Fears of pregnant women seeking antenatal care during the Covid- 19 pandemic: Disrupted maternity in South Sumatra, Indonesia

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Submission date: 08-Jan-2023 08:21PM (UTC+0700)
Submission ID: 1989729783
File name: eeking_antenatal_care_during_the_Covid2_Tom_nj_20_June_20221.pdf (1.05M)
Word count: 7665
Character count: 42975

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20 June 2022

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Presented in Asian Studies Association of Australia Conference in 2022, 5-8 July 2022

https://www.monash.edu/arts/Herb-Feith-Indonesian-Engagement/2022-asian-studies-association-of-australia-conference

Introduction

The outbreak of COVID-19 in 2019 marked a two-fold watershed in the development of Indonesia. After two decades of sustained, positive economic growth, 2019 saw Indonesia turn a corner as poverty slipped below the ten percent mark, and Indonesia's Human Development Index improved to an unprecedented level (UNICEF, UNDP, Prospera, and SMERU 2021).[1] The year also marked the beginning of one of the world's worst epidemics. One that has disproportionate impacts on Indonesia's low and middle socio-status groups, particularly women. Despite women having a higher COVID survival rate,[2] women often have a lower quality of care that can be only be explained in terms of cultural stereotypes, and gender socialization.[3]

Indonesian, women's proscribed or gendered role expectations are deeply enmeshed with the Islamic faith, and pregnancy is a part of the motherhood role or '*ibadah'* (worship). Consequently, women enjoy the status or social reinforcement incurred by pregnancy. When

[1] UNICEF, UNDP, Prospera, and SMERU (2021). Analysis of the Social and Economic Impacts of COVID-19 on Households and Strategic Policy Recommendations for Indonesia, Jakarta. https://www.unicef.org/indonesia/coronavirus/reports/socio-economic-impact-covid-19-households-indonesia.

[2] Wenham, C. Smith, J. Morgan, R. 2020, COVID-19: the gendered impacts of the outbreak. The Lancet. Volume 395, Issue 10227, pp 846 – 848. March 14 2020. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30526-2/fulltext.

[3] Pan American Health Organization, World Health Organization, 2020. Guide for Analysis and Monitoring of Gender Equity in Health Policies, Washington DC. https://www.bing.com/search?q=are+health+policies+gendered&first=21&FORM=PORE.

asked how the pandemic may have affected them, a common response by participants about their pregnancy was "[i]t is a blessing during lock down,"For mothers in this study, it is considered a great happiness for them, despite occurring during the COVID-19 pandemic. Despite this happiness, most participants signaled that they "worr[ied] too much" during the pandemic, particularly when accessing antenatal care to check their baby's progress. In early pandemic, pregnant women were worry of baby's health due to limited access for antenatal care and lack of HIV test for pregnant women in health services. Other women expressed concern with COVID-19 tests, thinking that somehow when they took the test, they might become infected with the disease, in addition to being concerned over the potential for exposure in hospital (*puskesmas*) (see Figure 1). During delivery, one of the pregnant mothers who got infected with COVID-19 expressed "*I am traumatised, I am traumatised, and I am traumatised".*Their worry, we argue, is a significant stressor of mental health of pregnant women. Because of these concerns, many mothers in the study expressed that it was difficult to check on the health of their babies during the first eighteen months of the pandemic, as the first cases of COVID-19 were announced in Indonesia.

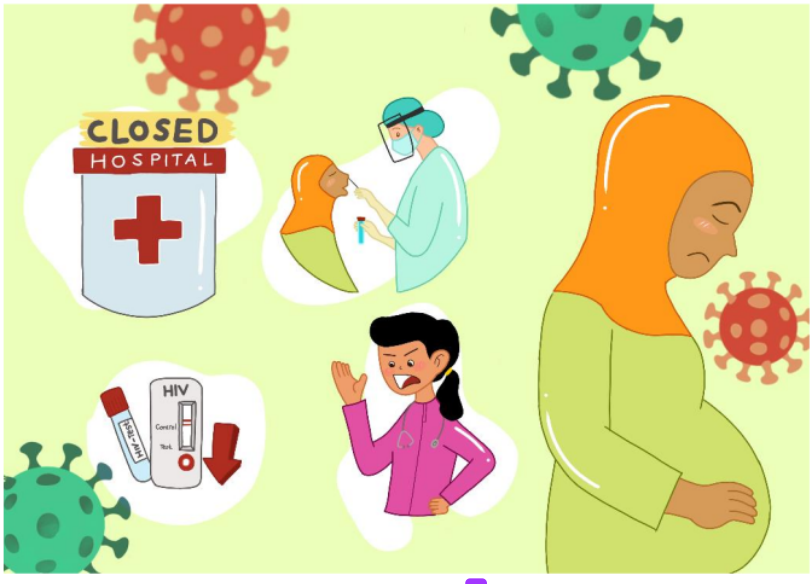

Figure 1: Experiences of pregnant women during the first 18 months of COVID-19 pandemic in Indonesia

Source: Booklet HIV and COVID-19: Voices from women in Indonesia, Najmah and Sharyn Graham Davies (Illustrator Chynta Rahma Vanvie)

Link: https://www.youtube.com/watch?v=-RNX6hEPO7s

This book chapter discusses experiences of accessing antenatal care among twenty women who were pregnant during the first eighteen months of COVID-19 pandemic, from March 2020 to July 2021 in South Sumatra, Indonesia. From our research three themes emerged and are discussed below:

1. The impact of early restrictions of health services on pregnant women
2. Get infected with COVID-19: "I am traumatised, I am traumatised….I am traumatised":
3. Gendered decision-making: neglecting HIV women's rights in critical health situations

Respondent's Characteristics

In this study there are forty-five women selected to participate. Twenty out of forty-five women were pregnant during the pandemic. Eight out of these women knew of their pregnancy before the pandemic, and twelve of them became pregnant during the pandemic. In terms of their employment status, ten were employee in the government sector, such as a nurse, a lecturer, or as administrative staff. Other participants identified themselves as *an ibu rumah tangga* (housewife). Their education ranged from Junior high school to post-graduate, or Masters Degree. The average family income was between Rp 1.500.000 ($100 US) to Rp 5.000.000 (US $500) monthly. Out of twenty, nine women accessed COVID-19 tests before their babies were born in a hospital. Other participants, who delivered in a private midwifery practice or obstetrician clinic, generally were not offered a COVID-19 test. Among non-HIV group, only six out of fifteen women who were tested for HIV, when they accessed antenatal care.

At Glance: Health Systems in Indonesia

On 1st January 2014, Indonesia initiated health reforms to increase universal health coverage (UHC) for all Indonesians, including for low-middle income families to improve the accessibility of healthcare in Indonesia for 'free'. The mechanism of JKN is based on social protection mechanism whereby some people need to pay monthly payment, like civil cervants, company employees and middle-high income families, while the state will cover for low income families. JKN is a contribution-based social protection mechanism whereby some people contribute for their own coverage and other people's contributions are covered by the

state. JKN has grown rapidly in Indonesia and now ostensibly covers more than 226 million people (84%)[4], the largest single-payer scheme in the world. Furthermore, in decentralisation era of health systems in Indonesia offers an integrated health systems, from posyandu, puskesmas (primary health centres), to hospitals and a chance for equal distribution of health services at province level and district/municipalities. In the last two decades, there is an increasing numbers of health infrastructure for these primary and referral health facilities to support UHC or JKN programmes[5].

In maternal health services, private midwifery practices is an important services for women in Indonesia. Private midwifery practices (praktek bidan swasta) can be found in all urban and rural communities and at the village and sub-village levels. Local and private midwifery services are affordable and have flexible opening hours, as midwives usually practise from their own homes. In 2013, 282 out of 323 (60%) pregnant women in South Sumatera province visited local midwives for their antenatal care, delivery, and postpartum care (Statistics Indonesia, National Population and Family Planning Board, MOH, & Measure DHS ICF International, 2013). Midwives can also be called upon in emergency services to visit patients in their homes outside office hours. Midwives are usually well known and respected by the locals and have lived in the community for some years.

Idealy, JKN, decentralisation of health system and accessibility of private midwifery services would reduce inequality access to healthcare, including for maternal health care services to ensure health of women during pregnancy, childbirth and the postnatal period. For note, the maternal mortality rate in Indonesia decrease from 275 per 100,00 live births in 2000, to 228 in 2010 and 177 in 2017 per 100,000 live births[6]. Yet, this rate is still higher than higher than other Southeast Asian countries such as Thailand and Malaysia. Some factors may contribute the high maternal mortality rate.

First, 'deep-rooted belief systems, from cultural and religious influences, pregnancy outcomes are influenced by magic, fate and God's. Therefore, maternal and child sickness and

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[4]BPJS Kesehatan. 2022. Pengamat sebut program JKN-KIS sdudah efektif dan efesien. Retrieved from https://bpjs-kesehatan.go.id/bpjs/post/read/2022/2171/Pengamat-Sebut-Program-JKN-KIS-Sudah-Efektif-Dan-Efesien

[5] Mahendradhata Y, Trisnantoro L, Listyadewi S, et al. The Republic of Indonesia health system review [Aust Health Syst Transit. 2017;7(1). Retrieved from https://apps.who.int/iris/bitstream/handle/10665/254716/9789290225164-eng.pdf

[6] WHO, UNICEF, UNFPA, World Bank Group, and the United Nations Population Division. 2019. Trends in Maternal Mortality: 2000 to 2017. WHO: Geneva. Retrieved from https://data.worldbank.org/indicator/SH.STA.MMRT?locations=ID

death and are rarely further investigated for evidence-based solutions.[7] Second, this ideal universal health coverages and health systems has not optimally worked once free public health services, including maternal health care in many provinces were privatised. [8] Private healthcare offers a comprehensive health services with excellent services, with less complicated procedures and long queue and competitive cost. Third, hospitals with a complete health care and well-traiend health workes in maternal health services, may need referral letters for public health insurance users, except in the emergency situation, lead to denial of services, and demand for payment prior to services.

Fourth, a long-distance to visit a well-trained and comprehensive health services. Though Indonesian has developed integrated health system at community level, from Posyandu, puskesmas and private midwifery services for primary services, however midwives at that level are able to provides maternal services for for normal pregnancy without obsetetric issues but they may be unable to provide services for complications for pregnant women and their newborn. Fifth, denials of health workers and policy makers about the chaos in health systems in Indonesia. Some requirements are required to gain licence and accreditation for private and public health care facilities. In addition, regular health facilities survey or RIFASKES (riset fasilitas kesehatan) were conducted routinly by Ministry of Health to evaluate pharamcy, puskesmas, clinics to hospitals[9]. However, accrediation of health services only marked by quantitatives numbers, not quality focus, and may consider for formality procedures to gain high accrediation for health services[10]. Finally, the disparities of health

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[7] National Library of Medicine (NIH). 2013. Reducing Maternal and Neonatal Mortality in Indonesia: Saving lives, saving the future. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK201708/

[8] Webster, P. C. (2012). Indonesia makes maternal health a national priority. *The Lancet*, *380* (9858), 1981-1982. Retrieved from https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)62141-2/fulltext?fbclid=IwAR2Y2YS9mFfqMs3kzXpEWUV0eeG5FUBrgib_VZ8tOnNLWj_nCE7mAd5KwzA

4 Mahendradhata Y, Trisnantoro L, Listyadewi S, et al. The Republic of Indonesia health system review [Aust Health Syst Transit. 2017;7(1). Retrieved from https://apps.who.int/iris/bitstream/handle/10665/254716/9789290225164-eng.pdf

[9] Research and Development Agency, Ministry of Health Indonesia. 2019. Research Reports for health facilities. Retrieved from https://www.litbang.kemkes.go.id/laporan-riset-fasilitas-kesehatan-rifaskes/

[10] Note: Di Indonesia, sistem keseahtan sudah ada, belum optimal working. Everything is there, but not accessible. Yang perlu dilakukan itu adalah mempebanyak campaign, dan turun ke bawah, dan membuat sistem lebih sederhana dan bisa diakses, untuk masyarakat dengan ltierasi rendah. Perlu kerja keras dari tenaga kesehatan, BPJS untuk lebih menyebarkan sistem yang bagus ini ke level-level lebih bawah. Bekerjasama dengan posyandu dan puskesmas. Setiap pihak jangan merasa ego dengan kerja masing2 dan sudah meakukan yang terbaik, tapi tidak ada impact yang nyata terhadap end-user. Seolah-olah sudah bekerja dengan baik, tetapi muter2 disitulah intinya adalah kolaberasi

workers in Java islands and outside Java islands is still exist. The number of Indonesian health workes is 0.25% out of Indonesian total pulations, and mostly work in Java island. Out of 10 the highest number of helath workers, the first to the fourth rank are located in East, west and Middle Java and DKI Jakarta, yet the ratio is still below WHO standard[11].

The Impact of Early Restrictions of Health Services on Pregnant Women

Pregnant women avoided to visit a public health services or hospital, except in an emergency situation. The issue of if you visit hospital, you would be tested COVID-19 were rampant and create another anxiety during pandemic. "I want to check my fetus, not COVID-19," some respondents expressed in this study. Therefore, a private small clinics or private midwifery services become a choice for pregnant to do their routine antenatal care compared to public health centres (puskesmas) or hospital. Therefore, statiscitally, it seems there was a decreasing number of visits for pregnant women during the early pandemic.

The health stakeholders during FGD in this study argue that Large-scale social restrictions, known as Pembatasan Sosial Berskala Besar (PSBB) to Micro-Scale Society Activities Restriction (*Pemberlakuan Pembatasan Kegiatan Masyarakat Mikro*) limit people's movement in public in Indonesia, including for pregnant women. In guidelines issued for pregnant women by Ministry of Health (MoH), Indonesia[12], it was suggested that, if the women did not have any particular issue during their pregnancy, they should focus on preventative measures such as eating nutritious food, and taking supplements. Taken together, these restrictions significantly reduced the number of visits by pregnant women during the pandemic. These phenomenon is also depicted by stakeholders related to health in a focus group discussion in this study.

> Micro-Scale Society Activities Restriction (Pemberlakuan Pembatasan Kegiatan Masyarakat Mikro) limit people's movement outside a house. In a guideline book for pregnant women, if the women did not have any complaint during their pregnancy, pregnant women were recommended to maintain their health by taking nutritious food, take vitamins. Therefore, there was a decreasing number of visits

[11] Databoks. 2021. Number of health workers in Indonesia is about 0.21 % from total populations. Retrieved from https://databoks.katadata.co.id/datapublish/2022/02/15/jumlah-tenaga-kesehatan-indonesia-021-dari-total-penduduk

[12] Ministry of Health (MoH), Indonesia. 2020. Guidelines for maternal health service, postnatal care and newborn babies (Pedoman pelayanan antenatal, persalinan, nifas dan bayi baru lahir) in New-Adapted Era. Retrieved in revisi-2-a5-pedoman-pelayanan-antenatal-persalinan-nifas-dan-bbl-di-era-adaptasi-kebiasaan-baru.pdf (covid19.go.id)

> for pregnant women during the early pandemic. The visit of pregnant women were based on Standard 10 T in Antenatal Care Services. As a result, a decreasing visit of pregnant women contribute to decreasing of triple elimination for HIV, Syphilis and Hepatitis B *(FGD with public health districts, December 2021).13*

Some pregnant women shared their experience why they need to postpone and deter their face-to-face routine antenatal care in the early pandemic. Yaya (24 years), Rini[14] (23 years), and Devi (24 years) a housewife or ibu rumah tangga both from low-income families, decided to make a puppet show and keep diary notes, to elaborate on their experiences. Both Yaya, Rini and Devi delivered their babies in August 2020, October 2020, and December 2020 respectively. They had different experiences within the context of their midwifery practices shutting down and limited well-trained health workers, such as obstertician during pandemic. These included: shutting down health services, restricted visits to other public health services, as well as restricted partner access during consultations and delivery and limited obstetrician in hospitals.

March, 2020: Shutting down and limited well-trained health workers

Rini, 23 years old, who was in first pregnancy, shared a story one month before and after the first cases of COVID-19 were announced in Indonesia. In January of 2020, she went to the public health center (*puskesmas*) for a checkup. Everything was normal, and she was able to access a complete blood test, including an HIV test, and health workers provided supportive ante-natal care. At this time, knowledge of Covid in Indonesia was limited, and many people, including health workers, were not aware of the existence or seriousness of the disease. Consequently, there were few precautions in *puskemas* at the time.

By March of 2020, when she accessed the *puskesmas*, the situation had clearly changed. She was required to wash her hands, carry out social distancing between patients, and wait in an outdoor area. When she arrived at the *puskesmas* and had just got off a trishaw (*becak*) with her mother, a health worker asked her some screening questions related to COVID-19

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[13] Banyaknya PPKM jadi pembatasan aktivitas di luar rumah. Ini juga di dalam panduan ibu hamil memang pembatasan aktivitas di luar rumah, untuk ibu hamil yang tidak mempunyai keluhan diharapkan melakukan kata kita penjagaan kesehatan sendiri melalui makanan yang bergizi, kemudian mengonsumsi obat-obatan atau masuknya vitamin itu kecuali kalau ada hambatan atau ada permasalahan baru di- melakukan pemeriksaan. Jadi itu salah satu terjadinya penurunan kunjungan ibu hamil. Sementara untuk kunjungan ibu hamil ini kami ee apa pelayanannya berdasarkan 10T, jadi standar pelayanan SPM mencakup salah satunya pelayanan pemeriksaan yaitu triple eliminasi, jadi dengan kunjungan ibu hamil yang rendah maka untuk triple eliminasi sendiri sangat rendah.

[14] These are pseudonyms for privacy reasons.

symptoms, such as whether or not they had any flu-like symptoms, such as a cough or a fever, though Rini just wanted to check her pregnancy. Afterwards, the health worker said, regarding her pregnancy, "we cannot check you. If you felt getting worse, such as having bleeding, then you can come to the *puskesmas* again" (Rini's diary notes, 2021). Disappointed, Rini went home and decided to access a private midwifery practice for the remainder of her pregnancy.

In March of 2020, on the way to the midwife, Yaya, who was pregnant for a second time, shared a different story and expressed her experiences of these difficulties. She said that after the midwifery practices that she visited was closed, she and her husband visited another clinic.

Husband: Sir, [is] the doctor still accepting the patient? We want to do a pregnancy check.

Security: Yes, he does... But only the patient is allowed to enter the clinic.

Husband: Why, sir?

Security: That's the rule, sir. I am just doing my work.

Yaya: Could we visit the obstetrician? Do they not accept or forbid us to bring our child?

Husband: No, you're the [only] one who can enter the clinic. Our child and I [can't] accompanying you.

Yaya: Oh, all right, let's go home. I don't want to check my pregnancy, then.

In a focus group discussion with stakeholders in the Public Health District of Palembang (*Dinkes Kota Palembang*) argues that due to the unavailability of personal protective equipment (PPE), and uncertainty of information in the early pandemic, many private midwifery services and clinics were closed, particularly more elderly midwives who were at greater risk of serious illness from Covid. In addition, use of PPE is not standard practice in midwifery consultations as it is more consistently used in public health centers. As a result of these limitations, there was a decrease in the number of visits by pregnant women to *puskesmas*. Despite these difficulties, participants in the study who were health workers, note that that they were able to overcome or mitigate these issues to a degree, by providing online consultations to pregnant women through Zoom or WhatsApp Groups; health cadre and key persons visits home and providing personal protective equipment for midwives and health workers (see Figure 1).

> The decrease in visits of pregnant women is K1 and K4 indicators very much down until July, so it is too drastic sometimes in the health center that there are only 3 or

4 pregnant women visiting. The impact of this visit has dropped, namely the achievement is below the target, well the visits of pregnant women have dropped a lot, including both from pregnant women and from health workers at this time, many are afraid, because the information is still confusing. [quotes online consultation (FGD with public health office, December 2021)[15]

Figure 1. Strategies to improve the visits of ANC during pandemic

Note:The World Health Organization (2022) describes mental health as, not only the absence of mental disorders, but is also an integral component of broader health, which is determined by a range of socio-economic, biological and environmental factors.16 In spite of the happiness of pregnancy during the pandemic, 1) Collaborate with health cadres and community leaders to provide counselling about ANC during the pandemic and mobilize the community for self-examination; 2) Conduct home visits according to data on pregnant women, infants and toddlers; 3) Create a WhatsApp group for pregnant women, mothers in labor and postpartu; 4) Cooperate with hospitals and health facilities in the work area in terms of health service data; and 5) Provide government

[15] Penurunan kunjungan ibu hamil ini K1 maupun K4 indikatornya sangat turun sampai bulan juli, jadi terlalu drastis kadang-kadang di puskesmas itu cuma ada 3 atau 4 ibu hamil yang berkunjung. Imbas dari kunjungan ini turun yaitu capaian di bawah target, nah kunjungan ibu hamil ini turun ini banyak, diantaranya baik dari ibu hamil maupun dari petugas kesehatan saat ini tuh kondisinya banyak yang takut, karena informasinya masih simpang siur.

[16] WHO. 2022. Mental health: Strengthening our response. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

assistance/support in terms of distribution of PPE according to standards for health workers at PMB (private midwifery services). [17]

December, 2020: Restricted partner access during consultations and delivery and limited obstetrician in hospitals

Devi's, 24 years, *Ibu rumah tangga* from low-income family, with a husband who work as a laborer in a traditional market, delivered her first baby on December 2020. She suffered from amniotic leakage, high blood pressure disorder, and sought help in a private hospital. She owned a public insurance (BPJS) and her condition caused her a great deal of stress before, and during her delivery.

Devi's expressed her experience in a short drama that she made with a help of her peers in FGD. She felt uncomfortable with vaginal discharge for four days leading up to her delivery, and initially she sought help from her local midwife. The midwife directed her to hospital. After arriving in the hospital, she went to the emergency room, and disclosed her condition to the nurse in the room. Her husband also arrived in a disheveled condition from working in traditional market. The nurse said:

Nurse: How many days the fluid has come out?

Devi: It is the fourth day

Nurse: Have you undertaken USG?

Devi: Not yet, miss. You know it was pandemic, we did not have money. Can we do a USG here?

Nurse: This is Saturday night, tomorrow is Sunday, if you want to stay in hospital now, it was too long to wait for the therapy. On Monday, obstetrician may come or not…

Devi: So, I cannot do USG here, can I?

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[17] 1) kerja sama dengan kader kesehatan, baik posyandu maupun kader pembangunan manusia, tokoh masyarakat ini untuk memberikan penyuluhan mengenai pelayanan ANC di puskesmas; 2) melakukan kunjungan rumah karena data kami kurang jadi kami juga bekerja sama dengan kader untuk mengetahui dimana adanya ibu hamil di wilayah kerja puskesmas masing-masing; 3) membuat grup whatsapp ibu hamil, nifas, maupun bersalin, jadi di sini kami membuat wa untuk mengetahui keadaan ibu hamil jadi kita bisa melakukan sharing baik itu penyuluhan maupun mengenai kesehatan ibu hamil, bersalin, maupun nifas; 4) adanya distribusi APD standard dari dukungan pemerintah.

Nurse: Yes, I suggest, you go home and seek another health clinic for USG, later after you undergo USG, you can return to our hospital again?

Then, because she felt so exhausted by the process and still concerned for the safety of her baby, she decided to give up and go home. The following morning, Devi went to another center to undertake a USG and needed to borrow money from her neighbor, Rp 70.000 (US $5) to pay for the test. After the USG, the obstetrician told her and her husband to rush to hospital as the amniotic fluids were almost depleted and doctor said "I am afraid the baby would get infected with some diseases" (Devi, FGD). She was rushed to the hospital again and brought her USG with her husband. Though, because of COVID restrictions, she was sad as she needed to undergo a caesarean section without her husband present, she expressed that:

> Finally, I deliver my baby safe through cesarean section, though this pandemic was very difficult and I need to perform some complicated testing. Finally, my efforts come to happiness, my little angle come to this world. (Devi)

In Devi' reflection note, they urged the health system in Indonesia to provide easier and equal access to health services using the public insurance system though Devi's got suported by the government to pay regular cost for the public insuranceshe needed to visit three different health services to gain access to a reasonable level of maternal care through the public insurance system. The delays she experienced, in our opinion, constitute a near-miss, where her health and that of her baby were threatened due to an overly bureaucratic and disconnected health systems in Indonesia, compounded by the limited number of health workers available during the pandemic.. In our experience, Devi's plight is, sadly, not unusual in middle income countries such as Indonesia.[18]

The experiences of the participants highlight the disproportionate level of difficulty placed on pregnant women by government COVID-19 initiatives. These added burdens may be seen in how health workers, including midwives and obstetricians, a frontline for antenatal care, may choose to close their practices and not provide their services.

When services were offered, they highlighted a disconnect between the government's COVID-19 requirements for social distancing and cultural practices within Islam. If health practices remained open, they often limited their services to unaccompanied, pregnant mothers

[18] Maternal Near Miss: An Indicator for Maternal Health and Maternal Care (nih.gov)

to come into obstetrician's room or engage in the delivery process without family (husband or parents). The issue here is, within Malay and Islamic cultures, not all pregnant women are comfortable with a health professional checking their baby in utero without the attendance of their husband in a closed consultation room.

A further issue with social distancing, is health offering online consultation (telemedicine). Telemedicine may not be an effective method for pregnant women from low to middle income families who are used to meeting directly with their doctors to address their health concerns. Internet access remains an issue in Palembang, particularly during the COVID-19 economic downturn and its resulting effects on unemployment.

"I am traumatised, I am traumatised….I am traumatised": A difficult birth during pandemic

Other participants who were a working, from middle income family, pregnant mother during pandemic, faced different pressures and spoke of the stress caused by COVID-19. In her case, she spoke of how the existence of the disease itself placed her considerable pressure during her pregnancy. When she thought of potentially catching the disease, it was unknown what effect it would have on her pregnancy and what impact it would have on the baby's health.

Limiting social mobility, especially migration, adds to the strain on businesses (including transport and supply chains), which lead to lower employment or job losses, which in turn, forces more women and their children into a vicious poverty cycle. As schools were closed and working at home became the norm, more family members spend more time at home, and a greater load of child-rearing and food preparation disproportionately falls to women. Add to the equation higher rates of violence perpetuated against women, and the impact becomes a destructive concoction added to the already difficult burden of pregnancy (Primandari, 2020).[19] These stresses were compounded when pregnant women themselves or a close family member, were tested positive for COVID-19. Other participants, Winda, Ani and Dina were in a similar position.

Winda, 28 years old, a lecturer in a public university shared her experience during her second pregnancy, and working from home (WFH) during the first year of pandemic. Winda was placed under a great deal of stress when she discovered her mother and grandmother, who

[19] Primandari, Fadhila, 2020. Gendering Indonesia's responses to COVID-19: Preliminary thoughts. New Mandala. New Perspectives on South East Asia. 19 Oct 2020. https://www.newmandala.org/gendering-indonesias-responses-to-covid-19-preliminary-thoughts/.

lived with her, were diagnosed as COVID-19 positive. Her mother then suffered from severe symptoms and was hospitalized. The resulting hospitalization of her mother placed even greater stress on her, as she had to shoulder even more household chores and other responsibilities. Fortunately, Winda's COVID-19 test was negative. But being pregnant, exposure to COVID-19 raised many issues for her. She expressed her experiences through her diary notes:

> The peak of concern finally arose when my mother, who lived in the same house with me, was confirmed positive for COVID-19… her symptoms were so severe, she had to be hospitalized… My grandmother was [also] confirmed positive but without symptoms, so she had to isolate independently at home.
>
> This is certainly a heavy psychological pressure for me. What if I have been infected without realizing it? What if my first child or husband is infected and I have to take care even though I am pregnant? That's all I can think of. Until we were in the same house and then we also did a COVID-19 check and thank God all were negative, but the thought still popped up, don't you think there will be something positive in the future? Moreover, my husband has started to go to work as usual and every time he comes home with a story that a friend from his office is positive for COVID-19, it makes me sometimes think, should my husband be told to sleep in another room so that I am safe? (Winda, February 2021 diary notes)

Ani, a forty-year-old midwife, shared her story when she was diagnosed with COVID-19, and was required to deliver her baby subject to COVID-19 restrictions in a public hospital in Palembang. At the same time, her husband was also hospitalized in an IC unit. Despite being asymptomatic, her COVID positive children were treated at home. Initially, her family members were afraid of taking care of her children as Ani needed to travel to Palembang for her Caesarian section.

> I was… infected with COVID-19 during my last term of pregnancy. No one wanted to take care of my children because I had to be referred to the Palembang [hospital] to deliver my baby. Finally, my brother-in-law got up the courage to take care of my asymptomatic children. I was referred to a different hospital from my husband in Palembang. I gave birth to my third child when my husband was unconscious and struggling in the ICU. In the hospital, the nurse only came into my room when injecting the medicine and immediately

> left me alone in the isolation room. After I delivered my baby, I was separated to my baby directly to prevent COVID-19 transmission. Thank God (*Alhamdulillah*), my husband and my family were still given a second chance to live and we have been declared negative for COVID-19. I am traumatized, I am traumatized, and I am traumatized (Ani, a working mother, 40 years old, access to caesarean section, online chatting through WhatsApp).[20]

Another participant (Dina) shared a different story of her pregnancy and being confirmed with COVID-19 in March 2021. She decided to admit herself to hospital after she knew she was COVID positive in order to protect her other young children and husband at home. She felt alone and extremely uncomfortable in the hospital. However, she explained how, with the support from health workers, she survived the disease, despite being treated by COVID positive staff.

> …a nurse who treated me was also infected with COVID-19 during my pregnancy. The nurse did not suffer any symptoms, [and] was diligent to check my fetus… three times a day. For me, I was lucky, the nurse did not be afraid of me and was friendly during my hospitalization (Dina, 32 years old, a working mother, informal interview).

The above observation reinforces our observations of lax COVID restrictions. There have been several incidents where health workers who have been affected by COVID should have isolated and rested at home instead, continued to work. Had they disclosed their COVID status, they risked being fired or being sent home, and would lose whatever benefits they accrued. This practice therefore remained hidden, reflecting the poor pay and precarious working conditions forcing COVID positive health professionals to work in spite of the clear risks to themselves and the broader public. Health workers are paid according to the number of working hours. In many cases, they are required to work overtime to augment their poor

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[20] *Saya trauma dengan COVID-19, kedua anak saya dan suami saya juga tertular COVID-19. Saya juga terinfeksi COVID-19 selama masa kehamilan terakhir saya. Tidak ada yang mau mengasuh anak saya karena saya harus dirujuk ke Palembang untuk melahirkan bayi saya. Akhirnya, kakak ipar saya memberanikan diri untuk merawat anak-anak saya yang asimtomatik. Saya dirujuk ke rumah sakit yang berbeda dari suami saya di Palembang. Saya melahirkan anak ketiga saya ketika suami saya tidak sadarkan diri dan berjuang di ICU. Di rumah sakit, perawat hanya masuk ke kamar saya saat menyuntikkan obat dan langsung meninggalkan saya sendirian di ruang isolasi. Setelah saya melahirkan bayi saya, saya langsung dipisahkan dengan bayi saya untuk mencegah penularan COVID-19. Puji Tuhan (Alhamdulillah), suami saya dan keluarga saya masih diberi kesempatan kedua untuk hidup dan kami dinyatakan negatif COVID-19. Saya trauma, saya trauma. Untuk saat ini, saya masih menutup praktik kebidanan di rumah saya. (Ani, ibu bekerja, 40 tahun, akses operasi caesar, chatting online melalui WhatsApp).*

earnings,[21] as well as making up for the lack of other staff available to work, due to absences caused by COVID (Focus group discussion with health stakeholders, December 2021).[22]

A further theme identified by research participants was a fear of the COVID-19 test itself, as a requirement before delivery of their babies. In our study, some participants spoke of the fear that the test might be a type of corruption, suspecting it might be a revenue-gathering exercise by health professionals. They were also, therefore, suspicious of measures that isolated patients. The result being that they chose not to deliver their babies in hospital, out of this fear, adding to an already challenging situation.

For those pregnant mothers who were confirmed to be COVID positive, dealing with fears of transmitting COVID to their babies and the added burdens of unemployment, as well as the extra stress of looking after family members has come at a heavy cost to those we studied. Experiences such as these, highlight how the issues identified in Section 2, have an impact at the individual level. We now turn to the experiences of HIV positive women and poor pregnant women interviewed in our research, and how COVID-19 exacerbated health services for women before or after giving birth in Indonesia.

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[21] *Ada beberapa kejadian dimana banyaknya tenaga kesehatan yang terkena covid seharusnya di isolasi dan di istirahatkan dirumah malah tetap masuk bekerja. Hal ini terjadi di lapangan tanpa ketahuan. Apabila terungkap maka akan didiskualifikasi atau dipecat. Alasan nya ialah kalau mereka terinfeksi covid, maka tunjangan mereka akan di potong. Para tenaga kesehatan digaji sesuai jam kerja yang mengharuskan mereka lembur.*

[22] *Saya beruntung, perawat yang menjaga saya di rumah sakit ketika terinfeksi COVID-19 saat hamil, juga positif COVID-19 tanpa gejala. Sang perawat cukup rajin memeriksa janin saya, 3x dalam sehari. Bagi saya, saya beruntung, sang perawat tidak merasa takut dan ramah dalam merawat saya (Dina, 32 years old, a working mother).*

Neglecting HIV Positive Women's Rights

In the third theme identified during our research, we discuss how shortages of health workers during the pandemic has resulted in a worsening of the lived conditions of disadvantaged groups, particularly HIV-positive, who rely solely on public insurance (BPJS) for their healthcare.

In 2016, the World Health Assembly endorsed three interrelated strategies for the elimination of mother-to-child transmission of HIV, and other sexually transmitted infections such as Hepatitis B and Syphilis (World Health Organization, 2018).[23] The strategy recognized that eliminating mother-to-child transmission, can be successfully prevented by a range of simple actions such as ante-natal screening, vaccination as well as providing treatment for women and their families. Sadly, it remains the case that many infants will be born with preventable infections in Indonesia (Dwi, 2019).[24]

As a result of the restrictions placed on pregnant women due to COVID, the result has seen a decrease in the number of visits by pregnant women to health centers, which has undermined the triple elimination goals (Public Health Districts, 2021).[25] On an individual level, the effects of this situation were expressed by Yana, an HIV-positive mother going by herself to check on the progress of her condition one day after the delivery of her first child. In tears, she expressed her feelings during a virtual interview:

[23] World Health Organization, 2018. Regional framework for the triple elimination of mother-to-child transmission of HIV, hepatitis B and syphilis in Asia and the Pacific, 2018–2030. Manila, Philippines, World Health Organization Regional Office for the Western Pacific.https://apps.who.int/iris/bitstream/handle/10665/274111/97892906185… · PDF file

[24] Dwi, P, 2019. Triple Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B in Indonesia, Towards Universal Coverage: Progress and Challenges. KIT - Royal Tropical Institute, Amsterdam, the Netherlands, https://bibalex.org/baifa/en/resources/document/476604.

[25] *Praktik Mandiri Bidan, banyak yang tutup. Praktik ini banyak yang tutup, di samping juga itu bidan yang sudah usia lanjut. Jadi lansia, karena termasuk apa yang rawat mereka tutup, di samping itu juga APD tidak standar, khusus PMB. Tetapi kalo misalnya di FKTP dia mereka kan kita dapat distribusi MB, untuk BPM salah satunya mereka tidak mempunyai APD yang standar ditambah juga banyaknya PPKM jadi pembatasan aktivitas di luar rumah. Ini juga di dalam panduan ibu hamil memang pembatasan aktivitas di luar rumah, untuk ibu hamil yang tidak mempunyai keluhan diharapkan melakukan kata kita penjagaan kesehatan sendiri melalui makanan yang bergizi, kemudian mengonsumsi obat-obatan atau masuknya vitamin itu kecuali kalau ada hambatan atau ada permasalahan baru di- melakukan pemeriksaan. Jadi itu salah satu terjadinya penurunan kunjungan ibu hamil. Sementara untuk kunjungan ibu hamil ini kami ee apa pelayanannya berdasarkan 10T, jadi standar pelayanan SPM mencakup salah satunya pelayanan pemeriksaan yaitu triple eliminasi, jadi dengan kunjungan ibu hamil yang rendah maka untuk triple eliminasi sendiri sangat rendah.*

(Crying) So, what is it like, my baby is not treated properly, basically, like that (her baby was treated in a room without air conditioners, alone and wore only diaper and a layer of blanket). I was suspected to get infected Syphilis. I was asked to check syphilis test by myself to the closest laboratory during my hospitalization. My husband cannot accompany me in the hospital as my husband took care my other three children at home. The health worker asked me to check my syphilis as quick as possible. [I answered the health worker] Okay, I'll check Syphilis in the closest laboratory in the hospital, my husband is at home, right, take care of the little child. A health worker usually takes my blood and send it to the laboratory, however now I needed to check by myself. I walked to the laboratory. I asked my son to come home quickly. The blood test showed negative syphilis, and my son didn't have any symptoms related to Syphilis. I am wondering, if my newborn baby suffer from the impact of stigma of HIV during COVID.

She was also suspected of having COVID-19 as she did not have time or resources to check before her delivery. Unfortunately, at that time, she needed to wait for a few days to get the COVID result. Though finally a few days later her test showed negative.

Discussion

In Indonesia, the majority of women are vulnerable to the economic impacts of COVID, as their work contracts are often either non-existent or insecure. A UNESCO study in 2020,[26] shows that women are disproportionately employed in the retail, food service and accommodation sectors. It is these sectors that have experienced the steepest decline. In addition, households led by women account for approximately fifteen percent of the population and more likely to have poor access to resources such as medical services, clean water, decent housing. Women are also exposed to a greater risk of catching COVID-19 as a result of unequal vehicle ownership, and consequently more women use public transport which presents a greater risk of infection (Godfrey, 2021).[27] Women are also more likely to be more stressed and anxious as a result of COVID and they are more likely to be caring for family members adding

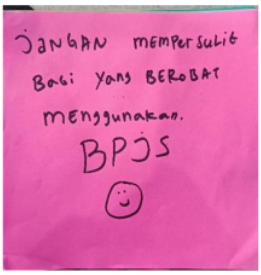
[26] UNESCO, Samudra, R. R. Diahhadi Setyonaluri Lembaga Demografi. 2020. Inequitable Impact of COVID-19 in Indonesia: Evidence and Policy Response. Retrieved in https://en.unesco.org/inclusivepolicylab/e-teams/inequalities-time-covid-19/documents/inequitable-impact-covid-19-indonesia-evidence-and-0

[27] Gofrey, Amanda. 2021. The Impact of COVID-19 in Indonesia. The Borgen Project. https://www.borgenmagazine.com/impact-of-covid-19-in-indonesia/

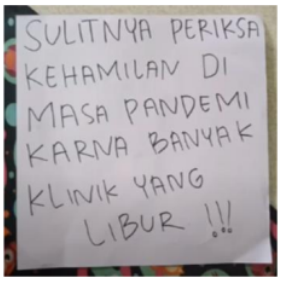
to an expanding workload, impacting their mental health even further (UN COVID-19 Response and Recovery Fund 2020).[28]

Strategic Development

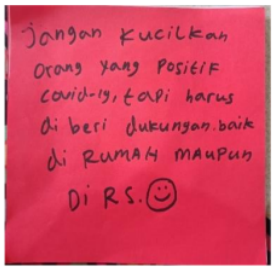
Voice from mothers



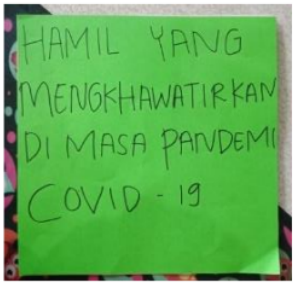
Asking for easier access to health services for those who used public health insurance



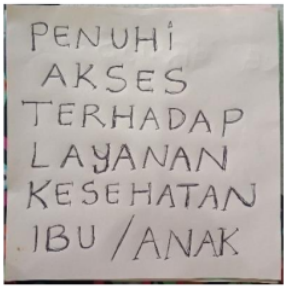
It is difficult to check pregnancy during the pandemic because many clinics arc closed



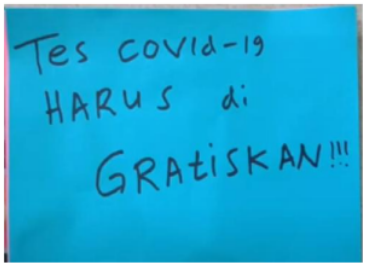
Friendlier health services [during pandemic]



Worrying about pregnancy during the COVID-19 pandemic



Please, fulfill all health services for mothers and kids



Free COVID-19 test

[28] UN COVID-19 Response and Recovery Fund, 2020. Counting the Costs of COVID-19 Assessing the Impact on Gender and the Achievement of SDGs in Indonesia. https://data.unwomen.org/publications/counting-costs-covid-19-assessing-impact-gender-and-achievement-sdgs-indonesia

Strategies to Improve ANC Service Outcomes

Problem	Strategy
Man • Limited human resources • WFH and WFO systems for health workers at public health centers or hospitals	Man • Hospital or public health centers staff need to schedule HIV screening for pregnant women • Prepare substitute staff so that there is no shortage of HIV screening officers
Money • Limited budget due to focus on COVID-19 budget	Money • Propose a specific budget for the HIV program
Material • Rapid HIV 2, HIV 3, and syphilis RPR still not available	Material • Propose to the Provincial Health Office regarding HIV rapid stock • Independent rapid procurement
Machine • Multiple use of laptop/computer • Low specification computer/laptop	Machine • Submit reports on time • Propose the procurement of computers and laptops
Method • Implementation of Large-Scale Social Restrictions (PSBB) and Community Activities Restrictions Enforcement (PPKM) so HIV screening decreases	Method • Counseling via WhatsApp • Taking ARV • Taking drugs by delivery (gosend, etc.) • Provision of HIV screening • Make MoUs with BPS, private clinics, and BPM
Environment • Compliance with taking medication for HIV patients • Complaints about taking ARV drugs • Family support • Fear of visiting the public health centre or hospital during pregnancy	Environment • Supervision of taking medication (PMO) from the family • Support from NGOs • ARV adherence test using Cotrimoxazole

Conclusion

Similar to previous epidemics, COVID-19 has challenged Indonesia and exposed how the nation as a whole governs itself, putting a spotlight on the important role of strong scientific input within the policy creation and propagation process. This research has drawn the attention of the reader to the way Indonesia has constructed a dated governmental gender narrative, falsely painting women as a heteronormative subject within the private sphere. Documenting the experiences of the women who were part of this study has exposed how mixed messages of Covid denial and assumptions of heteronormative sexual practices can have destructive effects on Indonesian society, particularly those living in precarious economic conditions. It is hoped that this chapter contributes to a broader, more open discussion on the role of the state and how it both acts as a gatekeeper for impeding the progress of women in Indonesia as well as having the potential to be a champion of women's rights with the broader Islamic world.

Attachment 1

Table 1: Pregnant women characteristics in this study during pandemic

Name	Age	Public insurance	Antenatal care services	Place of delivery	Access to		Group	Note
					HIV test	COVID-19 test		
1. Vela	25	Yes	Puskesmas	Hospital	Yes	Yes	HIV	A housewife, Senior high school
2.Widia	34	Yes	Private midwifery practice	Hospital	Yes	Yes	HIV	Family planning promoter Bachelor degree
3.Yana	25	Yes	Puskesmas	Hospital	Yes	No	HIV	A housewife, a senior high school
4.Nurlaili	36	Yes	Private obstetrician clinic and midwife	Hospital	Yes	No	HIV	A housewife, Senior high school
5. Yunita	25	Yes	Midwifery practice and puskesmas	Midwifery practice	Yes	No	HIV	A housewife, senior high school
6.Deva	23	Yes	Midwife and puskesmas	Hospital	No	Yes	Non-HIV	A housewife, vocational school (SMK)
7.Jiha	23	No	Private obstetrician	Private obsetrician clinic	No	No	Non-HIV	A housewife, junior high school
8.Mardhiyah	24	No	Private obstetrician	Private obsetrician clinic	No	No	Non-HIV	A housewife, a vocational school
9.Rina	23	Yes	Midwifery practice and puskesmas	Midwifery practice	Yes	No	Non-HIV	A housewife, senior high school
10.Fitriah	23	Yes	Private midwifery practice	Hospital	Yes	Yes	Non-HIV	An online seller
11.Ajeng	19	No	Private midwifery practice	Midwifery practice	No	No	Non-HIV	A housewife, Junir high school
12.Desi	28	Yes	Obstetrician clinic and Private midwifery practice	Clinic	No	No	Non-HIV	A employee, Bachelor degree
13.Widi	28	Yes	Obestetrician clinic	Hospital	No	Yes	Non-HIV	A lecturer, master degree
14.Rama	36	Yes	Private clinic	Private clinic	No	No	Non-HIV	A employee, Bachelor degree
15.Wennita	38	Yes	Hospital	Hospital	Yes	Yes	Non-HIV	A nurse, diploma

16. Lia	40	Yes	Hospital	Hospital	Yes	Yes	Non-HIV	A midwife, diploma
17 Yaya	33	Yes	Hospital	Hospital	Yes	Yes	Non-HIV	A lecturer, master degree
18 Oyen	30	Yes	Private clinic	Private clinic	No	No	Non-HIV	A lecturer, master degree
19. Nita	33	Yes	Hospital	Hospital	Yes	No	Non-HIV	A lecturer, master degree
20. Nana	25	Yes	Midwifery practice and puskesmas	Midwifery practice	No	No	Non-HIV	A housewife, senior high school

2

Box 1. Practice points for primary care physicians • Inform local authority about suspected cases and facilitate testing. • Promote social distancing signage at clinics asking patients to self-identify if they are having flu-like symptoms, have travelled abroad or have come into close contact with someone who has tested positive. • Screen patients over the phone before visiting the clinic. • Reduce in-person antenatal care services. • Promote teleconsultations. • Be aware of the levels of personal protective equipment to be used when a patient is under investigation and examine patients only with all precautions. • Report all patients with fever. • Prom

Fears of pregnant women seeking antenatal care during the Covid- 19 pandemic: Disrupted maternity in South Sumatra, Indonesia

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