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The Relationship Between Premarital Reproductive Counselling and Husband Support with Increased Coverage Pure K1 Maternity Visit Coverage

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ABSTRACT

Purpose: This study aims to evaluate the relationship between premarital reproductive counseling and husband support with increased coverage of pure K1 pregnancy visits at Puskesmas Ajangale in 2022.

Research Design and Methodology: This study used a correlation study design with a retrospective cohort approach. Secondary data were obtained from medical records and observational results, while primary data were collected through questionnaires. The study population consisted of first-trimester pregnant women who had their first contact with health workers at Ajangale Health Centre, and the sampling technique employed was total sampling.

Findings and Discussion: The analysis results showed a significant correlation between premarital reproductive counseling and husband support, as well as increased coverage of pure K1 visits. Of the respondents who participated in premarital counseling, the majority made a pure K1 visit. Similarly, respondents who received good support from their husbands tended to be more compliant in conducting pure K1 visits. The P-value of 0.002 indicates a statistically significant association between these variables.

Implication: This study confirms the importance of integrating premarital reproductive counseling programs in public health policies to increase the coverage of antenatal care visits. Husband support must also be improved through education and active involvement in antenatal care. The findings provide valuable insights for health practitioners and policymakers to improve maternal and child health.

Introduction

Pregnancy is a condition in which a woman has a growing fetus inside her body (womb). Pregnancy should receive good care by having a routine pregnancy check-up as early as possible, ideally as soon as a woman suspects she is pregnant. The factor that influences mothers to make antenatal visits is knowledge about Antenatal Care (ANC). High knowledge will illustrate the mother's broad insight and support the mother in considering positive things and tending to make visits (Yuliani, 2013). As many as 40% of the 85 million pregnancies in the world are unplanned pregnancies, and 38% end in abortion, miscarriage, and unplanned childbirth (Indah Pratiwi et al., 2020). Based on research by Oktalia & Herizasyam (2016), it was found that of the 96 mothers who were respondents, most did not prepare for their pregnancies; as many as 62 mothers (64.6%) had not prepared for their pregnancies, while 34 mothers (35.4%) had appropriately prepared for them. Unplanned pregnancies have become a

worldwide problem, with many ending up as abortions, miscarriages, and unplanned deliveries. In 2019, the Bone Regency government issued a regulation requiring all prospective brides and grooms to participate in a premarital counseling program to address these challenges. With this regulation, 100% participation is expected. Proof of participation in premarital counseling is required when registering for marriage. Premarital counseling materials include the philosophy of marriage and gender inequality in marriage, as well as information on pregnancy, childbirth, the postpartum phase, sexually transmitted infections, early detection of cervical cancer, and marriage myths.

Sexual and reproductive health counseling for prospective brides is an effort to improve the health status of mothers and newborns. This counseling is a practical approach to increase prospective brides' knowledge, enabling them to plan and prepare for a healthy pregnancy and give birth to a quality next generation. An ideal pregnancy is planned, desired, and adequately maintained throughout every stage of development. Candidates who have participated in reproductive counseling are expected to visit a health worker once they know immediately or suspect they are pregnant so that the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) can be reduced. Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) in Indonesia are still relatively high. According to the Indonesian Health Profile (2017), the maternal mortality rate (MMR) in Indonesia was 305 per 100,000 live births. Meanwhile, the results of the Indonesian Demographic and Health Survey (2017) indicate that the infant mortality rate (IMR) in Indonesia is 24 per 1,000 live births. Therefore, reproductive health counseling for prospective brides is essential as a promotive and preventive effort. Support from health workers and families, especially husbands, is crucial in encouraging pregnant women to comply with routine and early ANC examinations, which is expected to reduce MMR and IMR in Indonesia.Part Three

Recognizing the importance of maternal and infant health, every couple needs to conduct early detection by routinely attending ANC visits so that comprehensive improvements in maternal health status can be implemented. Maternal health program interventions can be targeted at pregnant women, adolescents, and young adults to promote healthy growth and development (MOH RI, 2015). Based on Permenkes No. 28/2017, midwives are authorized to provide counseling on women's reproductive health and family planning. Therefore, midwives play a promotive and preventive role in providing care. Additionally, the role of husbands is crucial in supporting pregnant women. Research by Meirita (2017) showed that the husband's support was closely correlated with adherence to antenatal care (ANC) examinations in pregnant women. The Chi-square statistical test results in the study showed a p-value ($p < 0.05$), indicating a significant relationship between husband support and antenatal visit compliance. Husband support has a positive impact on pregnant women, increasing awareness and compliance with the importance of antenatal check-ups. Thus, the active role of midwives and the support of husbands is essential in growing antenatal visits, which, in turn, can reduce maternal and infant mortality in Indonesia.

The Ajangale Health Centre in Bone Regency offers a sexual and reproductive health counseling program for brides-to-be, with 100% K1 visits in Bone Regency. However, the problem is that not all K1 coverage is pure K1, but many pregnant women visit after entering the second and even the third trimester. Pregnancy visits (ANC) in Bone Regency in 2020 showed that pure K1 was 10,324 (69.81%), and K1 access was 14,554 (98.42%), indicating that 1.18% of pregnant women had not visited during the first trimester. K1 access increased by 33.53% in the following year, specifically in 2021. K1 pregnancy visits at Puskesmas Ajangale in 2020, specifically pure K1, were 316 (76.88%), and K1 access was 403 (98.05%). In 2021, pure K1 is 302 (73.47%), K1 access is 365 (88.80%). This means that 15.33% of the population still needs to be included in pure K1 (Bone Health Office, 2022). Based on the description above, this study wanted to determine the relationship between premarital reproductive counseling and husband support by increasing the coverage of pure K1 pregnant women visits at Puskesmas Ajangale. This study aims to identify reproductive counseling for prospective brides in the hope of helping to reduce MMR and IMR. Is there a relationship between premarital reproductive counseling and husband's support with increasing the coverage of pure K1 maternal visits at Puskesmas Ajangale in 2022? This research question reflects the study's novelty, focusing on premarital intervention as one factor influencing ANC visit compliance among pregnant women. This study also aims to determine the coverage of pure K1 visits of pregnant women before and after

premarital reproductive counseling, as well as assess the impact of husband support in increasing the coverage of these visits. Thus, this study is expected to make a significant contribution to efforts to reduce maternal and infant mortality by increasing participation in early and planned antenatal visits.

Literature Review

Antenatal Care

Antenatal care, or antenatal care, is a form of supervision carried out before childbirth with the primary purpose of monitoring the growth and development of the fetus in the womb (Syahrir & Majid Lagu, 2020). Antenatal care is provided periodically during pregnancy by healthcare professionals, including obstetricians, general practitioners, midwives, and nurses. The aim is to ensure that pregnant women can receive safe and effective care throughout pregnancy, labor, and postpartum and give birth to healthy babies (Depkes RI, 2014). According to Riskesdas (2010), antenatal care is carried out in accordance with established antenatal care standards to ensure the health of mothers and babies during pregnancy. The primary goal of antenatal care is to ensure that the natural process of pregnancy progresses smoothly and remains so (Ariesetyawati et al., 2018). There are several specific objectives of antenatal care, namely promoting and maintaining the physical and mental health of mothers and babies by providing education on nutrition, hygiene, and the process of childbirth (Yani, 2020). In addition, antenatal care aims to monitor the progress of pregnancy, ensuring the mother's health and the baby's growth and development while also improving and maintaining the physical, mental, and social well-being of both the mother and the baby. Antenatal care also detects early medical, surgical, or obstetric abnormalities or complications during pregnancy, prepares for labor until birth, and is prepared to face complications with minimal trauma. Another goal is to prepare the mother to be able to provide exclusive breastfeeding, undergo an average postpartum period, and care for the child physically, psychologically, and socially. Antenatal care also prepares the mother and family for the role of accepting the birth of the baby, allowing it to grow and develop normally.

Antenatal care services that are carried out routinely are an effort to conduct early detection of risky pregnancies so that appropriate action can be taken immediately. Antenatal completeness consists of the number of antenatal visits and the quality of antenatal care. Based on the midwifery service standards established by the Central Board of the Indonesian Midwives Association (IBI) in Jakarta in 2003, there are six standards in antenatal care. First, it identifies pregnant women, where midwives conduct home visits and regularly interact with the community for counseling. They motivate mothers, husbands, and family members to encourage mothers to check their pregnancies early and regularly. Second, antenatal examination and monitoring, where midwives provide at least four antenatal services, which include careful history taking and monitoring of the mother and fetus to assess whether development is normal, detecting abnormalities in pregnancy such as anemia, malnutrition, hypertension, STDs/HIV-AIDS, providing immunization services, counseling, and education, recording data at each visit, and management and referral of emergencies in pregnancy. Third is abdominal palpation, where midwives perform a thorough abdominal examination and palpate to estimate gestational age, check the fetus's position, and assess the lowest part of the fetus and the entry of the fetal head into the pelvic cavity to detect abnormalities and make appropriate referrals. Fourth is the management of anemia in pregnancy, where midwives take action to prevent, identify, treat, and refer all cases of anemia in pregnancy by applicable regulations. Fifth, early management of hypertension in pregnancy, where midwives detect any increase in blood pressure in pregnancy, recognize signs and symptoms of pre-eclampsia, as well as appropriate management and referral. Sixth, preparation for childbirth, where midwives provide relevant advice to pregnant women, their husbands, and families in the third trimester to ensure clean and safe delivery preparation, transportation preparation, and costs, and conduct home visits.

The schedule for repeat visits in antenatal care includes the first visit at 16 weeks gestation, which aims to screen for and treat anemia, establish a delivery plan, identify complications related to pregnancy, and address them. The second visit is at 24-28 weeks of gestation, and the third visit is at 32 weeks of gestation, which aims to identify complications of pregnancy and their treatment, screen for pre-eclampsia, Gemelli, reproductive and urinary tract infections, and repeat delivery

planning. The fourth visit is conducted from 36 weeks gestation until birth, encompassing the same activities as the second and third visits, as well as assessing any abnormalities in location and presentation, refining the delivery plan, and identifying the signs of labor. Thus, antenatal care is a significant effort in maintaining the health of mothers and babies during pregnancy. Antenatal care ensures a normal pregnancy process and facilitates the early detection of complications, allowing for immediate and appropriate action. With established service standards, antenatal care is expected to improve maternal and infant health and reduce maternal and infant mortality. (Syahrir & Majid Lagu, 2020; Depkes RI, 2014; Riskesdas, 2010).

Monitoring indicators

To ensure maternal and child health, one crucial aspect that must be considered is monitoring antenatal coverage. Antenatal coverage monitoring indicators provide an overview of how well the antenatal care program is implemented and how effectively it reaches the broader community. According to the Maternal and Child Health Local Area Monitoring (PWS-KIA) Guidelines (MOH RI, 2004), this indicator is categorized into two main areas: K1 coverage and K4 coverage. K1 coverage, or access to antenatal care, refers to the first visit a pregnant woman receives during her pregnancy. This visit is essential because the best time to make an early pregnancy visit is when the woman first suspects she may be pregnant, typically around ten weeks of pregnancy (Indrayani, 2011). According to Lubis (2016), pregnant women should visit a midwife or doctor to receive the necessary antenatal care as soon as they suspect they are pregnant. This access indicator measures the reach of antenatal care and the program's ability to mobilize the community. In other words, K1 coverage demonstrates the extent to which antenatal care can reach pregnant women in the community. The formula used to calculate K1 coverage is the number of K1 visits divided by the expected number of pregnant women, then multiplied by 100 to get the coverage percentage.

K4 coverage, or coverage of services for pregnant women, refers to the fourth contact a pregnant woman has with a health worker to obtain antenatal care, as per established standards. The standard requires at least one contact in the first quarter, one in the second, and two in the third quarter. With this indicator, we can determine how much antenatal care is completed according to service standards and in a timely manner. This indicator measures the effectiveness of maternal and child health program management and its sustainability. The formula used to calculate K4 coverage is the number of K4 visits divided by the expected number of pregnant women, then multiplied by 100 to get the coverage percentage. The Making Pregnancy Safer program, launched by the MOH in 2010, set targets to increase K1 antenatal care coverage to 95%, including Fe1 and TT1 coverage, and increase K4 antenatal care coverage to 90%, including Fe3 and TT2 or repeat TT coverage (MOH, 2010). These targets demonstrate the government's commitment to ensuring that every pregnant woman receives adequate and timely antenatal care, reducing the risk of complications during pregnancy and childbirth.

Monitoring antenatal coverage through K1 and K4 indicators provides valuable information on the effectiveness of maternal and child health programs. By understanding the extent to which the program effectively reaches pregnant women in the community, we can identify areas that require improvement and take targeted action to enhance services. For example, if K1 coverage is low, it may indicate that many pregnant women did not receive antenatal care early in their pregnancy. In this case, possible interventions include increasing awareness about the importance of early antenatal visits and improving access to health facilities. Conversely, if K4 coverage is low, it may mean that pregnant women are not receiving the full range of antenatal care as per the established standards (Khasanah, 2017). To address this issue, steps that can be taken include improving the capacity of health workers to provide antenatal care and ensuring that health facilities have sufficient resources to meet the needs of pregnant women. Additionally, monitoring antenatal coverage helps measure the progress of maternal and child health programs over time. By comparing K1 and K4 coverage data from year to year, we can determine whether the program has successfully improved antenatal care or if there is a decline in coverage that requires attention.

Premarital Counselling

Premarital counseling guides couples preparing for marriage to help them understand and prepare for the various aspects of married life. Premarital counseling covers a range of medical, psychological, sexual, and social issues that couples may face after marriage (Latipun, 2010). The counseling is designed to provide couples with a better understanding of the potential challenges that may arise in their household and equip them with the skills to address such issues effectively. The main objective of premarital counseling, according to Eny Kusmiran (2012), is to provide knowledge to adolescents so that they can make responsible decisions regarding their reproductive health and reproductive organs. With a better understanding of themselves, individuals are expected to be able to direct themselves according to their potential, achieve optimal development, and solve problems independently. Counselling also aims to help individuals achieve greater satisfaction and adjust more effectively to themselves and their environment (Khalilah, 2017). In addition, premarital counseling seeks to achieve a level of self-actualization by the potential possessed by the individual and prevent symptoms of maladjustment.

As explained by Eny Kusmiran (2012), the characteristics of premarital counseling include several essential aspects. First, counseling is a form of guidance that involves two individuals: the counselor and the counselee. The interview is the primary tool in all counseling program activities. Premarital counseling is also a professional activity requiring counselors with specific knowledge, attitudes, and skills. The counseling process is characterized by significant changes in the counselee, particularly in attitude and behavior. The primary responsibility for decision-making remains with the counselee, with the counselor assisting. Counselling also focuses on the emotional rather than intellectual understanding of issues, typically through meetings. Several factors can influence the quality of premarital counseling. According to Eny Kusmiran (2012), the duration or period of counseling is one crucial factor. Additionally, individual motivation and the quality of environmental support play a significant role in the effectiveness of counseling. The degree of health a person has before starting counseling, as well as the level of health at the start of counseling can affect the outcome. The counselor's general skills and specific skills related to a particular issue also determine the quality of counseling. The counselor's motivation and the atmosphere they can create also play a crucial role in the success of the counseling process.

The stages in the counseling process can be remembered using the acronym GATHER, which stands for Greet, Ask, Tell, Help, Explain, and Return. First, greeting means welcoming the client warmly to establish an excellent initial rapport, and second, asking means inquiring about the client to understand their context and background, which helps clarify the problem. Third, telling means informing the client about the various possible solution alternatives. Fourth, helping means assisting the client in choosing the best solution that suits their situation. Fifth, explain each alternative solution, including its advantages and disadvantages. Finally, follow-up means encouraging the client to return, ensuring that the chosen solution is adequate and the problem can be resolved (Eny Kusmiran, 2012). By providing comprehensive guidance on various aspects of married life, premarital counseling helps couples understand the potential challenges they may face. It equips them with the skills to overcome these problems. Thus, premarital counseling contributes to the well-being of individuals and couples, as well as the overall stability and happiness of the household (Latipun, 2010; Eny Kusmiran, 2012).

Reproductive Health

Reproductive health is an essential aspect of overall health, encompassing complete physical, mental, and social well-being related to the reproductive system, its functions, and processes. This concept covers not only the absence of disease or disability but also a comprehensive understanding of reproductive-related health for both men and women. However, more emphasis is often placed on women (Ratu et al., 2018). Diseases and health conditions in women are usually related to their reproductive functions and capabilities, as well as social pressures faced due to gender issues (Eny Kusmiran, 2012; Obaid, 1994). Reproductive rights are fundamental rights that every individual, regardless of gender, must possess. This right includes the right to obtain information and access various safe, effective, and affordable family planning methods, as well as other birth control methods, by applicable laws and regulations (Nida, 2016). These rights also include access to

adequate health services, enabling women to experience pregnancy and childbearing safely, and providing opportunities for couples to have healthy babies (Eny Kusmiran, 2012).

Reproductive rights include several essential aspects. First is the right to obtain information and education about reproductive health so that each individual can make informed decisions about their health. Second is the right to access quality reproductive health services and protection, including health services during pregnancy, childbirth, and the postpartum period. Third, the right to freedom of thought and to determine the desired reproductive health services without coercion or discrimination. Fourth, the right to be protected from death due to pregnancy, which means access to adequate maternal health services must be guaranteed. Fifth, the right to determine the number and spacing of children is part of the right of individuals to plan their families according to their wishes and health conditions. Sixth, the right to freedom and security about reproductive life, which includes protection from persecution, violence, torture, and sexual harassment. This right is essential to ensure that every individual can live their reproductive life safely and without fear. Seventh, the right to benefit from scientific advances related to reproductive health so that everyone can receive the latest information and technology to improve their health. Eighth, the right to build and plan a family includes deciding when and with whom they will have children. This right is essential to give individuals complete control over their reproductive lives. Ninth, the right to be free from discrimination in family and reproductive life ensures that all individuals are treated fairly and equally regardless of gender, social status, or health condition. Tenth, the right to freedom of assembly and political participation related to reproductive health enables individuals to participate in decision-making that affects their reproductive health and rights. This participation is essential to ensure that policies and programs reflect the needs and interests of all individuals.

Husband Support

Husband support plays a vital role in the health of pregnant women and the success of the antenatal care (ANC) process. The research results conducted at Puskesmas Kasihan II, Bantul, Yogyakarta, showed that of the 79 respondents studied, most had sufficient husband support, which was 69.6% (Aureliya, 2015). This support manifests in various forms, including reminding mothers to undergo ANC checks, driving them to the examination site, and praising them if the examination is carried out regularly. However, husbands must learn about the purpose and benefits of ANC to provide more optimal support. Husbands who do not understand the importance of ANC may not encourage or remind their wives to have regular check-ups, which can hurt maternal and fetal health (Handayani & Rinah, 2019). This research aligns with the results of a study conducted by Yulistiana (2015) at Puskesmas Wates, Central Lampung. Of the 40 respondents studied, 60% (24 respondents) received husband support in the sufficient category. Factors such as age, education level, and employment status of pregnant women influence the level of support provided by their husbands. Pregnant women who are 20-40 years old, have a high school education, and do not work tend to get sufficient husband support. Better knowledge about the importance of maternal and child health makes pregnant women with higher education more compliant in conducting ANC checks.

Husband support is not only in the form of physical or logistical assistance but also includes moral and emotional support. Nasharillah (2011) emphasizes that husbands, as the closest companions of pregnant women, play not only a role as decision-makers but also serve as an essential source of moral support throughout pregnancy, from conception to delivery and the postpartum period. The husband's supportive role can provide a sense of security and comfort for the wife, which can indirectly affect the mental and physical health of pregnant women. Kusmiyati (2009) also stated that the most important person for a pregnant woman is usually the child's father. The presence and support of the husband can be a determining factor in the readiness and health of the mother during pregnancy. Optimal support from a husband can be realized in several ways. Firstly, husbands need to increase their knowledge about the importance of ANC and its benefits for the health of mother and baby. Health education and counseling for married couples can be an effective way to achieve this goal. Secondly, husbands should be actively involved in the ANC screening process, such as accompanying their wives to the screening center. The presence of husbands can provide significant emotional support for pregnant women.

Additionally, expressing appreciation and praise to wives who regularly perform ANC checks can enhance the mother's motivation to maintain her health and that of her fetus (Lubis et al., 2023). This support is crucial during pregnancy, labor, and the postpartum period. Husbands who are actively involved in postnatal care and support can help mothers recover more quickly and reduce the risk of complications. Husband support is a critical component in reproductive health and the success of ANC programs. Increasing husbands' awareness and knowledge of the importance of their role can significantly impact the health of pregnant women and their unborn babies. With the proper support, pregnant women can feel more supported and motivated to navigate the pregnancy and delivery process effectively, ultimately contributing to the health of future generations. Past studies have shown that adequate husband support can improve maternal adherence to ANC check-ups, which is crucial for detecting and preventing complications during pregnancy (Aureliya, 2015; Yulistiana, 2015; Nasharillah, 2011; Kusmiyati, 2009).

Research Design and Methodology

This study is correlational, examining the relationship between premarital reproductive counseling, husband support, and the coverage of pure K1 pregnancy visits (Notoadmojo, 2010). Using a retrospective cohort study approach, this study utilized secondary data from medical records, observational results at Puskesmas Ajangale, and primary data from a questionnaire on the level of husband support (Chandra, 2008). The study was conducted at the MCH Clinic of Ajangale Health Centre, Ajangale District, Bone Regency, South Sulawesi, from June to August 2022. The study population consisted of all pregnant women who had their first contact with health workers at Puskesmas Ajangale during the first trimester, and the sampling technique employed was total sampling (Sugiyono, 2007). The data collection instruments consisted of questionnaires, master tables, medical record data, and observational results. Stages of data collection include preparation, implementation, and data processing. Preparation included applying for a research permit and apperception with health workers. Implementation involved reviewing medical records and observing pure K1 pregnant women. Data processing was done through editing, coding, processing, and cleaning to ensure the data was ready for analysis. Data analysis included univariate analysis in calculating the frequency and proportion of variables, as well as bivariate analysis to determine the relationship between the independent variables (premarital reproductive counseling and husband support) and the dependent variable (pure Q1 coverage) using the Chi-Square statistical test at a 5% significance level ($p \leq 0.05$). This study also considered research ethics by obtaining permission from UPT Puskesmas Ajangale and following Ethical Clearance from Itkes Muhammadiyah Sidrap.

Findings and Discussion

Findings

Based on the results in Table 1, the respondents' education is predominantly junior high school, with 14 people (45%). The majority of respondents, aged 25-35, comprised 19 people (61%). The majority of mothers do not work outside the home (IRT), namely 23 people (74%), while those who work outside the home number eight (26%). Based on Table 2, most respondents had been exposed to premarital reproductive counseling before marriage, as many as 24 people (77%), while those who were not exposed to the counseling were seven people (23%). Table 4.3 shows that the husband's support for respondents was mainly in the excellent category, with 16 respondents (52%), followed by sufficient support from 13 (42%). Only two respondents' husbands (6%) provided support in the poor category. Most respondents received premarital counseling and had moderate to good support from their husbands, which could positively affect the coverage of prenatal care visits (K1). Based on Table 3, most respondents who received premarital reproductive counseling made the majority of their visits in the first trimester (K1 pure), with as many as 22 respondents (92%).

In contrast, the majority of pregnant women who did not participate in premarital reproductive counseling made their first visit not in the first trimester (K1 access), as many as six respondents (86%). The statistical test results showed a P-value of 0.002 ($P \leq 0.05$), indicating a significant relationship between premarital reproductive counseling and the coverage of pure K1 pregnancy visits

at UPT Puskesmas Ajangale in 2022. Table 3 shows that most respondents who made ANC visits in the first trimester (pure K1) received good support from their husbands, with 16 respondents (62%) reporting this. Among pregnant women who did not attend ANC visits in the first trimester (K1 access), the majority received sufficient support from their husbands, with as many as five respondents (71%), while two respondents (29%) received insufficient support from their husbands. The statistical test results showed a P-value of 0.002 (P ≤ 0.05), indicating a significant relationship between the husband's support and the coverage of pure K1 pregnancy visits at UPT Puskesmas Ajangale in 2022. Both premarital reproductive counseling and husband support have a significant influence on the compliance of pregnant women in conducting antenatal visits in the first trimester (pure K1). This confirms the critical role of counseling and husband support in improving the quality of reproductive health of pregnant women.

Table 1. Univariate Analysis of Respondents' Characteristics Distribution

Characteristics	Frequency	Percentage (%)
Education		
STRATA 1	5	16
High School	5	16
Junior High School	14	45
Elementary School	7	23
Mother's age		
25-35 Years	19	61
>35 Years	4	13
<25	8	26
Occupation		
Employed	8	26
Not working	23	74

Source: SPSS Processing Results

Table 2. Frequency Distribution of Premarital Reproductive Counselling and Husband Support in Pregnant Women

Premarital Reproductive Counselling	Total	%	Husband Support	Frequency	%
Yes	24	77	Good	16	52
No	7	23	Fair	13	42
		100	Less	2	6
Total	**31**		**Total**	**31**	**100**

Source: SPSS Processing Results

Table 3. Bivariate analysis of the association of reproductive counseling and premarital husband support with pure K1 coverage

Category	Pure K1 Coverage (F)	Pure K1 Coverage (%)	access Q1 Coverage (F)	access Q1 Coverage (%)	Total (F)	Total (%)	P Value
Yes	22	92	1	14	24	77	0.002
No	2	8	6	86	7	23	
Total	24	100	7	100	31	100	
Good	16	62	0	0	16	52	0.002
Fair	8	38	5	71	13	42	
Less	0	0	2	29	2	6	
Total	**24**	**100**	**7**	**100**	**31**	**100**	

Source: SPSS Processing Results

Discussion

Relationship between Premarital Reproductive Counselling and Increased Coverage of K1 Pure Maternity Visit

The results showed a significant relationship between premarital reproductive counseling and increased coverage of visits by pregnant women in the first trimester. This study supports the hypothesis that premarital reproductive counseling has a positive impact on increasing the compliance of pregnant women in conducting antenatal visits. This finding is consistent with the basic concept that adequate information and education before marriage can improve pregnant women's health awareness and behavior. Premarital counseling provides brides-to-be with the necessary

knowledge to understand the importance of antenatal visits, which in turn improves their adherence to visits in the first trimester. With good counseling, expectant mothers are better prepared and more aware of the importance of receiving timely and high-quality antenatal care. This suggests that premarital counseling programs are crucial in improving maternal and infant health and preventing complications that can occur during pregnancy. Premarital counseling also helps change perceptions and behaviors related to antenatal visits, resulting in more pregnant women regularly visiting in the first trimester. These findings underscore the importance of integrating premarital counseling programs in public health efforts to achieve better maternal and child health outcomes.

Theoretically, this study's results align with the view that reproductive health encompasses the effective use of reproductive organs and fertility regulation, as well as the safe management of pregnancy and childbirth and the ability to have a baby without significant risks (Manuaba et al., 2009). Premarital counseling, as part of reproductive health education, plays a vital role in ensuring that expectant mothers have the necessary information to maintain their health during pregnancy. This counseling helps to change perceptions and behaviors regarding antenatal visits, which are crucial for detecting and addressing health problems early. This study also aligns with previous findings showing the importance of premarital health education. The survey by Eny Kusmiran (2012) emphasizes that counseling is a direct encounter situation in which a trained counselor assists individuals in facing and overcoming adjustment problems. By providing appropriate information about reproductive health, premarital counseling can increase couples' awareness and understanding of the importance of antenatal visits in the first trimester. The results of this study can also be compared with previous studies that have shown a relationship between health education and improved health behaviors among pregnant women. For example, research by Siti Aminah (2018) found that pregnant women with adequate health education were more compliant in conducting antenatal visits. Triloka's (2017) study also showed that pregnant women who were more enthusiastic and fit about their pregnancy tended to have higher levels of adherence to antenatal visits.

The practical implication of these findings is the importance of integrating premarital reproductive counseling in public health programs to increase the coverage of pure K1 antenatal visits. An effective counseling program can help expectant mothers understand the importance of early antenatal visits and encourage them to adhere to the recommended schedule. This will not only improve the health of pregnant women but also reduce the risk of complications during pregnancy and labor. Premarital reproductive counseling should be designed to include information on the importance of antenatal visits, the benefits to the mother and baby's health, and ways to identify and address potential health problems early. Trained counselors should ensure that information is delivered clearly and concisely, making it easy to understand and relevant to the couple. In addition, strong and ongoing support from a husband is essential to ensure that pregnant women feel supported and motivated to attend antenatal visits. In addition, counseling programs should include strategies to raise husbands' awareness of their role in helping their wives' reproductive health. Good husband support has been shown to positively impact pregnant women's adherence to antenatal visits, as seen in this study.

Relationship between Husband Support and Increased Coverage of Pure K1 Maternal Visit

The analysis of the relationship between husband support and increased coverage of pure K1 antenatal visits showed a significant correlation. This study supports the hypothesis that the husband's support is essential in improving pregnant women's adherence to pure K1 antenatal visits. Good support from husbands provides significant motivation and encouragement for pregnant women to conduct antenatal visits in the first trimester. This aligns with the concept that social support, particularly from husbands, is a crucial factor in the health care of pregnant women. Husband support encompasses various forms of attention and involvement, such as reminding the partner to schedule a check-up, accompanying them during the visit, and offering appreciation afterward. This support provides a sense of security and comfort for pregnant women, helping to reduce stress and improve their emotional well-being. These findings suggest that husbands who are actively involved in their wives' reproductive health can enhance their wives' compliance in undergoing timely and quality antenatal care, which is crucial for early detection and prevention of complications during pregnancy.

Thus, increased awareness and education regarding the role of husbands in supporting the health of pregnant women is necessary to improve the coverage of pure K1 antenatal care visits.

Theoretically, husband support during pregnancy affects the emotional and physical well-being of pregnant women and their adjustment during pregnancy. This underlying theory emphasizes the importance of emotional support and appreciation from husbands to meet the psychological needs of pregnant women, which include feeling loved, valued, and spousal acceptance of the unborn child. Research shows that women who receive support and care from their partners tend to experience fewer negative emotional and physical symptoms, adjust more easily during pregnancy, and have a lower risk of labor complications. This study aligns with previous findings by Dina Rohmayanti (2014) and Cein Tamaka (2013), who noted that many pregnant women require motivation to attend antenatal care (ANC) visits and still lack knowledge about the importance of these visits during pregnancy. Good husband support motivates pregnant women to adhere to their visit schedule and provides the moral support needed to go through pregnancy with greater calm and confidence. However, the results of this study also show that there are still many husbands who do not provide adequate support for their wives' pregnancies. Factors contributing to this lack of support include husbands' prioritization of work over accompanying their wives to health facilities, as well as a lack of motivation and attention to the needs of pregnant women during pregnancy. This indicates the need for interventions that focus more on increasing husbands' awareness and knowledge of the importance of their role in supporting their wives' reproductive health.

The practical implication of these findings is that reproductive health programs should emphasize the importance of husband support. Health education programs that involve married couples can increase awareness about the importance of support during pregnancy. These interventions could include counseling and workshops designed to increase husbands' knowledge about their role in supporting their wives' health and encourage them to be more involved in the pregnancy process. In addition, health facilities such as Puskesmas Ajangale could adopt a more inclusive approach by providing counseling sessions that involve husbands. This will ensure that husbands receive the necessary information to support their wives more effectively. The program could also include strategies to overcome barriers husbands face, such as providing information on balancing work and supporting wives during pregnancy. Husbands who provide exemplary support play a significant role in ensuring their wives make antenatal visits in the first trimester, which is critical for early detection and prevention of pregnancy complications. Integrating these findings into public health policies and programs is expected to improve the reproductive health of pregnant women and reduce the risk of complications during pregnancy and childbirth. The results of this study provide strong evidence that husband support is a critical factor in the success of antenatal care programs.

Conclusion

This study has examined the relationship between premarital reproductive counseling and husband's support with increasing the coverage of visits to pregnant women in the first trimester (pure K1) at Puskesmas Ajangale in 2022. The results of the analysis show that premarital reproductive counseling and husband support have a significant correlation with the compliance of pregnant women in conducting antenatal visits in the first trimester. This finding suggests that both factors are crucial in encouraging pregnant women to receive more regular and timely antenatal care.

This study makes significant contributions to the field of reproductive health science and practice. In a scientific context, this study confirms the importance of premarital education and husband support as critical determinants for pregnant women's adherence to antenatal care visits. The findings support the integration of premarital reproductive counseling programs into public health policies to improve antenatal visit coverage. This study also offers new insights into how interventions based on education and social support can improve overall maternal and infant health.

This study has several limitations that need to be considered. Firstly, the study sample, limited to one health center, may not be sufficient to describe the broader situation. Secondly, the data used was mostly retrospective, so there may be bias in data collection. Future research should include a more extensive and diverse sample, as well as utilize more proactive and longitudinal data

collection methods. Additionally, examining other factors that may impact pregnant women's adherence to antenatal visits, such as education and access to healthcare facilities, will provide more comprehensive insights.

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