The Development of a Community-Based Model as an Assisting Approach in the Prevention of Pregnancy and Labor Complications in Pandeglang Regency, Banten, Indonesia

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Abstract

Most of the direct causes of maternal death is obstetrical complications. Some programs have been done to reduce the incidence of complications on pregnancy and childbirth complications unfortunately the implementation of the program has not been maximized. Community empowerment is required to ensure the sustainability of the program. This research was conducted to develop community-based Model in preventing pregnancy and labor complications based on asset and community participatory. This research was conducted with a mixed method approach. On the stage of model development is conducted qualitatively through Focus Group Discussion and in-depth interview with 4 key informants and 13 support informants. Furthermore, model is developed quantitatively by using cross sectional study design on 80 respondents. The analysis that used in this research is SEM PLS. Once the model is formed, the evaluation was conducted on 83 respondents by using pre and post-test design. Application of community-based Model in the society is done by mentoring models using Module of asset and participatory-based prevention of pregnancy and labor complication through community-based Model. The results show that community-based model can be achieved through community participation, community assets development, knowledge, attitudes and behavior. The results also reveal that the community-based model is statistically proven to increase knowledge (p 0.000), attitude (p 0.000) and the behavior of expectant mother (p. 0.000). Community-based Model consists of five variables and it was proved to be effective in improving the knowledge, attitude and behavior of expecting mothers on the prevention of pregnancy complication and childbirth.

Keywords: *Community-based Model, Pregnancy Complications, Community's participation, Labor Complication, Maternal Mortality.*

Introduction

Maternal Mortality Rate (MMR) is one of the important indicators of public health in Indonesia. The maternal mortality rate describes the number of women who die from a cause of death related to pregnancy disorders or their handling, excluding accident or incidental cases, during pregnancy, childbirth and postpartum 42 days after delivery, regardless of the length of pregnancy per 100,000 live births. Maternal mortality rates can be used in monitoring deaths related to pregnancy. This indicator is influenced by health status in general, education and services during pregnancy and childbirth.[1] Based on the 2012 Indonesian Demographic and Health Survey (IDHS)[2], MMR in Indonesia is still

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high at 359 per 100,000 live births. This figure increased compared to AKI in 2007 which was equal to 228. Meanwhile, the fifth global Millennium Development Goals target was to reduce MMR to 102 per 100,000 live births in 2015.

The biggest cause of maternal mortality during the period 2010-2013 was bleeding, which was consecutively from 2010 amounting to 35.1%, in 2011 amounting to 31.9%, in 2012 amounting to 30.1% and in 2013 amounting to 30.3%. While prolonged delivery is a contributor to the lowest maternal mortality. While other causes also play a significant role in causing maternal deaths. Other causes are indirect causes of maternal death, such as cancer, kidney, heart disease, tuberculosis or other illnesses suffered by the mother. [1] The direct cause of maternal mortality of more than 90% is a result of obstetric complications, especially labor complications. Complication is a complication, a condition that aggravates an illness. Pregnancy complications are obstetric emergencies that can cause death in the mother and foetus. Pregnancy complications include hypertension and preeclampsia, anaemia, placenta previa, and diabetes.[3] While complications of labor are difficult labor (dystocia) that causes a disease. Complications of labor include premature rupture of membranes, preterm labor, foetal position abnormalities, and others.[4]

Other factors that determine the regularity of pregnant women in their pregnancy checks by health workers, early detection of high risks and complications of pregnancy and childbirth, and family support in obtaining services for pregnancy and childbirth and emergency referrals.[5] Early detection of high risks and complications of pregnancy and childbirth needs to be done as an effort to reduce the risk of maternal death. The introduction or socialization of the causes of pregnancy complications must be early and handled with the right standards. Every pregnancy hazard if not found early and handled to the correct standard will cause further pregnancy complications and will have an impact on maternal and infant mortality. These deaths are the effects of pregnancy complications, namely bleeding, infection, hypertension.[6] Antenatal care plays an important role to be able to recognize risk factors in pregnancy as soon as possible so that deaths or unnecessary diseases in the mother and baby can be avoided.[7] There are still many mothers who are less aware of the importance of prenatal care, which does not detect high risk factors that may be experienced by them. Antenatal examinations are related to the availability of health care facilities. There is a relationship between the distance of the house to the health service place and antenatal use.[8]

The Government has carried out the Program for Maternity Planning and Complication Prevention (MPCP) as one of the efforts to accelerate the reduction of MMR. Maternity Planning and Complication Prevention is an activity facilitated by midwives in the village in the context of the active role of husbands, families and communities in planning safe deliveries and preparation for complications for pregnant women, including planning for the use of postpartum birth control, using stickers as a media notification target in order to improve coverage and quality of health services for mothers and new-borns. The program has been launched by the government since 2007.[9] Through MPCP, it is expected that every pregnant woman will be properly recorded and monitored. The technical form ofMPCPis that every pregnant woman gets stickers so that this sticker can be attached to every home that has a pregnant woman.[9]

The target to be achieved in MPCP begins with monitoring of targets with high, medium, low risk directly in the hope that complications can be prevented and addressed early. In fact, the MPCP has not been implemented optimally, only around 55%.[10] This is due to the lack of understanding of pregnant women to carry out high-risk early detection, lack of participation of cadres and health workers (midwives) in disseminating MPCP and unclear information delivery to pregnant women so that they do not understand the benefits and objectives of MPCP get support from husband and family.[10] Based on the explanation by Prasetyawati (2012),[11] it was stated that the health problems of

pregnant women and infants were not only focused on health workers but also needed community-based partnerships. MPCP is a program whose sustainability is highly dependent on government policies and budgets. Given the efforts to prevent these complications are important. So the sustainability of these efforts requires the active role of the community.

One strategic step is to increase the knowledge, awareness and motivation of pregnant women, husbands, families and communities towards improving behavior towards efforts to prevent complications of pregnancy and childbirth. This can be done through empowering and participating families or communities. Participation is the voluntary involvement of the community in self-determined changes, can also be interpreted as community involvement in the development of themselves, their lives and their environment.[12] Community empowerment is intended so that the community can determine practices / actions to solve problems faced and manage planned activities, both individual capacity building, increased efforts to control, institutional improvement and environmental improvement.[13] The purpose of empowerment is to increase community capacity and capability so that able to recognize the problem at hand, able to explore and utilize available resources, and be able to express themselves clearly.[14]

This community empowerment approach has become the government's concern. This can be seen from the formation of government programs that empower the community. One example is the Smart Healthy Generation Program, which is part of the government's efforts to improve the quality of basic social services, especially in the fields of basic education and maternal and child health through a community empowerment approach, especially rural communities.[15] Empowering rural communities in reducing maternal mortality is one of the important things, considering that maternal mortality rates are more prevalent in rural areas. These efforts are in line with the mandate of Law No. 6/2014 on villages, that villages have authority, based on village-based origin and local authority, to realize village independence as a strong foundation in implementing governance and development towards a just, prosperous society and prosperous. The development paradigm in the health sector as stated in Law No. 36/2009 on Health aims to increase awareness, willingness and ability to live a healthy life for everyone in order to realize the highest degree of public health as an investment for the development of human resources. This is in line with one of the strategic programs in the health sector, which is the development of Healthy Village Houses (HVH) mandated by the enactment of Law No. 6/2014 on villages that strengthens village autonomy in determining its development priorities and strategies.

A healthy village house is a facilitation to accelerate the improvement of the quality of basic health services in the village community which was initiated and facilitated by the government and implemented and managed by the village community in order to reduce the maternal mortality rate. Empowerment of village communities is used to increase public awareness and participation so that the potential / assets of the community in its implementation can be in accordance with the principle of village sovereignty. One approach is to increase community participation through the Participatory Action Research (PAR) approach. Research on the development and application of the mentoring model which is a combination of the theory of PAR and ABCD by including variables of knowledge, attitudes and behavior, such as those used in the community-based model has never been reported. The successful implementation of the community-based model as a mentoring approach to prevention of complications of pregnancy and asset-based childbirth and community participation in Banten Province is expected to be developed to be applied in other regions that have problems with high maternal mortality rates.

The concept of assistance in the community-based model that combines community empowerment with the use of community assets in order to reduce the complication rate of pregnancy and childbirth in line with the village development program as stated in Law No. 6/2014 on Villages. Village development, especially health development, is realized in the program of

Healthy Village Houses and Healthy Smart Generation (HSG). One of the implications of HVH's achievements in achieving indicators of changes in community behavior includes the prevention of complications of pregnancy and childbirth through public health education, information communication and education and community-based health efforts. Meanwhile HSG put forward the basics of community development and mentoring that combined aspects of critical awareness, capacity building and strengthening of local institutions towards the integration of village development (health). With the existence of HSG, it is expected to facilitate access to maternal and child health services, especially for the First 1000 Days of Life intervention, especially for the poor and marginalized groups.

This study resulted in a community-based model that is a participatory mentoring model which is a model of assistance to prevent pregnancy-based complications of asset-based labor and community participation developed based on a comprehensive approach, namely community participation approaches, asset development approaches and behavioral change theories where communities utilize the potential that exists in society to solve problems, namely the incidence of complications of pregnancy and childbirth. This model is a new approach used in dealing with the problem of complications of pregnancy and childbirth. The use of this model approach involves developing assets that exist in the community with community participation. The dimensions of each variable were obtained from the development of the theory which was constructed and tested statistically. The results obtained are that in a homogeneous population, social dimensions can be excluded from community assets. The approach to participation and development of community assets, simultaneously able to increase knowledge, attitudes and ultimately behavior related to prevention of complications of pregnancy and childbirth. This community-based model can be adaptively used integrated in supporting and achieving existing programs such as MPCP, Desa Siaga, Healthy Indonesia Program with Family Approach and Healthy Village House Program.

Research Method

The study approach used in this study is mixed method with a sequential exploratory approach strategy. The strategy of this approach is the collection and analysis of qualitative data carried out in the first stage then followed by the collection and analysis of quantitative data in the second stage which is built on the initial qualitative results. More weight / priority is given to qualitative. This sequential exploratory design is usually used to prove the findings of the first (qualitative) results with the results of the next (quantitative) analysis. So that with this approach the direction of theory formation is inductive. Qualitative data were collected through focused group discussion, In-depth Interviews and observations. To guarantee the validation of qualitative results, triangulation is carried out, so as to increase confidence in the answers given. This research was carried out in all villages in the District of Cimanuk, Pandeglang Regency. Cimanuk District consists of 11 villages. Based on the preliminary study conducted by the author, it is known that of the 35 sub-districts in Pandeglang Regency, the highest proportion of groups of pregnant women at high risk in the District of Cimanuk. Research groups were built from the grass root level. The groups built consisted of groups of mothers and cadres, husbands, paraji. The aim of building this group is to increase knowledge and insight along with efforts to strengthen resilience, self-confidence, and community responsibility. The total population in this study was as many as 800 pregnant women who lived in the working area of the Cimanuk District Health Center. The minimum number of samples taken by researchers directly through the object as many as 80 respondents with the following criteria:

a. Inclusion Criteria: Second and third trimester pregnant women with healthy conditions, domiciled in the working area of Cimanuk Sub-District Health Center, high-risk pregnant women, mothers and husbands agree to become respondents.

b. Exclusion Criteria: Pregnant women who have experienced complications, abnormal pregnancies,

respondents moved to domicile.

Samples were taken in accordance with the rules of the number of samples in the PLS (Partial Least Squares) guideline where the sample size is 5 to 10 multiples of the number of indicators to be examined.[16] In this study there were 16 indicators used to observe five variables, so in this case the sample size taken ideally was between 80 and 150. Sampling was done by simple random sampling (SRS). SRS is a sampling technique where each individual has the same opportunity to be selected as a sample. Since the population in this study is pregnant women, each pregnant mother who is in accordance with the inclusion and exclusion criteria has the same opportunity to become a sample.

Results and Discussion

Complications of pregnancy/Labor

Complications of pregnancy/Labor are estimated to occur in 15-20% of pregnant women, not all of which have been detected early. While those detected, not all have been handled in a timely and adequate manner. Delay in the detection and management of labor complications can threaten the mother and foetus. Labor complications include bleeding (25%), infection (14%), abnormalities of hypertension in pregnancy (13%), complications of unsafe abortion (13%) and the consequences of prolonged labor (7%). Bleeding is the main cause of death, which is largely due to retention of the placenta. As a result of the infection caused is an indicator that shows the poor efforts to prevent and treat infections in pregnancy and childbirth.

Research from the Ministry of Health of the Republic of Indonesia in 2013mentions factors related to complications of prolonged labor delivery (15.4%), 27.5% of respondents aged <20 years and ≥ 35 years experienced labor complications, 27.8% of respondents lived in rural areas, 23.9% parity ≥ 4 and 16.7% were never ANC (antenatal care), and 17.4% never received Fe tablets, 24.6% had no time to deliver at health facilities, 35.6% experienced complications during pregnancy.[1] Analysis of the factors causing pregnancy and childbirth complications is caused by distant determinants and determinants between. Both of these determinants have the opportunity to cause complications for pregnant women and childbirth which can ultimately lead to maternal death. Determinant variable factors include health status of pregnant women, reproductive status, access to health services and behavior / use of health services, while far determinants include maternal status in family and society, family status in society and community status.

Labor complications are difficult to predict and difficult to diagnoze, so the treatment is difficult to be applied with certainty. Several factors can cause high-risk labor including maternal age, maternal education level, maternal occupation, family income, knowledge of ANC examination, maternal attitudes toward ANC examination, practice of mothers in ANC examination, parity, pregnancy distance, medical history, obstetric history and quality of ANC services.[17]

Citizens' Participation

The Focus Group Discussion results indicate community participation in efforts to prevent complications of pregnancy and childbirth is in the form of mutual cooperation, regular meetings of pregnant women and socialization of pregnancy myths. According to Laksana (2013) the participation of the community in Cimanuk Village was included in the form of ideas and social participation.[18] Community empowerment and community involvement in reducing maternal mortality are also carried out by many other studies. A study conducted in Malawi in 2007 involved 729 women assisted by 81 voluntary facilitators to mobilize communities related to maternal and child health. Two years later, half of the group received a maternal and child health development program (part of the maternal and child health task force) which had a main focus to increase the coverage of ANC examinations, knowledge of maternal and child health and delivery in health services. In addition the group also identified high-risk pregnant women, promoted delivery in health services, ANC and PNC services, and conducted health education.[19]

Community involvement in improving health status is a contribution of the community to the health of community members through giving responsibilities related to certain issues. Of course this responsibility is also flexible in accordance with the characteristics of the community and region. In some conditions, sometimes communities only carry out social responsibility, such as making conditioning in the community that is able to support the implementation of health programs. But in other conditions, in addition to carrying out social responsibility, the community also carries out technical responsibilities. In general, the realization of the responsibilities carried out by the community towards the condition of public health can be through:

a. The adoption of behaviors to prevent health problems;

b. Effective participation in disease control activities;

c. Contribute to the design, implementation and monitoring of health programs;

d. Providing health resources.

In an effort to reduce the risk of complications that can cause maternal mortality, community participation can increase the coverage of the program. Participation can be in the form of community involvement and presence during health promotion, so that when participation increases, the information / knowledge delivered in the program is conveyed to more targets. As was done in Bangladesh[19] that communities form groups that actively hold meetings every month that discuss maternal, infant and toddler health. The result is that there are significant differences related to maternal mortality in areas that have active community participation compared to areas that do not have community participation. Community participation also means that people get additional learning about issues that are being worked on and at the same time take concrete actions. By attending the monthly meeting, the community will gain knowledge about ways to recognize pregnancy complications, ANC examinations and access to health facilities in the face of labor complications.

Impact of the Community-Based Model

Community-based model is carried out by involving health workers (midwives), families, cadres and the community. All elements that play a role need to get training to better understand the concepts and roles in implementing this model. In addition, training is also given to equalize common goals, namely the formation of preventive behaviors for complications of pregnancy and childbirth which can ultimately prevent complications of pregnancy and childbirth. The involvement of cadres and communities in this model is very appropriate. Based on the results of a systematic review, cadres were proven to be able to convey a message of intervention to prevent maternal and child health problems in developing and poor countries. Because cadres are able to convey messages directly to the target, namely the mother, by using cultural and customary approaches that apply in the community.[20]

The success of the community-based model in increasing knowledge, attitudes and behaviors about preventing complications of pregnancy and childbirth is a very good outcome in the effort to prevent complications of pregnancy and childbirth in particular, as well as increasing village health development in general. substantially the researchers have confidence that the community-based model can be applied and generalized to other villages. This is due to the relatively similar characteristics of villages in Indonesia, which are mostly self-help villages. The community-based model can be applied to support the Healthy Village and Healthy Smart Generation program launched by the Ministry of Village, Development of Disadvantaged Villages and Transmigration. This model comprehensively involves community participation and the development of community assets as carried out by the two programs. Healthy village houses are focused on the development and utilization of health assets, while the healthy smart generation focuses on community empowerment to raise awareness about health issues, one of which is the issue of maternal and child health. In addition, this model also

emphasizes community participation. This is consistent with the findings of Sulaeman (2012)suggesting that community participation has a contribution of 51.69% to solve health problems.[21] This is implemented by participating in village meetings that determine village development plans. Communities can participate in the form of conveying problems around them for later analysis and problem solving solutions. This is in line with what is applied in the community-based model.

The effectiveness of the community-based model in increasing the knowledge, attitudes and behaviors of prevention of pregnancy and childbirth complications at the time of this study needs to be maintained. Maintaining the sustainability of this program is a challenge in itself. One possible way to do this is to integrate this model into established programs in the community such as alert villages, MPCP, HVH and HSG and through family empowerment and women's empowerment. However, considering the issues that are of concern in the community-based model are specific issues related to complications of pregnancy and childbirth, it is necessary to refresh the material for the community-based model. Refreshing this material can be done every six months or once a year in a special activity, or also in a routine annual meeting of cadres in Cimanuk District. The results of this study indicate that there are assets that play a major role in preventing complications of pregnancy and childbirth. These assets need to be mapped in detail to continue to maintain their function in preventing complications of pregnancy and childbirth. With the complete asset mapping, even though there has been a change in leadership in the village, the focus on the use of assets remains unchanged, and may even develop. Community-based model significantly changes the level of knowledge of mothers about complications of pregnancy and childbirth. Knowledge. This result is in line with studies conducted in the United Kingdom, that significantly increased midwife knowledge in midwives who received obstetric emergency training.[22]

When the pre-test was conducted, the respondents' average knowledge score was only 41.01. This score falls into the category of low knowledge, meaning that less than 50% of knowledge about complications of pregnancy and childbirth is known by respondents. Knowledge about bleeding is the thing that most respondents know. The study conducted in Uganda showed results that were not much different. Only one third of respondents knew at least three danger signs during the pregnancy, childbirth and postpartum phases. Among them most of the respondents answered that bleeding during pregnancy and swelling of the hands and face were danger signs during pregnancy.[23] Knowing the signs and symptoms of pregnancy and childbirth complications will make respondents anticipate and prevent more to mitigate the impact of complications of pregnancy and childbirth by reducing the first three late and late third if the health facility is ready to deal with complications.[23]

The introduction of obstetric danger signs is the main key in finding health services for obstetric emergencies and in seeking prevention or promotion efforts during pregnancy and childbirth. So that the lack of awareness of danger signs will be related to the lack of preparation for normal delivery and preparedness in the face of complications.[24] Assuming that all pregnancies are at risk, the mother must be aware of the danger signs of complications of pregnancy, childbirth and postpartum. Efforts to increase this knowledge can be done through health promotion, both verbally, written and audio. One of the most recent approaches to increasing knowledge and delivery outcomes is Centering Parenting.[25] Centering Parenting is a model that involves groups of 6-7 mothers and babies together to get care for the first year. Through nine sessions, medical staff provide care and also provide information about health, infant development and issues of maternal and infant safety. This program integrates three main components of care, namely health, education and support in groups.[26]

Conclusion

The construction results of the community-based model state that variables of community participation, community assets, knowledge, attitudes and behaviors to prevent pregnancy and childbirth complications

are issues / discourses obtained based on qualitative findings. This result is in line with the basic concept of this research. The variable forming construct on the model is in accordance with the theory that applies to the present. The construction of the community-based model consists of community participation which consists of knowledge about prevention of complications of pregnancy and childbirth, attitudes about prevention of complications of pregnancy and childbirth, and behaviors about preventing complications of pregnancy and childbirth. The results of the development of the community-based model show that all variables have a significant relationship with the prevention behavior of complications of pregnancy and childbirth. At the time of validity testing, it is known that social assets are invalid in forming community assets. Likewise for the right construct is invalid in forming behavioral variables preventing complications of pregnancy and childbirth. The community-based model is applied through the process of mentoring pregnant women by cadres. This assistance is carried out starting from the second or third trimester of pregnancy until the mother gives birth. As a tool to assist pregnant women, cadres are equipped with a mentoring module to prevent the complications of asset-based pregnancy and childbirth and community participation with the community-based model approach. The community-based model was significantly able to increase the score of knowledge, attitude and behavior to prevent complications of pregnancy and childbirth. This model is the novelty obtained from this study.

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