Refinement of Pregnancy Class Strategy to Improve Utilization of Maternal Healthcare

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Introduction

As stated in the Minister of Health (MOH) Regulation No. 97/2014 Article 48, the Indonesian Pregnancy Class Program (KIH) aims to improve pregnant women's knowledge and skills regarding pregnancy, delivery, postnatal care, family planning, and newborn care. The class is held in groups during antenatal visits, in which health providers meet face to face with pregnant women, their partners, and/or families.[1] Improved knowledge of pregnant women regarding danger signs and complications may increase use of necessary maternal healthcare in Indonesia.

"Only 29.3% of pregnant women receive ideal ANC. From those women, 45% have complete participation in pregnancy classes, 38.4% have incomplete participation, and 27.1% do not attend pregnancy classes."

Although coverage of skilled birth attendance and health facility-based delivery in Indonesia is adequate, the maternal mortality rate (MMR) is still far higher than the Sustainable Development Goals (SDGs) target of 70 per 100,000 live births by year 2030.[2] Previous studies[3, 4] have documented that the high MMR in Indonesia is caused by various factors linked to healthcare access, such as low coverage of antenatal care (ANC) in the first and third trimester, low utilization of skilled birth attendance, and delays in reaching a health facility and receiving appropriate care and/or referrals.

In one strategic effort, the KIH should refine its role in improving pregnant women's knowledge and increasing their utilization of maternal healthcare—specifically, ANC. Studies in Indonesia have demonstrated that women's knowledge has improved through pregnancy classes, but overall the program has not shown optimum impact[5–8] and is limited in scale.[5,6,9,10] There is also a discrepancy between the number of pregnancy classes reported by primary healthcare centers (*puskesmas*) and the number of pregnant women who participate in a class, indicating the need for improving the implementation of KIH. This study assesses the influence of the KIH program on use of maternal and neonatal health (MNH) services, and includes recommendations on how to improve the program strategy.

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Methods

We performed a statistical analysis using data from the 2016 National Health Indicator Survey (*Sirkesnas*), conducted by the National Institute of Health Research and Development (*Balitbangkes*), to assess how KIH pregnancy classes influence the continuum of maternal healthcare (ANC, skilled birth attendance, and health facility-based delivery) (Table 1).[14] We performed a descriptive analysis and logistic regressions to quantify the association between use of pregnancy classes and ideal ANC utilization and birth attendance, and a multinomial logistic regression to understand KIH's influence on delivery at a health facility.

Table 1. Definitions of Variables

Dependent Variables	1. Ideal vs. non-ideal ANC 2. Skilled birth attendance: Birth attendance by midwife or doctor during the last stage of delivery vs. non-skilled birth attendance 3. Health facility-based delivery, divided into three categories: not a health facility, health facility (*puskesmas*, clinic), or hospital
Independent Variables	Participation in pregnancy class: Pregnant woman's participation in pregnancy class is divided into three categories: (1) "complete participation," meaning a minimum of 3 sessions and 7 topics of pregnancy class; (2) "incomplete participation," meaning participation outside of the criteria for #1; and (3) non-participation in pregnancy class
Control Variables	Demographic characteristics of pregnant women (age and education), residence (rural vs. urban), region (Java-Bali vs. not in Java-Bali)

We also conducted a literature review on KIH pregnancy class implementation and reviewed the Minister of Health Regulation No. 97/2014 and Pregnancy Class Implementation Guideline. Last, we conducted interviews with personnel in charge of the KIH program at the Family Health Directorate, MOH.

Results

1. **Correlation between KIH program and utilization of maternal healthcare**

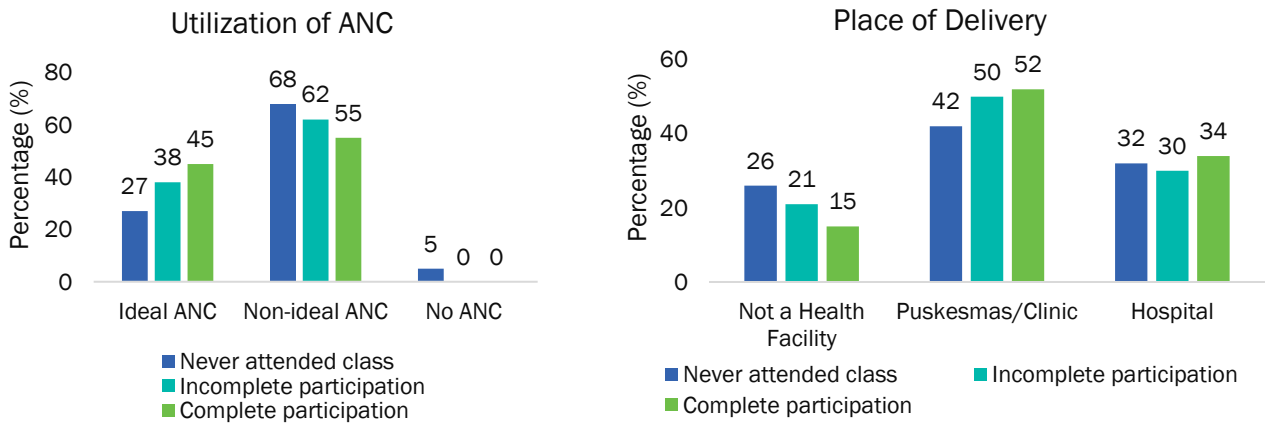
   a. ANC utilization was low; however, it was higher for those who complete pregnancy classes (Figure 1). Overall, only 29.3% of pregnant woman made ≥four ANC visits. Those who actively attended pregnancy classes sought ANC services more than those who were not active; 45% of mothers with complete participation in the program sought ANC care, whereas 38.4% with incomplete participation used ANC services.

"National-level data report that the coverage of pregnancy classes at *puskesmas* in the last 3 years [were] 95.3% (2016), 97.3 % (2017), and 97.9 % (2018). However, community data from Sirkesnas reports that the majority of women in Indonesia (81.8%) do not participate in pregnancy classes that are organized by the government."[11]

b. Quality of pregnancy classes was low. We observed discrepancies between the number of pregnancy classes reported by *puskesmas*, the number of class participants, and the number of participants who actually attended classes. The 2016 *Sirkesnas* reports that the majority (81.8%) of pregnant women in Indonesia do not attend government-organized pregnancy classes and, of those who do attend, only a small percentage (6.8%) attend classes completely (the remaining 9% attend classes incompletely). To address the situation, the Family Health Directorate of the MOH revised the operational definition for *puskesmas* that hold pregnancy classes as having a minimum of one class for pregnant women and one class for mothers of children under age five per village among at least 50 percent of the villages/*kelurahan* in the *puskesmas'* catchment areas.

c. Women who attended pregnancy classes tended to experience higher skilled birth attendance at a health facility compared to women with "incomplete" or no use of pregnancy classes. Women who participated in pregnancy classes also experienced greater use of health facility-based delivery at *puskesmas*, clinics, or hospitals. Mothers who delivered outside of a health facility tended not to have "complete participation" in pregnancy classes.

Figure 1. Use of Maternal Healthcare Based on Women's Participation in Pregnancy Classes



2. Distance/geographic location of women's home and work obligations limited their participation in pregnancy class

Monitoring and evaluation by the Family Health Directorate reports that distance/geographic location constrains optimal participation in pregnancy classes. Similar to findings from a previous study,[8] women who work outside of the home also have limited participation in pregnancy classes.

3. The role of the community and private health providers is not yet optimal

Implementation of pregnancy classes is incorporated into the MOH No. 97/2014 in Article 46, which aims to empower the community to help women achieve optimum health status. The MOH regulation does not specify who should support pregnancy class implementation, but the class is expected to take the form of some kind of community empowerment, in which the

community, families, and cadres work together to organize the class, with support from religious and community leaders, and various sectors. In practice, management of the program still relies heavily on *puskesmas* staff and does not sufficiently engage other parties. Cadres also seem to play a minimal role,[8] and there is a need to increase support from private midwives and the private sector.[8,12] Currently, no regulations mandate private health providers, including private hospitals, to participate in implementation of pregnancy classes and associated reporting.

Discussion and Policy Recommendations

The Pregnancy Class Program (KIH) is essential for improving the knowledge of pregnant women and their families in understanding pregnancy and recognizing danger signs and complications, and increasing utilization of maternal healthcare services, especially health facility-based delivery. Implementation of pregnancy classes still needs to be improved, and a refined strategy is needed to increase pregnant women's participation in high-quality pregnancy classes to improve maternal healthcare utilization. Our recommendations to refine the implementation of the KIH program in Indonesia are as follows:

Improve the participation of pregnant women with distance/geographic constraints	Improve the participation of pregnant women who work outside of the home	Diversify activities that promote community empowerment and involve private facilities
• Integrate the KIH pregnancy class program with other MOH programs (e.g., hold pregnancy classes in the maternity waiting home). • Equip the *Nusantara Sehat* (Healthy Nusantara) team with materials on the pregnancy class program and community empowerment initiatives.	• Increase female private sector worker participation in pregnancy classes by involving labor organizations and integrating activities with the *GP2SP* (Workers' Movement for Healthy and Productive Female Workers) Program. • Advocate to the Ministry of Manpower to issue a regulation that mandates workers and companies to hold pregnancy classes. • MOH should advocate that other ministries/government agencies should follow the MOH's example and hold pregnancy classes in each respective institution to allow pregnant civil servants to reap the benefits of pregnancy classes. The goal is that each ministry/agency will then issue a policy that supports pregnancy class implementation, such as incorporating the class into existing routine exercises that each institution organizes.	• Include real examples of community empowerment in the Pregnancy Class Implementation Guideline as lessons learned from creative initiatives. An example is what is done in Cipacing Village, Sumedang District, where pregnancy classes are integrated with knitting classes.[13] • Integrate the Pregnancy Class Program with the pregnant women supplementary feeding program (PMT), such as food preparation using fresh ingredients from the environment. This initiative also helps reduce stunting. • Involve the Indonesian Midwives Association (IBI) to mobilize midwives in disseminating information about pregnancy classes and work with cadres and religious/community leaders to build community ownership of the Pregnancy Class Program. • Revise MOH Regulation No. 97/2014 to specify the parties that must be involved in pregnancy class implementation, including the community and the private sector.

References

1. Kemkes RI. Peraturan Menteri Kesehatan Republik Indonesia Nomor 97 Tahun 2014: Pelayanan Kesehatan masa Sebelum Hamil, Masa Hamil, Persalinan, dan Masa Sesudah Melahirkan, Penyelenggaraan Pelayanan Kontrasepsi, Serta Pelayanan Kesehatan Seksual [Internet]. Kementerian Kesehatan RI; 2014 [disitasi 2017 Oct 29]. Diakses: http://kesga.kemkes.go.id/images/pedoman/PMK No. 97 ttg Pelayanan Kesehatan Kehamilan.pdf.
2. Badan Pusat Statistik. Potret awal Sustainable Development Goals (SDGs) di Indonesia. 2016. https://www.bps.go.id/publication/2017/02/01/9a002f0067c89e511f042c13/kajian-indikator-lintas-sektor--potret-awal-tujuan-pembangunan-berkelanjutan--sustainable-development-goals--di-indonesia.html.
3. Teplitskaya L, Dutta A. Has Indonesia's National Health Insurance Scheme Improved Access to Maternal and Newborn Health Services? Washington, DC: Health Policy Plus Project; 2018.
4. Aeni N. Faktor Risiko Kematian Ibu. *Jurnal Kesehatan Masyarakat Nasional*. 2013;7(10):7.
5. Arifin DA, Kartasurya MI, Purnami CT. Strategi Pengembangan Program Kelas Ibu Hamil Di Kota Banjarbaru, Universitas Diponegoro; 2014.
6. Yanti HP, Kartini A, Purnami CT. Evaluasi Program Kelas Ibu Hamil di Dinas Kesehatan Kabupaten Batang Tahun 2012, Universitas Diponegoro; 2013.
7. Nurdiyan A, Yulizawati YY, Bustami LE, Iryani D. Analisis Sistem Implementasi Kelas Wanita Hamil di Puskesmas Malalak dan Biaro di Kabupaten Agam. *Journal of Midwifery*. 2016;1(1):45–54.
8. Fuada N, Setyawati B. Pelaksanaan Kelas Ibu Hamil Di Indonesia. *Jurnal Kesehatan Reproduksi*. 2015;6(2):67–75.
9. Maryani S, Respati SH, Astirin OP. Association Between Pregnant Woman Class and Pregnancy Complication in Tegal District, Central Java. *Journal of Maternal and Child Health*. 2017;1(4):214–219.
10. Wahyuningsih E, Rohmawati W. Implementasi Pertemuan Kelas Kedua Ibu Hamil di Wilayah Kerja Pusdiklat Karangdowo. Proceeding of the URECOL. 2018;820–827.
11. Badan Penelitian dan Pengembangan Kesehatan. Laporan Survei Indikator Kesehatan Nasional (Sirkesnas) 2016.
12. Kusbandiyah J, Kartasurya Martha I, Nugraheni Sri A. Analisis Implementasi Program Kelas Ibu Hamil oleh Bidan Puskesmas di Kota Malang. Diakses: https://core.ac.uk/display/13653679.
13. Astuti Sri, Susanti Ari I, Mandiri A. Pemberdayaan Perempuan untuk Meningkatkan Kesehatan Ibu Hamil di Desa Cipacing Kecamatan Jatinangor Kabupaten Sumedang. *Jurnal Pengabdian Kepada Masyarakat*. 2017;1(5):288–291.

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