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Evaluation of minimum service standards for maternal health services at a primary health center

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Abstract

Background: Minimum Service Standards are mandatory benchmarks for local governments and primary healthcare facilities to ensure the provision of essential maternal health services. Their achievement is important for improving antenatal care and reducing maternal morbidity and mortality.

Purpose: To evaluate the achievement of Minimum Service Standards for maternal health services.

Method: This qualitative evaluative study used a descriptive approach and the logic model framework, covering input, process, and output components. The study was conducted from November 2025 to August 2026. Fourteen informants were selected purposively, including the head of the primary health center, the maternal and child health coordinating midwife, a physician responsible for the maternal and child health cluster, six implementing midwives, and five pregnant women. Data were collected through in-depth interviews, observation, and document review and were analyzed thematically. Data credibility was supported through source and method triangulation.

Results: Human resources were generally adequate in number and educational qualifications, although access to technical training was uneven. Maternal health facilities and basic equipment were available, but ultrasound services were underutilized because of the reassignment of trained physicians and limited service-room capacity. Antenatal care procedures and dual recording through manual registers and the e-Cohort system were generally implemented according to standard operating procedures. However, funding constraints affected outreach activities. Coverage of the first antenatal visit was 81.8%, while coverage of the sixth antenatal visit was 71.9%, both below the national target of 100%. Delayed first visits, refusal of triple elimination screening, sociocultural beliefs, and incomplete continuity of care contributed to the low achievement.

Conclusion: Maternal health Minimum Service Standards at Penyengat Olak Primary Health Center have not yet reached the national target despite generally adequate human resources and service procedures. Improving technical capacity, continuity of antenatal care, community education, outreach financing, and cross-sectoral collaboration is necessary to improve maternal health service coverage.

Keywords: Antenatal Care; Logic Model; Maternal Health Services; Minimum Service Standards; Primary Health Center.

INTRODUCTION

Health development is an integral part of national development, aiming to increase awareness, willingness, and ability to live a healthy life for everyone, thereby achieving the highest level of public health. As a commitment to fulfilling citizens' basic rights, the government issued Government Regulation Number 2 of 2018 concerning Minimum

Service Standards and Minister of Home Affairs Regulation Number 59 of 2021, which requires every regional government to implement Minimum Service Standards (MSS) in the health sector. MSS stipulates the type and quality of basic services that every citizen must receive at a minimum (Legal Documentation and Information Network, 2021).

Community health centers as first-level health care facilities, act as the spearhead of health services in the community, playing a key role in achieving MSS indicators in their jurisdictions (Indonesia, 2009). The Minister of Health Regulation stipulates 12 basic service indicators that must be met by district/city governments. One crucial indicator in the national priority program is Maternal Health Services. Comprehensive prenatal care through quality Antenatal Care (ANC) services is crucial for early detection of pregnancy risk factors, anticipating maternal complications, and reducing the Maternal Mortality Rate (MMR) (Ministry of Health of the Republic of Indonesia, 2009).

Globally, the World Health Organization (WHO) estimates that by 2023, approximately 260,000 women will die from complications of pregnancy and childbirth, representing more than 700 maternal deaths every day. In Indonesia, the MMR remains a serious challenge, with an estimated rate of 140 per 100,000 live births in 2023. This situation requires concerted efforts to achieve the 2030 Sustainable Development Goals (SDGs) target of 70 per 100,000 live births. In Jambi Province, maternal deaths in 2023 were still dominated by complications of bleeding (18 cases) and hypertension/preeclampsia (9 cases). Muaro Jambi Regency itself recorded 2 cases of maternal death that year (World Health Organization, 2023).

In Indonesia, the Maternal Mortality Rate (MMR) remains a serious challenge. In 2023, the national MMR is estimated to be 140 per 100,000 live births, down from the previous decade but still far above the 2030 SDGs target of 70 per 100,000 live births. This condition reflects structural barriers such as limited access to primary health care facilities and low antenatal visits. Therefore, an in-depth evaluation of Community Health Center MSS indicators is necessary as the government strives to achieve the 2024 RPJMN target of 183 per 100,000 live births (Sukmawati, Mamuroh, & Nurhakim, 2025).

Based on the Muaro Jambi District Health Office Profile report for the 2021-2024 period, the overall performance of the MSS health sector in the district remains relatively low, with only 16.66% of indicators (health services for toddlers and the elderly) successfully meeting their functional targets (Muaro Jambi District Health Office, 2025). At Penyengat Olak Community Health Center, the 2025 MSS evaluation data shows contradictory performance.

While postnatal child health programs, such as Toddler Health Services, successfully exceeded their target of 109%, coverage of Maternal and Child Health Services stalled at 72%, far below the national target of 100%. This low coverage is directly related to sociological constraints on the ground, such as a public mindset that trivializes routine first-trimester checkups, resistance to triple elimination blood screening, and non-medical delivery practices (Penyengat Olak Health Center, 2025).

Previous studies have confirmed a decline in Maternal and Child Health MSS performance due to external sociological constraints and incomplete data collection at health facility records. Therefore, the research question in this study focuses on an in-depth evaluation of the implementation of Maternal and Child Health MSS in maternal and child health services at Penyengat Olak Community Health Center, from the perspective of input, process, and output. The general objective of this study was to analyze the supporting and inhibiting factors in achieving the MSS indicators for pregnant women as a basis for developing strategic recommendations for improving the primary maternal care system (Nugraheni, Lurinsa, & Landau, 2024).

Other research also revealed that one of the lowest MSS targets was maternal health services at 40.23%. This achievement is quite low compared to the established target of 100%. These results indicate obstacles in program implementation, one of which is that pregnant women within the Linggarjati Community Health Center are not examined at the facility, thus not being recorded in the target achievement (Fauziah et al., 2026). Furthermore, Zudi's (2021) research found six indicators that had not been achieved: Maternal Health Services, Toddler Health Services, Elderly Health Services, Diabetes Care Services, Hypertension Care Services, TB Care Services, and HIV Care Services. Not meeting the MSS target is caused by the quality and quantity of human resources being less than optimal, wide coverage area, less than optimal monitoring and evaluation as well as public and cultural awareness which are external factors (Fauziah, Rizqi, Rohiyatun, & Negara, 2026).

RESEARCH METHOD

This study employed a qualitative design with a descriptive analytical approach to deeply explore the meaning, phenomena, and realities of maternal and

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child health program governance in the field. The study was conducted at the Penyengat Olak Community Health Center in Muaro Jambi Regency, with field data collection ranging from November 2025 to August 2026. Informants were selected using a purposive sampling technique based on inclusion criteria of policy authority, clinical technical competence, and direct involvement as program targets.

The study involved 14 informants, divided into three classification levels: Key Informant, namely the Head of the Community Health Center (1 person); Key Informants consisting of the MCH Person in Charge/Coordinating Midwife (1 person), the MCH Cluster Doctor (1 person), and the Implementing Midwives (6 people); and Supporting Informants, namely pregnant women within the Community Health Center's work area (5 people). The primary instrument in this qualitative study was the researcher herself, assisted by a structured in-depth interview guide, physical facility observation sheets, an audio recorder, and a cohort register documentation logbook.

Primary data was collected through verbatim in-depth interviews and participant observation, while secondary data was collected through document review of monthly MMS reports, annual community health center reports, and population data. Data analysis followed the Thematic Analysis model, with the stages of Data Reduction (condensation and categorization of field data), Data Presentation (narrative matrix), and Conclusion Drawing/Verification. Data validity was ensured through Source Triangulation (comparing information across levels of informants) and Method Triangulation (combining interview results, physical observations, and secondary document records).

This study received ethical approval from the Health Research Ethics Committee of Jambi University with approval number: 250/UN21.8.5/PT 01.04/2026. All participants were informed about the objectives of the study, confidentiality procedures, and their right to withdraw from participation at any stage of the research process.

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RESEARCH RESULTS

Table 1. Characteristics of Technical Competence of Internal Informants

Code	Clinical Position / Role	Highest Educational Qualification	Maternal Health Training Status
Inf-1	Head of Public Health Center (Managerial Person in Charge)	Bachelor's Degree in Health Sciences	Health Service Management and MSS Training
Inf-2	Cluster 2 Coordinator / Maternal and Child Health (MCH) Coordinating Midwife	Bachelor's Degree in Midwifery with Professional Qualification	Integrated Antenatal Care (ANC), Midwifery Update, and Normal Delivery Care (APN) Training
Inf-3	Maternal and Child Health Cluster Physician	Medical Doctor (Bachelor of Medicine and Professional Qualification)	Basic Obstetric Ultrasound Screening Training (Preliminary Level)
Inf-4	Immunization Program Coordinator / Midwife	Bachelor's Degree in Midwifery with Professional Qualification	Cold Chain Management and Midwifery Update Training
Inf-7	Quality Assurance Coordinator / Health Promotion Coordinator / Mental Health Coordinator	Bachelor's Degree in Midwifery with Professional Qualification	Maternal and Child Health Counseling and Maternal Mental Health Screening Training
Inf-9	Junior Staff Midwife	Bachelor's Degree in Midwifery with Professional Qualification	Has Not Attended Formal Maternal Health Training

Qualitative analysis of the sub-component of human resource quality demonstrates a significant leap in the quality of formal functional education at Penyengat Olak Community Health Center. All midwives assigned to Cluster 2 (Mother, Child, and Adolescent) have completed Bachelor's (S1) degrees in Midwifery and professional education, eliminating the need for Diploma 3 (D3) qualifications within this service unit. This was confirmed directly by the Head of the Community Health Center:

"...for our services now, we're cluster-based, and all our human resources in those clusters have Bachelor's degrees. Previously, we had Diploma 3 degrees, but thank God, today, all have Bachelor's degrees, and there are no longer any Diploma 3 degrees..." (Inf-1)

Despite the equitable quality of formal education, the distribution of clinical competency through formal on-the-job training remains limited due to restrictive APBD/Dinkes quotas. To anticipate these obstacles, the community health center implemented a tiered knowledge transfer policy (knowledge sharing system) from the Coordinating Midwife to the implementing staff:

"...the latest knowledge upgrades are gradual, not everyone can participate in training, but for the Coordinating Midwife, like me... usually it has to be the Coordinating Midwife, because the Coordinating Midwife is the one who informs other members in the Cluster..." (Inf-2)

In terms of quantity, staff availability is considered sufficient, with a total of 27 midwives and 3 doctors, flexibly allocated to maintain in-house operations and mobilize services outside the building (Integrated health service post and home visits). The physical constraints complained of by health facility informants actually stemmed from the limited space of the MCH service area since the integration of the polyclinic into the service cluster integration system.

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Medical Facilities and Infrastructure

Based on direct physical observations and interviews, the availability of essential basic medical supplies (such as Td vaccine, iron tablets, LiLA measuring devices, and basic laboratory screening reagents) is safe and ready for use. However, this study identified a critical flaw in the operationalization of advanced supporting equipment, such as ultrasound (USG). The ultrasound equipment is in good physical condition, but its utilization has stalled or been suboptimal due to the transfer of USG-certified general practitioners to other health facilities, as well as minor logistical obstacles such as the depletion of USG gel at the community health center:

"...If the equipment is available, the USG is also available. The USG functions well, but there are no trained doctors. This is new; there was one transferred last year. USG is not the responsibility of midwives..." (Inf-4)

In addition to the USG constraints, the community health center has experienced a shortage of MHC (Maternal and Child Health) books from the Health Office for the past few fiscal years, forcing midwives to record on alternative sheets or rely on books left over from previous independent procurement.

Service Regulations and Policies

Regulatory aspects demonstrate high levels of compliance with clinical care governance. Healthcare workers, in carrying out service activities, strictly adhere to the Integrated Antenatal Care Standard Operating Procedures (SOP) and the minimum K6 quantity performance targets outlined in Minister of Health Regulation No. 6 of 2024. The Community Health Center also utilizes an online digital reporting system, which is monitored periodically through monthly mini-workshops by the Head of the community health center to evaluate deviations from indicator achievement.

Program Budget Allocation

Operational funding for maternal health services at Penyengat Olak Community Health Center is funded by a dual scheme: Health Operational Assistance (BOK) funds from the State Budget (APBN) for off-site operations (Public Health Efforts/UKM), the Regional Public Service Agency (BLUD) budget, and BPJS capitation funds for on-site operations (Individual Health Efforts/UKP). The BPJS integration policy ensures that prenatal care services are free of charge. However, the current year's budget efficiency and rationalization policies have resulted in reduced transportation costs for field staff, which risks limiting the intensity of outreach to high-risk pregnant women at the village level:

"...There's no impact on regular services, except for the community health efforts activities we go to the villages for. There are many more that aren't funded..." (Inf-4).

Process Evaluation Results

The implementation of maternal health services in the field combines in-house activities through standard 12T examinations and out-of-house activities to expand the reach of the target population. Staff consistently implement a double-entry system to ensure data validity. Patient clinical data is manually recorded in a register/cohort book and digitally inputted into the Ministry of Health's e-Cohort application.

To optimize target absorption, the community health center regularly runs the Pregnant Women's Class program in eight villages within its working area, with an attendance rate of 99%. This class was structured in four meeting cycles, covering early pregnancy education, childbirth preparation, recognizing danger signs of childbirth, and implementing pregnancy exercises in the third trimester to minimize clinical risks. Furthermore, village midwives utilized social media by establishing WhatsApp groups specifically for pregnant women per village as a digital IEC platform and providing real-time announcements of Integrated Health Post schedules.

Although the service mechanism from the health workers was well-structured, the target uptake process faced massive external resistance stemming from patients' socio-cultural factors. Some pregnant women refused to have blood samples taken for triple elimination laboratory testing due to psychological fear of needles and the negative sociological stigma surrounding HIV/syphilis screening results. Technical operational obstacles, such as sudden power outages, were also reported to disrupt the online internal referral process and real-time data entry at community health centers.

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Table 2. Trend of K1 and K4 Visits for Pregnant Women (2022-2025)

Maternal MSS Performance Indicator	MSS Target (%)	Achievement 2022 (%)	Achievement 2023 (%)	Achievement 2024 (%)	Achievement 2025 (%)	Final Achievement Status (2025)
First Antenatal Care Visit Coverage (K1)	100	88.2	84.6	81.1	81.8	Target Not Achieved
Fourth Antenatal Care Visit Coverage (K4) / Sixth ANC Visit (K6)	100	78.4	76.0	72.4	71.9	Target Not Achieved

Based on secondary data and a compilation of the MHC register, the final output for achieving the Minimum Service Standards (MSS) for Maternal Health Services at Penyengat Olak Community Health Center in the 2025 evaluation year was 72% for cumulative quantitative performance, stagnating and showing a downward trend compared to previous years. In-depth screening of visit history revealed the actual K1 rate reached 81.8%, and the final K6 rate was 71.9%. This empirical evidence confirms that Penyengat Olak Community Health Center failed to meet the national MSS target for health, which sets an absolute target of 100%.

From a sociological and patient behavior perspective (demand-side), in-depth interviews revealed that this failure to achieve the 100% target was driven by delays in the first visit of pregnant women. Many pregnant women only reported their pregnancies or visited the village midwife after three months of pregnancy (the end of the first trimester or the beginning of the second trimester). Reasons for delays range from lack of information about early pregnancy to long travel/homecoming, as explained by the following informant:

"...I knew about it yesterday, but it was the end of the month, so I automatically went back to my hometown, hmmm..." (Inf-14)

Delays in K1 automatically create a negative domino effect on the quality of MSS outcomes, as they hinder the implementation of essential first-trimester blood screening, increase the risk of dropout from K6 visits, and allow potentially high-risk maternal emergencies to go undetected in the early embryonic phase. This behavioral pattern is exacerbated by the

reliance of some rural communities on traditional, non-medical birth attendants due to cultural ties.

DISCUSSION

The application of the Logic Model to the evaluation of the MSS for Pregnant Women at the Penyengat Olak Community Health Center revealed a structural disconnect between the readiness of high-value input components and the final output results, which fell below national standards. From the input dimension, the transformation of midwives' quality to a Bachelor's degree (S1) and the sufficient number of interprofessional teams were excellent internal modalities. However, this superior human resource quality was functionally weakened due to the inoperability of ultrasound equipment following the transfer of trained doctors. This condition reduced the clinical pull factor of the community health center. The lack of routine daily ultrasound services led pregnant women to postpone visits or seek alternative, paid private clinics located far away, resulting in their visits not being recorded in the community health center's e-Cohort system (Kellogg, 2004).

In terms of the quality and quantity of health human resources at the Penyengat Olak Community Health Center, all midwives at the community health center met the S1 Professional Midwifery standard as mandated by Law No. 4 of 2019. This increase in educational level correlates with improvements in cognitive and clinical competency. However, the distribution of technical training, such as Integrated ANC and maternal emergency care, is uneven, especially for new personnel (National Legal Documentation and Information Network, 2019).

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Optimizing human resource performance is hampered by limited service space capacity, not by the number of personnel. On the other hand, the quality of non-clinical services is considered good. Patients experience the friendly, patient, and empathetic attitude of midwives, which builds trust and compliance during antenatal visits. Overall, the readiness of human resource input at Penyengat Olak Community Health Center is good in terms of qualifications and quantity. The main challenges lie in the equitable distribution of technical training and limited infrastructure. Future improvements in the quality of MSS services for pregnant women need to be supported by strengthening ongoing training and restructuring the physical capacity of services (Yasmin, 2024).

From the budget aspect, in the context of evaluating the Minimum Service Standards (MSS) for Maternal Health, the adequacy and efficiency of budget allocation determine the extent to which the Community Health Center is able to provide Antenatal Care (ANC) services that meet quality standards, both inside the building through Individual Health Efforts (UKP) and outside the building through Community Health Efforts (UKM) (Armahedi & Witcahyo, 2020). In financing Antenatal Care (ANC) services at the Community Health Center, it is guided by compliance with Minister of Health Regulation No. 21 of 2021 concerning the Implementation of Health Services which requires the implementation of quantity standards (minimum 6 ANC visits) and 12T service quality standards with a target of 100% achievement (National Legal Documentation and Information Network, 2021).

The facilities and infrastructure for maternity services at the Penyengat Olak Community Health Center meet MSS standards. Facilities such as ultrasound, laboratory, hemoglobin (Hb) testing, Doppler, iron tablets, and IEC media are available and functioning well. However, facility utilization is suboptimal. Ultrasound and other equipment are rarely used routinely due to the lack of trained doctors following the transfer and the limited authority of midwives. The implementation of the Cluster 2 system also increased the workload of doctors, shifting the schedule from twice weekly to only high-risk cases. This finding aligns with previous studies that suggests underutilized facilities can reduce service quality and satisfaction (Dewi, Kartasurya, &

Purnami, 2026).

In the implementation of 12T at the Penyengat Olak Community Health Center, the activities component is at the core of the transformation system in health service management. At this stage, all available inputs (human resources, policies, and budget) are coordinated to drive service delivery to achieve the Minimum Service Standards (MSS) for Maternal Health (Priyatna, Pratiwi, Mawaddah, Ridwan, & Hasibuan, 2024). Overall, the activity components or service delivery at Penyengat Olak Community Health Center have a strong foundation of clinical quality thanks to health workers' compliance with the 12T Standard Operating Procedures (SOP) and the online reporting system. Strengthening cross-sectoral advocacy, involving religious leaders, community leaders, and village officials, is an urgent need to change community mindsets that hinder access to modern midwifery services (National Legal Documentation and Information Network, 2019).

K1-K6 services at Penyengat Olak Community Health Center demonstrate good process achievements in basic clinical services, but there are still shortcomings in diagnostic support. Based on observations of the 12 MSS service standards for pregnant women, 10 of the 12 have been implemented effectively. Failure to perform ultrasounds and delays in K1 visits are the main obstacles to meeting K1-K6. K4 coverage was only 34.9% (104/298 targets), indicating a high dropout rate for ANC visits. The decline in K4 coverage was triggered by incomplete ANC visits due to weak post-trimester tracking and delays in K1 visits, resulting in insufficient remaining pregnancy time to meet the minimum visit frequency (Winanti, Azwa Anjaini, Lubis, Suryani, Israyani, & Andini, 2025).

A deeper analysis of the output aspect demonstrated that the primary root cause of the low MSS achievement (72%) in Puberty stems from socio-cultural barriers (demand-side barriers). The sociological paradigm that views pregnancy as a normal biological process that does not require medical intervention as long as the body is healthy is a major barrier. Delays in K1 and the rejection of triple elimination demonstrate the community's low maternal health literacy. To overcome this problem, the management of Penyengat Olak Health Center cannot work alone within the health sector, but must strengthen aggressive cross-sector collaboration

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(involving village officials, family welfare empowerment (PKK) organization, and traditional leaders) to carry out social conditioning, change sociological mindsets, and enforce social sanctions or village-level regulations that require early pregnancy reporting in order to break the chain of non-medical deliveries and achieve the 100% MSS target (Penyengat Olak Health Center, 2025).

CONCLUSION

Maternal health Minimum Service Standards at Penyengat Olak Primary Health Center remained below the national target, with K1 coverage of 81.8% and K6 coverage of 71.9%. Although human resources and routine antenatal care procedures were generally adequate, service achievement was constrained by limited utilization of ultrasound services, uneven technical training, reduced outreach funding, delayed first antenatal visits, refusal of triple elimination screening, and sociocultural barriers. Strengthening continuity of antenatal care, technical capacity, community-based education, outreach services, and cross-sectoral collaboration is required to improve maternal health service coverage.

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