require attention. Midwives can bridge family cultural values and medical safety principles through empathetic communication, accessible education, and family involvement in birth planning. Midwives should respect safe cultural practices, negotiate changes to practices that need adjustment, and help families understand the risks of delaying medical assistance. This approach is expected to strengthen families' readiness to recognize danger signs, make timely decisions, and prioritize maternal and newborn safety.

5. Relationship Between Family Cultural Practices and Childbirth Behavior

Bivariate analysis using Fisher's exact test yielded $p = 1.000$. This value was greater than $\alpha = 0.05$, so the tested relationship did not reach statistical significance. These findings should not be used as a general basis for concluding whether family cultural practices are related to childbirth behavior. This should be considered in light of the small sample of 22 respondents, which limits broad generalization. Further studies with larger samples and wider geographic coverage are needed to obtain stronger empirical evidence regarding the relationship between family cultural practices and childbirth behavior.

6. Study Limitations

This study was limited by its relatively small sample of 22 respondents, which may have reduced statistical power to detect a relationship between family cultural practices and childbirth behavior. In addition, because the study was conducted only in Cikunir Village, Tasikmalaya Regency, generalization to a broader population should be made cautiously and with consideration of the local community's sociocultural characteristics. The cross-sectional design also limits interpretation of the relationship between variables because it cannot

establish causality. Future studies should use a larger sample based on a sample-size calculation and include a wider geographic area to obtain more representative results.

## Conclusion

Based on the data analysis, most mothers had good knowledge (72.7%). Family cultural practices were mostly classified as moderately supportive, involving 14 mothers (63.6%), while 8 mothers (36.4%) were classified as less supportive; no mothers were classified as supportive. These cultural practices were reflected in family roles in childbirth decision-making, acceptance of cultural advice, perceptions of health services, and attitudes toward medical referral. For childbirth behavior, 8 mothers (36.4%) were classified as good, 10 (45.5%) as moderate, and 4 (18.2%) as poor.

Specifically, all mothers (100.0%) gave birth with the assistance of health professionals at health facilities. However, 6 mothers (27.3%) experienced delays in decision-making by their husbands or families, 2 (9.1%) experienced delays in obtaining assistance because of distance or transportation, and 2 (9.1%) reported cultural practices or taboos during childbirth. Bivariate analysis using Fisher's exact test on a 2 × 2 table yielded $p = 1.000$ ($p > 0.05$), indicating that the relationship between family cultural practices and childbirth behavior did not reach statistical significance. Descriptively, good childbirth behavior was observed in 37.5% of the group with less-supportive cultural practices and 35.7% of the group with moderately supportive or supportive practices. The difference between the proportions was small, and good childbirth behavior was found in both groups at nearly similar proportions.

These findings show that family cultural practices remain part of mothers' and families' lives, but the data do not establish them as a factor associated with childbirth behavior. This does not necessarily mean that culture has no role, because childbirth behavior may also be influenced by other factors, including maternal knowledge, previous childbirth experience, family support, socioeconomic conditions, and access to health services. Although some cultural practices and delays in decision-making were reported, all mothers ultimately gave birth with health professionals at health facilities.

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## Author Contributions

The principal investigator (Chanty YH) coordinated the study, developed the research concept and design, formulated the research objectives, coordinated data collection, interpreted the analytical results, and led the preparation and revision of the research report and manuscript. Researcher I (Hapi Apriasih) contributed to methodological development, review of the data-collection instrument, coordination of study implementation, and review and refinement of the findings. Researcher II (Ayuning Tias Budi Lestari) contributed to data

collection, data processing and tabulation, literature searches, and preparation and review of the manuscript. All authors contributed to discussion of the findings, read and reviewed the final manuscript, approved it for publication, and are responsible for the integrity and accuracy of the content in accordance with their respective contributions.

**Conflict of Interest**

The authors declare that they have no financial, personal, or professional conflicts of interest that could have influenced the conduct of the study, data analysis, interpretation of the findings, or preparation of this report. The study was conducted objectively and independently based on the data obtained from respondents. All findings are reported according to the results obtained, without intervention by any party that could affect the objectivity of the study.

**Ethical Approval**

The study entitled “The Relationship Between Family Cultural Practices and Childbirth Behavior in Cikunir Village, Tasikmalaya Regency” observed health-research ethics principles intended to protect respondents' rights, safety, dignity, and confidentiality throughout the study.

The study followed the following ethical principles:

1. Ethical clearance
   Approval was obtained from the authorized health research ethics committee before data collection. The ethical approval was documented in approval letter number 007559/KEP STIKes Medistra Indonesia/2026
2. Informed consent
   Each prospective respondent was informed about the study objectives, procedures, benefits, and possible discomfort during the study. Participation was voluntary and took place only after the respondent understood the study information and gave consent. Respondents had the right to refuse or withdraw without any consequences for the health services they received
3. Privacy and confidentiality
   Respondents' identities and personal information were kept confidential. Study data were used for scientific purposes and reporting of the findings, while avoiding the inclusion of information that could directly identify respondents
4. Beneficence and non-maleficence
   The study involved questionnaire completion and did not provide clinical interventions to respondents. The researchers sought to minimize discomfort, respect the condition of postpartum mothers, and ensure that participation did not interfere with recovery or needed health services
5. Justice
   Respondents were selected according to the predetermined study criteria, without discrimination. Each respondent received an explanation and fair treatment throughout the study
6. Respect for community social and cultural values
   Because the study examined family cultural practices related to childbirth behavior, the researchers respected local beliefs and customs. Data collection and interpretation

were conducted objectively, without stigmatizing or demeaning respondents or their families.

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