

"I am just what was bought": A qualitative study on the configuration of social pressure and biblical interpretation on women's health

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Fotarisman Zaluchu^{1*} and Cashtri Meher²

Social Anthropology Department, Universitas Sumatera Utara, Indonesia¹; Faculty of Medicine, Universitas Islam Sumatera Utara, Indonesia²

*For Correspondence: Email: fotarisman.zaluchu@usu.ac.id

Abstract

One of the key factors contributing to poor health outcomes among women is the persistent prevalence of gender inequity, which relegates women to a marginalized position within their communities. This condition is reinforced by deeply rooted cultural traditions, particularly those associated with marriage, which impose long-lasting consequences on women's lives post-marriage. This paper draws from the authors' experiences conducting health research and health interventions in Nias Island, Indonesia. A total of 30 mothers with children under five, who participated in health education sessions, were interviewed six times. We also gathered information from mothers-in-law, husbands, midwives, and religious leaders in the study area. Through interactions with social agents from the Nias community, the study reveals the severe challenges faced by Nias women regarding their health, the neglect of their health priorities, and the formidable difficulties they encounter in escaping the constraints of norms that regulate both their thoughts and bodies. (*Afr J Reprod Health 2025; 29 [10]: 109-117*).

Keywords: gender; norms; bodily control; women's reproductive health

Résumé

L'un des principaux facteurs contribuant aux mauvais résultats en matière de santé chez les femmes est la prévalence persistante des inégalités entre les sexes, qui les marginalise au sein de leurs communautés. Cette situation est renforcée par des traditions culturelles profondément ancrées, notamment celles liées au mariage, qui ont des conséquences durables sur la vie des femmes après le mariage. Cet article s'appuie sur l'expérience des auteurs en matière de recherche et d'interventions sanitaires sur l'île de Nias, en Indonésie. Trente mères d'enfants de moins de cinq ans, ayant participé à des séances d'éducation sanitaire, ont été interrogées à six reprises. Nous avons également recueilli des informations auprès de belles-mères, de maris, de sages-femmes et de chefs religieux de la zone d'étude. Grâce aux interactions avec les acteurs sociaux de la communauté de Nias, l'étude révèle les graves difficultés rencontrées par les femmes de Nias en matière de santé, la négligence de leurs priorités en matière de santé et les formidables difficultés qu'elles rencontrent pour échapper aux contraintes des normes qui régissent leurs pensées et leur corps. (*Afr J Reprod Health 2025; 29 [10]: 109-117*).

Mots-clés: : genre; normes; contrôle corporel; santé reproductive des femmes

Introduction

Reproductive health is defined by the World Health Organization (WHO) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”.¹ If this definition serves as the reference, then women's reproductive health must be comprehensive. It extends beyond the provision of healthcare facilities by the government to include the elimination of all forms of “gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion,

exploitation, and gender-based violence” against women.²

Women's health status is significantly influenced by the social determinants of health.³ Extensive scientific evidence highlights the socio-cultural relationships impacting women's health across various stages of their lives. For example, in their research, D'Ambruoso *et al.*⁴ explain that healthcare services operate within “cultural landscapes” where their utilization is largely determined by awareness, willingness to seek care, and factors related to the health status of pregnant women. These cultural landscapes also reveal that women's health decisions are often made by others,

delaying necessary assistance during critical moments when women are most in need.⁵

The tragic fates of two pregnant women in Pakistan, Shida and Zainab, who died during childbirth, illustrate this stark reality. Their deaths could not be prevented because they belonged to the lowest caste, were poor, socially inferior, and, most importantly, because they were “just” women.⁶ Similarly, a daughter-in-law in another context was powerless to refuse her mother-in-law's decision to give birth with a traditional healer, despite the risks to her own health. She lacked the autonomy to reject this choice.⁷ Gender-based discrimination continues to restrict women's rights to access healthcare services and make decisions about their own health.⁸

Countries in Asia and Africa generally still have various traditions linked to the poor conditions experienced by women. This is reflected in the maternal mortality, a key indicator representing women's health, which continues to be dominated by these two regions. The latest report from the WHO states that 87% of maternal deaths are contributed by these areas, despite decades of efforts to improve the situation.⁹ Therefore, although this research report may not originate from Africa, the profile of women presented in this paper will complement information from other regions in the global south.

One of the issues closely related to maternal health is stunting. Like many other countries in the global south, Indonesia is also struggling to address this problem, as the prevalence of stunting remains alarming. On average, 2 to 3 out of every 10 children under five years old in Indonesia still suffer from stunting.¹⁰

Between 2022 and 2024, we conducted health campaigns (training) on Nias Island focused on reducing stunting rates in Indonesia, supporting the Indonesian government's efforts to lower stunting prevalence to the target of 14% by 2024. Given the high prevalence of stunting on Nias Island,¹⁰ we assumed that this condition was closely linked to social factors, which are often overlooked and rarely addressed through government policies. Through interactions with various social agents in the field during the training sessions, this report reveals the severe challenges faced by Nias women concerning their health, the neglect of their health priorities, and the significant difficulties they encounter in breaking free from the constraints of

norms that regulate both their thoughts and bodies. The report on these activities has been published,¹¹ but it was limited to the methods of module development used. In this paper, the authors will present several narratives that reveal other compelling aspects. Few studies have explored how local religious interpretations and intergenerational norms sustain gender inequality, with profound impacts on women's health.

Methods

Research location

The setting of this research is Nias Island, located to the west part of Indonesia (Figure 1). The island is predominantly inhabited by the Nias ethnic group, which is classified as part of the Austronesian population, sharing genetic similarities with the indigenous people of Taiwan.¹² Nevertheless, the Nias people believe their ancestors descended from the heavens.¹³ This belief, passed down orally across generations, has shaped distinct customs and traditions that set the Nias apart from both the mainland Nias communities of Sumatra and other ethnic groups in Indonesia. The Nias people practice a strongly patrilineal tradition and adhere to rigid rituals, particularly in marriage customs.^{14,15}

Over the course of one year, we conducted a health education campaign targeting mothers with children under five. The education sessions were held in community halls or local churches closest to the participants' residences. After each education session, we gathered 30 participants to conduct Focus Group Discussions (FGDs).

Informants

A total of 30 informants participated in FGD. We conducted FGDs with them each time a training session concluded. The health training was carried out over six meetings with two-week intervals between sessions. After each training session, we gathered the participants for a one-hour discussion. The discussion questions focused on their lives, particularly their experiences within the family, with an emphasis on marriage and its consequences on their health. The FGD sessions were led by the first author and recorded using a mobile phone after obtaining consent from the participants. These 30 informants were training participants selected by a

local church in collaboration with the District Health Office. They were chosen based on proximity of residence and availability of time.

In addition to the FGD participants, we also gathered supplementary information from other sources. These additional sources included 10 mothers-in-law, 5 husbands of the FGD participants, 3 midwives working in the study area, and 3 religious leaders from the local community.

Topics

Given that the main informants were participants in the training activities, we chose not to complete all discussions in a single session. Instead, we selected discussion topics based on conditions that were relevant to the situation at the conclusion of each training session. The topics discussed included: their perspectives on their position and role as Nias women and daughters-in-law; their experiences at the time of marriage and their situation after moving into their in-laws' household; the social norms they believed were important to uphold; their understanding of the Bible in relation to their role as daughters-in-law; and various aspects of health.

Meanwhile, in the interviews with additional informants, we explored their views on norms related to women, wives, husbands, and the relationships between mothers-in-law and daughters-in-law, as well as between husbands and wives.

Data processing and analysis

The discussion recordings were transcribed verbatim. Since most discussions were conducted in the Nias language, the first author, a native of the Nias ethnic group, ensured the accuracy of the transcription. After transcription, the data were processed using NVivo software to generate initial coding by both authors. Once each author had completed the coding independently, the final coding framework was agreed upon. The authors then organized the emerging themes based on the agreed coding framework.

Ethics declarations

We obtained ethical approval from the Health Research Ethics Committee of the Faculty of

- Medicine, HKBP Nommensen University, with approval number 487A/KEPK/FK/VII/2023 that work under Helsinki Declaration procedure. Before

conducting the FGDs, we first obtained verbal informed consent from the participants. Verbal consent was preferred over written consent because most of the mothers were unable to read and write. We explained the purpose of our research and their right to decline participation or withdraw from the discussion at any time without any consequences.

Results

The main demographic characteristics of the FGD informants are presented in Table 1. After summarizing the themes from all respondents (main informants and additional informants), the configuration of the themes emerging from this study is presented in Figure 2. The three themes above are interconnected. This pattern can be observed in the research findings described below.

Theme 1: Nias women position

During the data collection, we encountered various unique narratives, two of which stood out: an interview with a mother-in-law and a discussion with a husband. The interview with the mother-in-law aimed to understand the normative constructs of the Nias ethnic group that might influence women's health. The underlying assumption was that the position of women within the household significantly impacts a woman's health, and a mother-in-law could serve as a valuable informant on such matters.

When we inquired about the position of Nias women within the family, the mother-in-law provided a startling response. She explained that a Nias wife should never oppose her husband but instead must submit completely to him. She referenced a biblical verse stating that the head of the wife is the husband, and the head of the husband is Christ. When we probed further, asking what would happen if a wife did not submit to her husband, the mother-in-law asserted that adherence to this principle is absolute and must be followed as a divine truth. Failure to comply, she argued, would lead to spiritual deviation as Christians.

Table 1: Main demographic profile of informants.

Demographic Profile	N
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Age	
<25	15
26-35	12
+36	3
Education	
No formal education	21
Elementary School	7
Junior High School	1
Senior High School	1
Age of the youngest child	
<1 years old	16
1-2 years old	9
3-5 years old	5

During the FGDs with the mothers, their narratives clarified the prevailing situation. One mother expressed,

"I know that I am merely a daughter-in-law. I am just someone who was bought." Another mother stated,
"I did not come to my in-laws' house on my own. They brought me to this house. Without them, I would not be here. Therefore, I must obey them."

An interview with the husband of one FGD participant provided another entry point for understanding the prevailing situation. When we asked the husband about the differences in the roles of husbands and wives, he stated, "a husband is the *ga'a* (older sibling), while the wife is the *akhi* (younger sibling). Since the *ga'a* is older, it is automatic that the *akhi* must obey the *ga'a*." When the first author asked what would happen if the *akhi* did not follow this rule, the husband replied, "As the *ga'a*, I would educate her in a kind manner. If that doesn't work, I would educate her with *tanga* (a beating)."

This response was particularly intriguing because the husband's narrative aligned with the argument of the mother-in-law mentioned earlier. Both narratives reveal a moral framework that is expected to be followed and upheld within the community, with direct or indirect implications for the lives of women, whether as daughters-in-law or as wives. What was expressed by both individuals represents the concrete reality of the prevailing social conditions, which persist to this day in many areas, including within the Nias ethnic group, which positions women as "those who are bought." This explanation will be further elaborated in the

following section. The weak position of women is revealed in the following story we encountered. During one of the sessions, a mother raised her hand and said, "can we also invite our mothers-in-law? The thing is, if we follow what is being taught here, and it differs from what our mothers-in-law understand, we might get scolded by them."

This statement was particularly insightful, as it highlighted the strong connection between health education and the configuration of social actors. It became evident that these mothers of young children operate within a network of relationships, including their interactions with their mothers-in-law, which significantly influence their ability to apply the knowledge they receive.

We discussed with FGD participants about the formation of this obedient morality. Almost all participants conveyed that they learned their position from a very young age. They explained that from an early age, Nias girls are taught to dream of happiness in their future family life. During the discussion, one participant shared that she was taught by her biological mother to

"behave well and work diligently so that you will be happy when you are married." Conversely, if a young Nias girl behaved poorly towards her parents, her mother would say,

"You will regret it later. If you get married and remain lazy and unproductive, you will suffer because your mother-in-law will scold you. You must change your bad behavior."

The information from FGD participants highlights how cultural norms are deeply embedded in the upbringing of Nias girls, preparing them from a young age to internalize expectations tied to their future roles within the family structure.

Not all participants express these ideas in precisely the same way, but verbatim narratives like these are still commonly heard as advice given to young and very young girls. Future happiness in family life is believed to be closely tied to their behavior in the present. To achieve this happiness, young girls are expected to begin practicing from an early age. It is therefore unsurprising that Nias girls are required to learn how to serve their families before marriage. They must be capable of doing tasks such as washing family clothes, fetching water



Figure 1: Indonesia and Nias Island

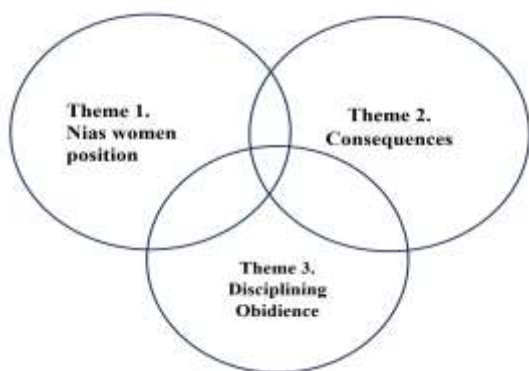


Figure 2: Research Themes

for daily needs, and tending to livestock. These activities are seen as training for their future roles in their own families. This transmission of norms is strict and prolonged, as Nias girls remain under their mothers’ supervision until they marry.

Since family norms are central to life, marriage is automatically regarded as the gateway to happiness. Forming a family does not necessarily require a foundation of love. Arranged marriages

between families are still quite common, especially in rural areas of Nias.

Some participants revealed that they had never even met their prospective husbands before their marriages were arranged. Parents of these women often convince their daughters that forming a family is their primary calling and must be pursued without delay. One participant stated that

“women who remain unmarried or are considered ‘late’ in getting married are viewed as a disgrace in this place. They are labeled as ‘unwanted,’ as no one is perceived to have shown interest in them.”

This stigma extends to their families, particularly their parents, who bear the shame of their daughter's unmarried status. Consequently, they submit to the family's decision to marry.

Ironically, marriage often takes precedence over education. During our health education sessions, we frequently encountered young mothers who were far too young to have children. On one occasion, we were particularly shocked to discover that one of the participants was only 16 years old, yet

she was already married—and, tragically, she was illiterate. This situation starkly illustrates the alarming impact of these norms on those who are subjected to them.

Theme 2: Consequences

The conditions that place women in such highly subordinate positions have far-reaching consequences. The lower status of women, both before and especially after marriage, significantly limits their autonomy. For instance, the young mother who asked us to include her mother-in-law in the health education sessions reflects her lack of autonomy—if not a complete absence of it. One FGD participant said,

“My mother-in-law holds a higher position because she is recognized as the woman who gave birth to her daughter-in-law's husband.” Another participant added, *“I must not oppose the woman who bought me.”* This statement echoes what was previously mentioned.

In Nias culture, there is a concept of dowry (*bōwō*). The mother-in-law is referred to as *“ina sowōli,”* which literally means *“the mother who buys.”* Meanwhile, the daughter-in-law is called *“bōli gana'a,”* meaning *“one bought with gold.”* Why use terms that carry transactional connotations? In practice, marriage in Nias indeed resembles an asset exchange. The bride's family hands over the bride, while the groom's family sacrifices their assets in the form of gold as a dowry to secure the bride. Before her son marries, the mother-in-law works hard with the family's assets, gathering money and gold for the dowry, which is then exchanged during the marriage ceremony. This transaction underpins the title *“bōli gana'a”* given to the daughter-in-law. The direct consequence of this cultural dynamic is the limited access of women to healthcare services and valuable health information for themselves and their children. In one interview, we encountered a young mother who had stopped exclusively breastfeeding her baby. Her explanation was striking: after giving birth, she had to return to work immediately to support her family's needs. If she didn't, she feared being labeled lazy and scolded by her mother-in-law. Returning to work so soon after childbirth left her no time to recover. When she had to leave her baby at home under the care of others, particularly her

mother-in-law, the door to substituting exclusive breastfeeding with other forms of feeding opened wide.

This lack of autonomy does not lead women to view their circumstances as unjust. For them, being a diligent worker is far more important than prioritizing their own health. Even when healthcare is accessible, traditional remedies are often preferred, as they are seen as less disruptive to their work routines. Agricultural labor, in particular, is closely tied to the family's future.

In some of the locations we visited, midwives expressed frustration over their inability to persuade mothers to attend ante-natal care (ANC). These health professionals struggled to find effective ways to encourage even basic health education participation. For many women, work and family obligations were far more important than healthcare. Adherence to these norms has led many Nias women to neglect their own health. They often work relentlessly on family assets, as being the backbone of the family takes precedence over their well-being.

Theme 3: The discipline of Obedience

The situation is even more challenging for Nias women. Many endure physical violence from their own husbands. An unpublished report from an NGO working on Nias Island revealed that they had recorded dozens of domestic violence cases within a single year. This indicates significant difficulties in fostering mutual respect between partners, particularly in a context where hierarchical structures are so deeply entrenched.

Another participant shared an experience about her neighbor:

“My friend is often beaten by her husband. Her husband gets angry if his afternoon nap is disturbed by their baby's crying. He thinks his wife is incapable of taking care of the child. When she complained to her mother-in-law, her mother-in-law said, 'Just be patient. The Holy Spirit will come into your husband's heart. That's what she said.'”

This story vividly illustrates the heavy burden placed on women. On one hand, they are expected to fulfill the moral obligations imposed upon them, while on the other, both the mother-in-law and the husband act as enforcers of those moral standards.

Both parties—the mother-in-law and the husband—believe they hold authority over the

woman. Through the concept of *bōli gana'a*, the mother-in-law assumes a position of privilege over her daughter-in-law. She dictates what behaviors are expected, continuing the moral guidance that the daughter-in-law's biological mother instilled over many years.

The traditions governing Nias women have largely persisted to this day, sustained not only by social configurations but also by subjective interpretations drawn from scripture. Biblical verses are selectively chosen and intentionally used to uphold the status quo, reinforcing gender-biased norms within the community.

The Bible verse cited by the mother-in-law is 1 Corinthians 11:3, which is a letter from Paul stating,

"But I want you to realize that the head of every man is Christ, and the head of the woman is man, and the head of Christ is God."

Meanwhile, the verse often referenced by men comes from the story of human creation. In Genesis 2:21 and 23, it is described that woman was created from the rib of man. This appears to suggest a sequence of creation where man is "older" than woman.

The undeniable fact is that the misuse of biblical verses stems from subjective manipulations aimed at demeaning women. The actions of the mother-in-law and husband discussed earlier, highlights the entrenched nature of gender injustice that directly or indirectly impacts women's health. This understanding is perpetuated across generations, in line with the enduring cultural practices of Nias society. Biblical verses have been utilized to create a biased framing that force women to meek. Gender-biased framing of this nature often masquerades as being grounded in biblical teachings.

Discussion

In most communities, socio-cultural conditions overwhelmingly place women in positions of significant disadvantage. The emergence of such oppressive circumstances generally occurs without overt coercion, creating the perception that these dynamics are entirely normal. Women often internalize this situation, perceiving their roles as aligned with what they believe to be their destiny as women.^{16,17} While men also undergo a process of gender norm formation, they generally benefit more

from their position due to the advantages it provides.¹⁸ Women, on the other hand, are less fortunate, as they are perceived to bear responsibility for tasks assigned to them: matters of reproductive health, economic productivity, and social roles.¹⁹ This socially fragmented system is inherently unjust, frequently leaving women as victims of inequality. Male dominance is evident across all domains²⁰, leaving women unable to assert their individuality, relegated instead to opportunities dictated by men.²¹ At the household level, the division of labor, economic management, social rituals, and other aspects consistently place men in a position not only of higher status but also of power to control these spheres.^{20,22-24}

The process through which men dominate social spaces often does not involve overt violence. One of the strategies used to maintain this status quo is by employing women themselves. Values in the form of praises directed at women, designed to make them perceive their unequal position as an honor, are embedded in many cultures, accepted, and practiced within society. This phenomenon is what Bourdieu refers to as symbolic violence.²⁵ So subtle are these values that they operate as though normal and are perpetuated across generations.

The concept of symbolic violence is intertwined with the term passionate aesthetics of heteronormativity, introduced by Saskia Wieringa, a prominent women's rights activist working extensively in Asia.²⁶ Wieringa defines passionate aesthetics as a normative force that inspires women to wholeheartedly embrace and strive to embody an ideal norm as a guiding principle for life.²⁷ Women who are considered perfect, dignified, and commendable are those who adhere to these norms.

What kind of norms? Saskia Wieringa describes them as norms centered on upholding and preserving the family. The family is perceived as the ultimate purpose for a woman, and the happiness of the family becomes a lifelong pursuit for married women.

As a result, a woman may feel discontented or even unhappy if she does not follow the customary marriage rituals, which are often dictated by familial agreements and resemble transactions between two families. Once married, a wife may feel dishonorable if she disobeys her in-laws or her husband. A daughter-in-law may experience

profound guilt if she fails to seek advice from her mother-in-law regarding family matters, particularly related to the well-being of her husband and children. These abstract norms become ingrained within a woman's body, materializing into behaviors deemed ideal by society.¹⁷ They are embodied and enacted in ways that reinforce the societal expectations placed upon women.

The norm of passionate aesthetics of heteronormativity positions the family as the ultimate aspiration for women, particularly in Asian contexts.²⁷ To achieve the ideal of a happy family, women often desire marriage at all costs, prioritizing the shift in their status from unmarried to married. Furthermore, to maintain family unity, many Asian women endure domestic violence, choosing to bear the suffering within their marriage rather than facing the psychological stigma associated with being labeled a widow or divorcee. For the well-being of their entire family, many Asian women tirelessly work day and night, seemingly without pause. They do so to ensure that their family members have enough to eat and access to education, sacrificing their own comfort and well-being for the sake of their loved ones.

The interconnectedness among the themes, as we mentioned earlier, is clearly evident from the findings of this study. This persistent inequality cannot be separated from the deeply entrenched belief that the ideal woman aspires to and prioritizes family unity. Striving for family happiness and taking on the role of the family's backbone are norms highly revered by Asian women, including Indonesian women. Ironically, religious teachings are often used as a reference, even though their true meaning has been distorted. The interpretations used by the mother-in-law and husband clearly contain minimal accuracy. Calvin²⁸ in his commentary on 1 Corinthians 11:3, explains that Paul was not referring to a physical hierarchy between men and women. According to Calvin, Christ never taught a leadership model where He leads only men, who then lead women. Instead, Christ leads both men and women spiritually, as He is the spiritual leader for all humanity. Paul's statement about male leadership reflects the political context of the time when the letter was written, rather than endorsing the domination of one group over another. Research conducted by previous study²⁹ concludes that *Bible overclaiming* is closely linked to incidents of

violence against women by their partners. Men often believe their position to be inherently correct, and even acts of violence against their partners are perceived as actions that please God.³⁰

Conclusions

This research demonstrates that women's health issues are deeply intertwined with gender imbalances affecting women. Nias women occupy a subordinate position within their cultural structure, a structure that is profoundly unjust yet upheld by norms perceived as virtuous and further reinforced by misinterpretations of biblical scripture.

The paper highlights how social contexts can have profoundly detrimental impacts on women's health. These situations should be critically examined through a feminist lens. The path toward achieving gender equality remains long, and until that equality is realized, many women will continue to suffer from poor health outcomes as a direct consequence of systemic inequalities.

Thus, efforts to address the poor health status of women must involve a localized approach like local church.³¹ It is impossible to conduct health campaigns without involving observation and in-depth exploration of local issues, especially in regions where women's health status remains a serious concern.

Contribution of authors

Fotarisman Zaluchu (Conceptualization, Methodology, Organizing data collection and Writing—Review and editing). Cashtri Meher (Conceptualization, Supervision, and validation, Original draft; and Writing—Review and editing). All authors have read and approved the final version of the manuscript for publication.

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