



## An Analysis of The Role and Support on Stakeholders of Village Level in The Implementation of Maternal and Child Health Programs Through Optimizing The Utilization of Village Funds in Tegal Regency

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### ABSTRACT

Maternal and infant mortality rates are one of the health problems in Indonesia, including at the village level. Currently, the Village has its own authority to manage village funds in an effort to prosper the community. The purpose of the study is analysis the role and support stakeholders in the Maternal and Child Health (MCH) Program through optimizing village funds, with a quantitative design and analytical descriptive approach. The study analyzes the role of stakeholders (attitudes, influencing power, and interests), with respondents, namely village level stakeholders in Tegal Regency who were selected by purposive sampling technique and analysis by Rank Spearman Test. Education has a significant relationship with power of influencing stakeholders (p value= 0.002, CC = 0.561) Stakeholder attitudes/perceptions (p-value = 0.047; CC = 0.379) and power of influence (p-value = 0.017; CC = 0.449) has strong correlation towards optimizing village funds for MCH program. Stakeholder interests (p value=0.003; CC=0.534) have a strong correlation with the implementation of the MCH program in the village. In optimizing allocation village funds, support and the role of stakeholders are needed, especially the attitude and power in making decisions, planning strengths and formulating allocation policies. Likewise, the role of stakeholders in the interests of the MCH program for community welfare will increase multi-sectoral cooperation.

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## Analisis Peran dan Dukungan Stakeholder Tingkat Desa dalam Pelaksanaan Program Kesehatan Ibu dan Anak melalui Optimalisasi Pemanfaatan Dana Desa di Kabupaten Tegal

### ABSTRAK

Angka Kematian Ibu dan Bayi menjadi salah satu permasalahan kesehatan di Indonesia termasuk di tingkat Desa. Saat ini Desa memiliki wewenang sendiri untuk mengelola dana desa sebagai upaya mensejahterakan masyarakatnya. Tujuan penelitian ini adalah analisis peran dan dukungan stakeholder dalam Program KIA melalui optimalisasi dana desa, dengan desain kuantitatif dan pendekatan deskriptif analitik. Penelitian menganalisis peran stakeholder (sikap, kekuatan mempengaruhi, dan kepentingan), dengan responden yaitu stakeholder tingkat Desa di Kabupaten Tegal yang dipilih berdasarkan teknik purposif sampling dan dianalisis dengan uji Rank Spearman. Pendidikan memiliki hubungan yang signifikan dengan kekuatan mempengaruhi stakeholder (p value=0.002, CC=0,561) Sikap/persepsi stakeholder (p value=0.047; CC=0.379) dan kekuatan mempengaruhi (p value=0.017; CC=0.449) memiliki korelasi yang

#### Kata kunci:

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kuat terhadap optimalisasi dana desa untuk program KIA. Kepentingan stakeholder ( $p$  value=0.003;  $CC=0.534$ ) memiliki korelasi yang kuat terhadap pelaksanaan program KIA di Desa. Dalam optimalisasi alokasi dana desa sangat dibutuhkan dukungan dan peran stakeholder terutama sikap dan kekuatan dalam membuat keputusan, merencanakan kekuatan dan merumuskan kebijakan pengalokasian. Begitupun dengan peran stakeholder terhadap kepentingan program KIA bagi kesejahteraan masyarakat akan meningkatkan kerjasama multisektor.

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## INTRODUCTION

The amount of maternal mortality, infant and toddlers is one of the main health problems and it is the focus of achievement in the Sustainable Development Goals (SDGs) by 2030. Maternal mortality is the death of a pregnant woman or death within 42 days after the end of pregnancy without considering the age and type of pregnancy as a complication of childbirth or postpartum with causes related to or aggravated by pregnancy and pregnancy management, but not due to accidents. (Soediono, 2014)

It is estimated that there are approximately 529,000 women who die during childbirth or due to complications arising from pregnancy, so it is estimated that the maternal mortality rate (MMR) is 400 per 100,000 live births annually worldwide. (Nurhidajat, 2018) In Indonesia, the Maternal Mortality Rate (MMR) is quite high at 305 per 100,000 live births in 2015. In 2015, Tegal Regency was still ranked in the top fifth with high MMR compared to other regencies or cities. Tegal Regency is also a Regency or City in Central Java Province which needs comprehensive efforts to reduce stunting prevalence. (Central Java Provincial Health Office, 2019) The number of MMR in Tegal Regency in 2019, was 12 cases out of 26,945 live births or 44.54 per 100,000 live births. (Tegal District Health Office, 2019)

In addition to the maternal mortality rate (MMR), the infant mortality rate (IMR) in Indonesia is also still high compared to other ASEAN countries. (Meisuri et al., 2018) The Neonatal Mortality Rate based on the Indonesia Demographic Health Survey (IDHS) in 2017 amounted to 15 per 1000 live births, the Infant Mortality Rate (IMR) is 24 per 1000 live births, and the Toddler Mortality Rate is 32 per 1000 live birth. This is certainly very far from the target of the Indonesian Ministry of Health and the SDGs. (Directorate General of Public Health, Ministry of Health, 2020) in Tegal Regency, the IMR is 6.1 per 1000 live births or 160 infant deaths from 26,945 live births. Toddler Mortality Rate 6.9 per 1000 live births or 180 under-five deaths from 26,945 live births. In Tegal Regency, the total cases of stunting under five in 2019 = 5,896 cases. (Tegal District Health Office, 2019).

Currently, the increase in maternal and infant mortality is also threatened with an increase due to the Coronavirus Disease-2019 (COVID-19) pandemic. The Covid-19 pandemic has hampered several programs related to maternal and child health both in terms of quantity and quality, such as the implementation of Antenatal Care (ANC), Complete Basic Immunization, health care center and so on. This makes it difficult to monitor the growth and development of infants under five and mother's health. (Cibro, 2016)

In Indonesia, the health quality of pregnant women and childbirth is still not good, with indicators of MMR and IMR still being high. The causes of maternal death in Indonesia are very complex, both direct, indirect and basic causes,

including bleeding, eclampsia, complications of abortion, infection and prolonged labor. While the cause of infant mortality is the result of problems in the neonate such as asphyxia, newborns with low birth weight (LBW), and neonatal infections. Another problem that can be the cause of maternal and infant mortality is the problem of poor nutrition and malnutrition. The high mortality rate is a reflection of the quality of maternal and child health services that still need to be improved. (Cibro, 2016)

Various government policies to accelerate the decline in MMR have been carried out, among others, by increasing the accessibility and quality of services by bringing health services closer to the community through the placement of midwives and policlinic village in various regions. In Tegal Regency, the midwifery adequacy rate is very good at 543.8%. (Central Java Provincial Health Office, 2019) Meanwhile, from the aspect of service quality, it is carried out through efforts to increase the ability/competence of health workers and basic and referral health facilities Comprehensive Emergency Neonatal Obstetric Service and Basic Emergency Neonatal Obstetric Service, as well as other intervention programs. The current program to accelerate MMR is the Expanding Maternal And Neonatal Survival (EMAS) Program to improve maternal health. It is expected that there will be cooperation between the government, health services and the community.

According to previous research, it is stated that the implementation of a health program is planned for interventions to reduce maternal and infant mortality by means of an institution that facilitates the health community. (Haver et al., 2015) Research conducted in Tanzania, one of which was carried out in reducing MMR is to evaluate the health system as well as the existence of policies and consider changes from an economic and educational perspective. (Shimoda et al., 2015)

In the era of decentralization, the government also stipulates that the provincial, district/city government health budget is allocated a minimum of 10% (ten percent). (Ministry of Finance, 2017) Each district/city will receive delegation of authority and responsibility from the central government to be able to administer government and regional development including in the health sector including MCH and efforts to reduce maternal and infant mortality both in planning, budgeting and implementing regional development. For this reason, it is necessary to carry out planning that involves all stakeholders from the district level to the village level.

In the planning and budgeting mechanism for maternal and child health programs at the village level, village level stakeholders can use village fund allocation policies. The village fund allocation policy gives full authority to the village to plan and finance village development according to its needs. The village fund policy is also intended for health

development where in managing the allocation of village funds it also involves several stakeholders such as youth organizations, building family well-being team, and the Village Consultative institute. (Karimah et al., 2014) Research conducted at the village level is In Malinau Regency, data shows that only a small portion of the village funds budget for health development. (Suarsih et al., 2017) This is certainly an opportunity as well as a challenge in an effort to improve the health status of the community through the implementation of various health program innovations and their implementation through optimization. use of village funds, including maternal and child health programs. Tegal Regency is one of the regencies in Central Java Province that has 100% utilization of village funds, however, has the allocation been optimized in the health sector? Considering that during the Covid-19 pandemic, Tegal Regency experienced an increase in maternal deaths and is also still a priority for the convergence of stunting reduction actions. (Central Java Provincial Health Office, 2019) Based on the above problems, it is necessary to analyze the role and support of village level stakeholders in Tegal Regency, especially in optimizing village funds.

**METHOD**

This research is a quantitative research with a descriptive analysis approach. The dependent variable of this research is

the optimization of village funds and the implementation of the MCH program, while the independent variable of this reserach is the role and commitment of stakeholders based on the dimensions of attitude, ability to influence and the interests of institutions on various activities involved, respondents' education and characteristics of respondents. The research was conducted on June 2021 in Tegal Regency. The research sample is 28 stakeholders at the village level, which are the villages with the lowest and highest MMR/IMR in Tegal Regency. The research subjects were the chief of village, Village Consultative institute, building family well-being team, Midwife, Village Institution, Head of MCH, Head of Health Service, Public Health Center, and Head of community and village empowerment office. The sample selection used purposive sampling criteria based on their direct or indirect relevance in village management or the MCH program. Data was collected by analyzing the results of the research instrument (questionnaire) where the score per item was assessed with a score of Strongly Agree = 4, Agree = 3, Disagree = 2, and Strongly Disagree = 1. The data is processed by normality test, if normal then the data is categorized based on the mean with good category ( $X \geq \bar{X}$ ) and not good ( $X < \bar{X}$ ), if not normal it is categorized based on the median value, namely good category ( $X \geq \text{Median}$ ) and not good ( $X < \text{Median}$ ). Data were analyzed using Chi-Square Test and processed using IBM SPSS 20. This study has met the research ethic standard No:203/EA/KEPK-FKM/2021.

**RESULT AND DISCUSSION**

**Table 1**  
**Characteristics of Respondents**

Variables	f	%
<b>Age</b>		
Adult	19	67.9
Elderly	9	32.1
<b>Gender</b>		
Male	11	39.3
Female	17	60.7
<b>Education</b>		
Low	11	39.3
High	17	60.7
<b>Agency</b>		
Health Office	3	10.7
Midwives	3	10.7
Public Health Centre	3	10.7
Sub-district	2	7.2
Community and Village Empowerment Office	2	7.2
Chief of Village	4	14.3
Village Institution	9	32.1
Building family well-being team	2	7.1

Table 1 shows the distribution of respondents' characteristics. Most of the respondents are women, as many as 17 respondents (60.7%) with 67.9% of respondents having an adult age, with a vulnerable age of 26-45 years of the 28 respondents, 17 respondents (60.7%) had higher education, namely > SMA/SMK/Equivalent. Respondents from villages include village heads, midwives, village institutions and building family well-being team were 64.2%.

There are several factors that influence community participation, including age, gender, and education. People

with middle age and above tend to participate more than other age groups. Males have more time to participate in each program than women because they are busy taking care of the house. Education is said to be one of the absolute conditions for participation. Jobs and good job income and sufficient income can encourage participation (Jatmiko, 2017).

Based on the results of the research, it showed that there were 19 respondents (67.9%) who stated that village funds in their area were not optimal, while 32.1% of respondents

stated that the utilization of village funds in their areas had been optimal. For the implementation of the MCH program, most of the respondents (78.6%) stated that the implementation of the MCH program in the village was optimal.

**Table 2**  
**Description of Village Fund Optimization and Implementation of the MCH Program**

Variables	f	%
Village funds		
Not optimal	19	67.9
Optimal	9	32.1
MCH Program		
Not optimal	6	21.4
Optimal	22	78.6

**Table 3**  
**Description of Stakeholder Roles and Commitments**

Variables	$\bar{X}$	Median	SD	Min	Max	f	%
<b>Attitudes/perceptions*</b>	<b>59.39</b>	60.00	<b>6.646</b>	50	84		
Not so good						13	46.4
Good						15	53.6
<b>Power of influence</b>	52.25	54.00	5.784	36	60		
Low						9	32.1
Strong						19	67.9
<b>Interest*</b>	<b>60.11</b>	<b>56.00</b>	7.598	54	72		
Less important						18	64.3
Important						10	35.7

The results of the research are shown in table 3 that attitudes/perceptions (53.6%) and power of influence (67.9%) on stakeholders are quite good while 64.3% still think that the health sector is considered less important.

Several previous researchers stated that stakeholder participation and involvement will help develop collective commitment and capacity in turning ideas and plans into real actions. (Harbianto et al., 2016) Stakeholder involvement will result in better decision making, realizing resource allocation (Tumaji & Gurendo Putro, 2018) Other studies have also stated that the process of stakeholder engagement is difficult due to unclear roles and responsibilities. (Nabiha & Saad, 2015)

Several factors are considered to be obstacles in the participatory approach, namely the lack of political will of policy makers at the planning stage because of the implications for the distribution of power and resources as well as the lack of participation and awareness from stakeholders at the implementation stage. (Ariyani et al., 2020) To be successful, the implementation of the concept of participation requires several prerequisites, namely a strong network, an adequate level of trust, and accountability from each actor. (Mahfud et al., 2014) factors that increase stakeholder engagement are stakeholder mindset, engagement capacity, stakeholder relations and stakeholder adaptability. (Waligo et al., 2013).

Based on the results of the research in table 4, it can be seen that the level of education has a significant correlation with the influencing power possessed by stakeholders (p value = 0.004). The value (OR=13.125) means that stakeholders with education level > SMA/Equivalent tend to

Villages as the spearhead of development in Indonesia can carry out development activities aimed at achieving prosperous rural communities with the Village Building Index (IDM). In villages in Malinau District, health development is still focused on physical development so that the allocation of funds for intangible health development is minimal. (Suarsih et al., 2017) This is similar to the results of a document study in NTT where the types of proposed activities in the field Most of the health activities that are accommodated are proposals for physical activities and only a few are non-physical. (Saputra et al., 2013)

Optimization of the MCH program in the village also needs to be done such as the MCH innovation program, providing training for health cadres so that they can learn skills, receive education and interact with professional staff for preventive, curative and communication efforts with the population in an effort to reduce MMR/IMR, providing cadre incentives etc. . Providing incentives, rewards and compensation will be able to improve the performance of cadres. (Susiana, 2019)

have the ability to influence policies, advocacy, etc., by 13,125 or 13 times greater than stakeholders with education level SMA/Equivalent.

To increase the capacity of stakeholders, it can be done by developing human resources through education and training. The level of education is one of the important factors in honing abilities and skills. Education makes a major contribution in interacting with the environment, skills and knowledge help facilitate one's grasping power in communicating so that various efforts can be made such as advocacy, facilitation, negotiation etc.

From the table 5, it can be seen that the influencing power possessed by stakeholders (p value = 0.022) has a significant correlation with the optimization of village funds in the health sector. Table 4 also shows that the value (OR=7.583) means that stakeholders with strong influencing power tend to be 7 times more likely to support the optimization of village funds in the health sector. Budget problems are the main reason for the lack of cross-sectoral support. This also occurs in village fund budgeting, where there are still many stakeholders who have not prioritized village fund budgets for health activities, especially in community empowerment. (Yusman et al., 2012)

One of the efforts to increase village budget allocations for health development is to advocate for the Government to make regulations in determining the amount of funds for development in the health sector from the Regional Government Budget. (Cibro, 2016) The public health center and village health care workers are tasked with advocating for villages and taking advantage of opportunities. Meanwhile, the building family well-being team or cadres as

the spearhead of the field can provide input related to problems in the field so that they can be prioritized and allocated village funds for empowerment activities.

**Table 4**  
**Correlation between Education Level with Optimization of Village Funds, Implementation of the MCH Program, and Stakeholder Roles and Commitments**

Variables		Education		p-value	OR
		≤SMA Equal	>SMA Equal		
<b>Village Fund Optimization</b>				0.142	3.208
Not Optimal	Count (%)	7 (25.0%)	6 (21.4%)		
Optimal	Count (%)	4 (14.3%)	11 (39.3%)		
<b>Implementation of the MCH Program</b>				0.544	1.750
Not Optimal	Count (%)	3 (10.7%)	3 (10.7%)		
Optimal	Count (%)	8 (28.6%)	14 (50.0%)		
<b>Attitudes/ Stakeholder' s perceptions</b>				0.142	3.208
Not so good	Count (%)	7 (25.0%)	6 (21.4%)		
Good	Count (%)	4 (14.3%)	11 (39.3%)		
<b>Influencing Power Possessed by stakeholder</b>				0.004*	13.125
Law	Count (%)	7 (25.0%)	2 (7.1%)		
Strong	Count (%)	4 (14.3%)	15 (53.6%)		
<b>Stakeholder' s Interest</b>				0.119	4.000
Less important	Count (%)	9 (32,1%)	9 (32,1%)		
Important	Count (%)	2 (7,1%)	8 (28,6%)		

The power of influencing stakeholders can be optimized through the scaling up model. Where the implementation of Maternal and Child Health Integrated Planning is integrated with minimum service standard and Healthy Indonesia Program through Family Approach at the district to village

level. In addition, it can also be supported by a collaboration model which is a strategy that involves the full support of all relevant parties in the form of cooperation, interaction, compromise, either personally or institutionally in solving a problem.

**Table 5**  
**Relation of Stakeholder Roles and Commitment to the Optimization of Village Funds.**

Variables		Optimization of Village Funds		p-value	OR
		Not Optimal	Optimal		
<b>Attitudes/ Stakeholder' s Perception</b>				0.978	0.980
Not so Good	Count (%)	6 (21.4%)	7 (25.0%)		
Good	Count (%)	7 (25.0%)	8 (28.6%)		
<b>Influencing Power Possessed by stakeholder</b>				0.022*	7.583
Law	Count (%)	6 (25.0%)	13 (7.1%)		
Strong	Count (%)	4 (14.3%)	15 (46.4%)		
<b>Stakeholder' s Interest</b>				0.611	1.500
Less Important	Count (%)	9 (32,1%)	9 (32,1%)		
Important	Count (%)	4 (14.3%)	6 (21.4%)		

From table 6 it can be seen that the variables of attitude/perception, power of influence and interests of village level stakeholders do not have a significant correlation to the implementation of maternal and child

health programs. The absence of written communication and regulations governing these roles, forms and responsibilities makes it difficult for stakeholders to make decisions because the basis of commitment is less strong and less binding. This

results in weak multi-sectorial involvement, including in the support and facilitation of human resources, costs, materials and infrastructure, as well as monitoring support for evaluation. (Tumbel Mentari, 2014) Stakeholders do not focus on solving health and malnutrition problems because they prioritize technical service in their respective sectors. The involvement of stakeholders in formulating policies and

regulations according to their authority will strengthen understanding as well as the basis for decision making. The main challenges identified include the lack of specific roles of institutions in program implementation, ineffective mechanisms in linking national and regional institutions, and lack of awareness to develop specific plans and budgets allocated by each agency.

**Table 6**  
**Relation of the Roles and Commitments of Stakeholders to the Implementation of the MCH Program**

Variables		Crosstab		p-value	OR
		The Implementation of MCH Program Not Optimal	Optimal		
<b>Attitudes / Stakeholder's Perception</b>				0.843	1.200
Not so Good	Count (%)	3 (10.7%)	10 (35.7%)		
Good	Count (%)	3 (10.7%)	12 (42.9%)		
<b>Influencing Power Possessed by stakeholder</b>				0.360	0.350
Low	Count (%)	1 (3.6%)	8 (28.6%)		
Strong	Count (%)	5 (17.9%)	14 (50.0%)		
<b>Stakeholder's Interest</b>				0.891	1.143
Less Important	Count (%)	4 (14.3%)	14 (50.0%)		
Important	Count (%)	2 (7.1%)	8 (28.6%)		

**CONCLUSION OF SUGGESTIONS**

In optimizing the allocation of village funds in Tegal Regency, the support and role of village level stakeholders is very much needed, especially on the influencing power of stakeholders in making decisions, planning and formulating policies and budgeting village funds for the health sector. Stakeholders involved in the formulation of village fund budget allocations are expected to be able to advocate for the Village Government to maximize village funds in the health sector, both in the construction of MCH program infrastructure, MCH service approaches, stunting handling, as well as community empowerment or the establishment of MCH alert villages.

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