The Role for Social Marketing in the Program of Saving Lives at Births in Indonesia

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Suami SIAGA or the “Alert Husband” since 1999
• to improve husbands’ knowledge about pregnancy and delivery by focussing on maternal mortality prevention.

The Bidan SIAGA “Alert Midwives”
• to train and place healthcare workers (midwives) at the front line in every village providing antenatal care to save lives and help mothers give birth at home.

Desa SIAGA or the “Alert Village” since 2006
• to mobilize community involvement by providing pregnancy registration, financial support, transport availability, blood donations and family planning information.
SIAGA Success

2009 evaluation showed SIAGA program was successful in terms of:

• mobilization to provide registration, finance, transportation, blood transfusion and family planning systems

• Husbands’ involvement during prenatal care & delivery up from 16 to 32%

• 70% of women exposed to the campaign used skilled birth attendants compared with 44% in those unexposed

• 2000-2006 Desa SIAGA expands to 50 villages in Nusa Tenggara Timur (NTT) and 90 villages in NBT provinces

• by 2009 NTT & NBT reported 888 out of 911 villages as Desa SIAGA
More work needed

- low levels of knowledge and awareness of the dangers signs during pregnancy and delivery continued
- many provinces experienced difficulties in implementing SIAGA program

Based on the 2012 IDHS Report,
- maternal mortality rates & infant mortality rates in NTT province remained high: 307 deaths per 100,000 live births and 57 deaths per 1,000 live births, respectively
Case Study in NTT Province

Over decades, Nusa Tenggara Timur (NTT) province has had higher rates of maternal and child mortality due to the lack of health service provision in terms of accessibility, distribution/coverage, and equality.

Most births occur at home rather than at health facility, with complications often leading to maternal/child deaths.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>National</th>
<th>Yogyakarta (more developed)</th>
<th>NTT (less developed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Fertility Rate (TFR)</td>
<td>2.6</td>
<td>2.6</td>
<td>1.9</td>
</tr>
<tr>
<td>2. Maternal Mortality (MMR)</td>
<td>307</td>
<td>228</td>
<td>120</td>
</tr>
<tr>
<td>3. Infant Mortality Rate (IMR)</td>
<td>35</td>
<td>32</td>
<td>20</td>
</tr>
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</table>
Case Study in NTT Province

Population
• 5,343,902 (est. 2012)
• 1.5% growth rate
• 80.7% in rural area

Geography
• 1,192 Islands
• 43 settlement areas
• 22 districts
• 306 sub-districts
• 2,994 villages
Case Study in NTT Province

Revolusi KIA (Kesehatan Ibu dan Anak) since 2009:

• to answer unsolved challenges, NTT government initiated a new strategy for maternal and child health (MCH).

Main objectives:

**Saving lives at birth:**
• to encourage all births to be in health facility births, such as a puskesmas—a public health centre at the sub-district level or a hospital at the district level.

**Better health care:**
• to ensue health facilities are adequately supported
• including well trained health staff, adequate health facilities, and sufficient budget
Maternity Care/Service

PONED: Provide services for obstetric and basic neonatal emergency

PONEK: Provide services for obstetric and comprehensive neonatal emergency.

Note: ANC (antenatal care) is done during pregnancy period.
Some improvements 2010-2011

- Maternal mortality rates decreased from 287 deaths per 100,000 live births to 216 deaths per 100,000 live births.
- Overall, about 60% to 78% gave birth in a health facility birth, but % varies for the 22 districts in NTT.
- % health facility-based births was as low as 38% to as high as 90%.
- Maternal mortality varied between 84 deaths per 100,000 live births to 618 deaths per 100,000 live births.

Study aim:
- to understand why the implementation of Revolusi KIA program has achieved variable results in within NTT province.
- to identify barriers to program participation and giving birth at health care facilities.
Health Facility Birth in NTT: 2009-2014

Source: NTT Provincial Health Office (2014)
Method: Case Study

Context: District of Manggarai Baratwas

Puskemas *Wae Nakeng* was purposively selected
- acceptable health facility w/a moderate rate of facility delivery
- relatively accessible serving two villages with poor populations

Qualitative Data Collection (18 interviews in each village)
- Group Interviews w/program implementers
- In-depth Interviews w/community members (village leaders, midwives, traditional birth attendants), mothers and influencers (husbands, mothers-in-law).
Qualitative Method

- NTT Province
- District: MANGGARAI BARAT
- Community Health Centre WAE NAKENG
- Revolusi KIA Implementers (Group Interview)
- Nurses and Midwives (Group Interview)

**Daleng Village (close to CHC)**
- Village Leader (IDI)
- Traditional Birth Attendant
- Village Midwife
- Women who delivered in facility
- Women who delivered at home, but received ANC in facility & delivered around same time as women with facility deliveries
- Key Birth Decision Influencer (Mother, Mother-in-law, or Husband)

**Golo Ndeweng Village (1 hr travel time)**
- Village Leader (IDI)
- Traditional Birth Attendant
- Village Midwife
- Women who delivered in facility
- Women who delivered at home, but received ANC in facility & delivered around same time as women with facility deliveries
- Key Birth Decision Influencer (Mother, Mother-in-law, or Husband)
Method: Case Study

Quantitative Data Sources

- Mother’s Card program data collected by Puskesmas and reported by midwife at village level.
- Indonesia DHS and National Health Survey (for comparison purpose to provincial and national levels).

Analysis

Descriptive statistics to examine geographic residence, education, and other equity-related characteristics of delivery place.
**Information collected:**

- Basic demographic, education, employment, and insurance ownership.
- Obstetric history
- Antenatal care history
- Delivery plan & preference (due date, place, assistance)
- Actual delivery (date, place, weight, assistance etc.)
Findings:
Characteristics of mothers by place of delivery.

<table>
<thead>
<tr>
<th>Mother’s Age</th>
<th>Health Facility (%)</th>
<th>Home (%)</th>
<th>Total (%)</th>
<th>Number Birth (N)</th>
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<tbody>
<tr>
<td><strong>Indonesia (IDHS 2012)</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt;20</td>
<td>54</td>
<td>46</td>
<td>100</td>
<td>1,526</td>
</tr>
<tr>
<td>20-34</td>
<td>65</td>
<td>35</td>
<td>100</td>
<td>12,757</td>
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<tr>
<td>35+</td>
<td>64</td>
<td>36</td>
<td>100</td>
<td>2,665</td>
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<tr>
<td><strong>NTT Province (IDHS 2012)</strong></td>
<td></td>
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<tr>
<td>&lt;20</td>
<td>56</td>
<td>44</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>20-34</td>
<td>45</td>
<td>55</td>
<td>100</td>
<td>273</td>
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<tr>
<td>35+</td>
<td>52</td>
<td>48</td>
<td>100</td>
<td>154</td>
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</tbody>
</table>
Findings

Distribution of Women by Place of Delivery

% (Percent)

Home
Health Fac.

15-19 20-24 25-29 30-34 35-39 40-44 45+

FACULTY OF BUSINESS AND ECONOMICS
Barriers & Benefits of Custom Cultural traditional practices

• Childbirth is seen as natural – women’s business
• Home births are less disruptive – no need to travel, extended family can easily visit and provide assistance
• Traditional birth attendants (TBAs) – are valued and influential members of the community. They not only assist in delivery but also provide emotional support and practical assistance during pregnancy and after delivery
Cost as a Barrier

- **Economic cost** is one of the influencing factors in both villages. Mothers and fathers see delivery cost as expensive. They also cannot pay for transportation to the health facility. Those who can afford the costs give birth at the health centre.

  - “Health centre is good; but the problem is that I didn’t have money if I should give birth there. So in fact I didn’t have a plan to give birth at home”  
    (farmer in closer village, 34 years old)

- **Social cost** or opportunity cost is also an influencing factor. Delivery at health facility is seen as a special occasion. They have to think about organising a celebration and providing for extended family living cost away from home and taking care of their other children.
## Recommendations

<table>
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<tr>
<th>No.</th>
<th>Barriers</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>1.</td>
<td>Traditional health beliefs and practices</td>
<td>Increase community engagement and practices towards better maternal and child</td>
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<td>health through the effective use of health promotion materials endorsed by the</td>
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<tr>
<td></td>
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<td>village leader and other influential community members.</td>
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<td>2.</td>
<td>Integration of nurse and midwives with</td>
<td>Improve the availability of nurses and midwives at the village level to be</td>
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<td>traditional birth attendant services</td>
<td>accompanied by increased service quality. Strengthen and maintain the</td>
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<td></td>
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<td>partnership between TBAs and midwives towards better maternal and child health.</td>
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<td>3.</td>
<td>Cost related with health facility birth</td>
<td>Communication of existing and alternative community health insurance schemes</td>
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<td></td>
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<td>that currently are not widely known by the community.</td>
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<tr>
<td>4.</td>
<td>Lack of father’s involvement</td>
<td>Include fathers/partners into the existing and alternative health education</td>
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<td>programs provided by midwives and nurses that often focus on mothers/women.</td>
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Promotion & Advocacy
Acknowledgement

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Research team member’s organizations:
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Thank you