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HASIL PENILAIAN SEJAWAT SEBIDANG ATAU *PEER REVIEW*
KARYA ILMIAH: JURNAL ILMIAH

Judul Artikel Ilmiah : **Stakeholder Perception of Health Resources and Village-Funds Optimizing for Maternal and Child Health Program**

Nama semua penulis : **Ayun Sriatmi, Sutopo Patria Jati, Martini Martini, Syamsulhuda Budi Mustofa, Budiyono Budiyono**

Status Pengusul (coret yg tidak perlu) : ~~Penulis Utama~~ **Penulis Utama & Korespondensi** ~~Penulis Korespondensi~~ ~~Penulis Anggota~~

Status Jurnal:

• Nama Jurnal : KEMAS: Jurnal Kesehatan Masyarakat

• Tahun terbit/Vol/No/halaman : 2022/Vol. 17/No.4/ 594-605

• Edisi (bulan, tahun) : Juni, 2022

• ISSN : eISSN : 2355-3596 | pISSN : 2355-3596

• DOI : <https://doi.org/10.15294/kemas.v17i4.34334>

• Alamat WEB Jurnal : <https://journal.unnes.ac.id/nju/index.php/kemas/article/view/34334>

• Terindexdi : SINTA 2 (SK No. 10/E/KPT/2019)

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• Jurnal Internasional [] Jurnal internasional bereputasi & memiliki impact factor

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[] Jurnal Internasional

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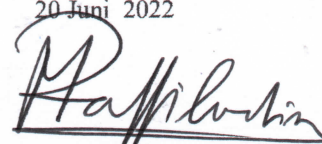
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| b | Ruang lingkup & kedalaman pembahasan | Membahas persepsi stakeholder desa tentang sumberdaya desa yang ada dan optimalisasi penggunaan dana desa untuk program KIA di Kab Tegal. Dianalisis secara kuantitatif melalui perbedaan persepsi 3 (tiga) kelompok (Decision Making; Provider; Client & Representatives), serta diuji statistik menggunakan uji komparasi Kruskal Wallis. |
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Semarang, 20 Juni 2022
 Reviewer 1



Dr. M. Zen Rahfiludin, SKM, M.Kes
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| b | Ruang lingkup & kedalaman pembahasan | Artikel secara fokus menganalisis persepsi para stakeholder tingkat desa tentang sumberdaya kesehatan desa dan optimalisasi penggunaan dana desa untuk program kesehatan ibu dan anak. |
| c | Kecukupan dan kemutakhiran data/informasi dan metodologi | Jumlah sitasi yang menjadi referensi sebanyak 42 artikel nasional dan internasional yang terbit dalam 10 tahun terakhir. |
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Semarang, 18 Juni 2022
 Reviewer 2



Dr. dr. Sri Achadi Nugraheni, M.Kes.
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Tentang Hasil Akreditasi Jurnal Ilmiah Periode 2 Tahun 2019

KEMAS: Jurnal Kesehatan Masyarakat

E-ISSN: 23553596

Penerbit: Department of Public Health, Faculty of Sport Science, Universitas Negeri Semarang

Ditetapkan sebagai Jurnal Ilmiah

TERAKREDITASI PERINGKAT 2

Akreditasi berlaku selama 5 (lima) tahun, yaitu
Volume 14 Nomor 2 Tahun 2018 sampai Volume 19 Nomor 1 Tahun 2023

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No announcements have been published.

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education, namely Universitas Negeri Semarang, Universitas Negeri Malang and Universitas Negeri Gorontalo. Mu Agreement No: 75/UN.37.1.6/KS/201

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|  | 2,147 |  | 648 |
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|  | 653 |  | 239 |



KEYWORDS

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Knowledge Leptospirosis
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ISSN: 2355-3596



Marriage Pattern and Fertility in DKI Jakarta Province

Rina Herartri[✉], Darojad Nurjono Agung Nugroho, Reni Pebrianti

Puslitbang Kependudukan, Badan Kependudukan dan Keluarga Berencana Nasional

Article Info

Article History:

Submitted September 2020

Accepted August 2021

Published April 2022

Keywords:

Fertility, Marriage Pattern,
Fertility Decomposition,
Intermediate Determinants.

DOI

<https://doi.org/10.15294/kemas.v17i4.26132>

Abstract

Birth rate or fertility is one of the elements playing a role in determining the population number and age structure in an area. To maintain stable population growth, it is necessary to strive for a total fertility rate (TFR) of around 2.1 children per woman. DKI Jakarta Province had reached this condition before the 2000 period. But in the next period, there was an increase ranging from 2.2 - 2.3 children per woman. Fertility is affected by various factors, including marriage patterns and contraception usage. This study aims to determine the effect of marriage patterns on fertility in DKI Jakarta Province by using the concept of fertility decomposition. The data used are the results of the Indonesian Demographic and Health Survey (IDHS) 2002/03 and 2017 with the unit of analysis for women aged 15-49 years. The results showed that there was a slight increase in the effect of the marriage pattern on fertility restrictions, from 14% or preventing 1.89 births in the 2002/03 IDHS to 19% or preventing the occurrence of 2.1 births in the 2017 IDHS. in DKI Jakarta Province by 2.2 children per woman in the 2017 IDHS, although there was a sharp decline in the effect of contraceptive use. It is necessary to study the relationship between the pattern of marriage and the use of contraception because these two variables play an important role in determining the fertility rate in DKI Jakarta Province.

Introduction

Apart from being the nation's capital and government center, DKI Province is also an economic, educational, social, and cultural center that attracts many immigrants from outside the region. The DKI Provincial Government has succeeded in suppressing the population growth rate, but the population continues to increase, from 8.35 million in 2000 to 10.15 million in 2015 (BPS Provinsi DKI, 2016). The population density continues to increase as DKI Jakarta becomes the province with the highest population density in Indonesia. In 2015, the population density in DKI Jakarta Province reached 15,330 people/km². While Indonesia's population density was only 134 people/km². Population growth

in DKI Jakarta Province is affected by births, deaths, and migration (BPS Provinsi DKI, 2016).

Before the 2000 period, the total fertility rate in DKI Jakarta Province had reached a condition known as the replacement level, namely a TFR of 2.1 children per woman (Gietel-Basten & Scherbov, 2020; DHS, 2017). If the TFR 2.1 can be maintained for a long time and there is no migration, then the population in the new generation will be the same or replace the population of the previous generation. It refers to balanced population growth. However, the enactment of Law no. 22/1999 on Regional Government, which delegated the authority to manage development programs including family planning programs to local governments,

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**Bintaro Leaves (*Cerbera manghas*): Toxicity to *Aedes aegypti* Instar III Larvas**

Tutut Indria Permana[✉], Nur Ilmi Dwi Sasmitasari¹, Eko Susetyarini, Moh. Mirza Nuryady, Anka Muhammad Dinindra, Jihan Ully Agustin, Muhammad Ahman Lutfi, Putri Ayu, Zada Alimatul Biology Education Study Program, Faculty of Teacher Training and Education, Universitas Muhammadiyah Malang

Article Info

Article History:
Submitted December 2020
Accepted June 2021
Published April 2022

Keywords:
Aedes aegypti,
Cerbera manghas, Toxicity

DOI
<https://doi.org/10.15294/kemas.v17i4.27670>

Abstract

DHF cases tend to increase from year to year in Indonesia. So the government makes efforts to control cases of Dengue Fever (DHF) which are usually done chemically and harm the environment and health. There is a need for safer, more effective, and environmentally friendly controls, such as using natural ingredients as natural larvicides. Among the natural ingredients having potential as a larvicide is Bintaro leaves (*Cerbera manghas*). The purpose of this study was to determine the toxicity of Bintaro leaf extract against third instar larvae of *Aedes aegypti* mosquitoes. This experimental study used 7 treatments of Bintaro leaf extract concentration (5 %, 15 %, 25 %, 35 %, 45 %, 65 %, 75 %), abate as a positive control, and distilled water as a negative control. Each treatment used ten instar III *Aedes aegypti* larvae with four repetitions. The data obtained were then analyzed using probit analysis to determine the toxicity of Bintaro leaf extract to *Aedes aegypti* larvae by calculating the LC50 and LC90 values. The results showed that the most effective concentration was 75 % because it could kill 100% of the test larvae. The LC50 value of 5,097 % and the LC90 value of 25,300 % indicate that the level of toxicity is very toxic. The probit regression analysis shows a linearity line equation $y = 1.15 + 1.43x$ with a correlation (R^2) of 0.512 which indicates that the correlation is strong enough. It is related to the content of flavonoids, tannins, saponins, triterpenoids which are toxic to the abdomen, nervous system, and respiratory system of larvae. From the research results, Bintaro extract with a concentration of 75 % can be used as a natural larvicide candidate. Furthermore, further research to see the toxicity to the environment can be done.

Introduction

Dengue fever is often a concerning problem, especially in the health sector for the community. DHF is a disease caused by the dengue virus (Halstead, 2012). Dengue virus is a type of flavivirus virus consisting of 4 serotypes, namely DEN-1, DEN-2, DEN-3, and DEN-4 (Costa et al., 2012). There is still no vaccine for it (World Health Organisation, 2014). Patients with DHF are characterized by symptoms of fever for 2-7 days, accompanied

by a decrease in platelets, headache and muscle aches (Itrat et al., 2011) as well as abdominal pain, vomiting, diarrhea, weakness, and joint pain (Halsey et al., 2012). In general, the spread of dengue disease is carried by mosquito vectors of the *Aedes* genus, namely *Aedes aegypti* and *Aedes albopictus*. The main vector of dengue fever is the *Aedes aegypti* mosquito (Hamid et al., 2017). It has a biting preference indoors, which is different from *Aedes albopictus* having a biting preference outside the home

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The Determinant of Lung Function Disorders of The Textile Industry Spinning Section

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Article Info

Article History:

Submitted June 2020

Accepted Decemehr 2021

Published April 2022

Keywords:

Determinant, lung function, textile industry

DOI

<https://doi.org/10.15294/kemas.v17i4.25069>

Abstract

Many factors affect lung function capacity in textile industry workers. This research aims to determine the factors that affect the vital role of pulmonary spinning workers in the textile industry. This research used an analytic observational research design with a cross-sectional approach. The sampling technique used total sampling and getting the sample was 96 people, and measurement of lung vital capacity used spirometry. The Low Volume Sampler was applied to measure dust concentration, and the questionnaire was used to assess the individual characteristics. Bivariate analysis of the variables is the working environment dust, exercise habits, smoking behavior, and gender are significant. The result of multivariate analysis of dust is the most affecting to the lung vital capacity. In conclusion, dust concentrations are classified above the Threshold Limit Value (TLV), so the company should control the source of dust exposure.

Introduction

Occupational respiratory disease is a major global public health problem that accounts for up to 30% of all occupational diseases. Besides, 10-20% of deaths are caused by respiratory disorders (Gizaw et al., 2016). Exposure to dust in textile industry workers can be at risk of causing lung function disorders. Health effects, in the form of impaired lung function, have been documented in workers exposed to dust in both small, medium, and large industries (Subbarao et al., 2009). Occupational Lung Disease (OLD) is a pulmonary disease arising from prolonged or repeated exposure that causes toxic effects, both acute and chronic (Stobnicka and Górny, 2015). Occupational diseases are caused by pathological responses from patients to their working environment (Qian et al., 2016). There is a growing consensus on the adverse impact of organic dust on the symptoms and respiratory

function of industrial workers, one of which is impaired lung function (Khodadadi et al., 2011).

ILO shows that annually there are more than 250 million accidents at workplaces. While 160 million workers become sick due to hazards in the workplace. Also, around 1.2 million workers die due to accidents and occupational diseases. New materials for the production process are distributed annually in the workplaces, and many of them cause lung disease (ILO, 2013). Indonesia is one of the developing countries with many companies producing dust from the production process. OLD is a group of occupational diseases in which the target organ of the disease in the lung (Sumakmur, 2014).

The textile industry is one of the many vital sectors in Indonesia, especially in the Surakarta Raya region. Workers can be exposed to a variety of different environmental factors,

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Hearing Aids and The Quality of Life of Children with Hearing Loss

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Article Info

Article History:
Submitted October 2020
Accepted April 2021
Published April 2022

Keywords:
Hearing loss, hearing aid, quality of life

DOI
<https://doi.org/10.15294/kemas.v17i4.26574>

Abstract

Hearing loss in children may cause social isolation and poor communication skills, potentially affecting mental disorders and quality of life. Hearing aids (HA) provide auditory stimuli that can improve children's speech ability and influence their quality of life. A cross-sectional study in three special schools-B (SLB-B) in Semarang was carried out. A total of 82 children (7-12 years old) with severe hearing loss with or without hearing aids were included. Quality of life was assessed by the Hearing Environments and Reflection on Quality of Life (HEAR-QL) questionnaire. The results showed that 48 (58.54%) subjects used hearing aids, and 34 (41.46%) did not use hearing aids. The average subject's age was 10.77±1.56 years old. Hearing-aid use was associated with a good quality of life of children with hearing loss ($p<0.001$). Good quality of life was found in 68.8% of children with hearing aids compared to only 2.9% in children without hearing aids. Duration of hearing-aid use ($p<0.001$), mother education ($p<0.006$) was associated with good quality of life of children, whereas gender ($p=0.49$), number of siblings ($p=0.06$), and socioeconomic status ($p=0.63$) were not. The quality of life of children who use hearing aids is better than without hearing aids.

Introduction

Hearing loss in children that is not immediately treated can harm speech, language, academic, emotional, and psychosocial development (Madell, 2014). With the maturity process, the auditory function, and lasts speech development. A person's speech and language proficiency can only be achieved when sensory and motor input are normal. Speech development is closely related to the stage of hearing development (Suwento et al., 2017). Severe sensorineural hearing loss can cause more severe impairment in language and speech development, especially in the pre-lingual phase (Sobreira et al., 2015).

According to WHO, as many as 360 million people (approximately 5% of the world population) experience hearing loss, and nearly 32 millions of them are children (World Health Organization, 2016). Based on 29

countries' data, Stevens and colleagues (2013) reported that 1.4% of children and 9.8–12.2% of suffer hearing loss, whose prevalence is high, especially in low- and middle-income countries (Stevens et al., 2013). Sensorineural hearing loss (SNHL) is a result of damage to the auditory nerve or the hair cells of the inner ear and may be acquired, genetic or idiopathic. About 1–4 per 1000 babies are born with SNHL (Prosser et al., 2015). At the Ear, Nose, and Throat (ENT) outpatient clinic of Dr. Kariadi Hospital Semarang, there were up to 60 children visits monthly due to speech delay, in which nearly 50% had moderate-to-severe hearing loss. Hearing loss can cause social isolation and poor communication skills, which eventually may affect mental health and quality of life, (Azizi et al., 2013).

Quality of life that refers to individual health is called health-related quality of life

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“Health Belief Model” in the Prevention of Chronic Disease in the Elderly

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Article Info

Article History:
Submitted November 2020
Accepted June 2021
Published April 2022

Keywords:
Health belief model,
prevention and main-
tenance, elderly

DOI
<https://doi.org/10.15294/kemas.v17i4.27296>

Abstract

Chronic disease is a non-communicable disease categorized as a long-term disease due to physiological changes in the body in the elderly. Chronic disease can be prevented with a healthy lifestyle and education through the Health Belief Model with the belief that someone takes a series of actions to overcome disease and reduce side effects. This study aims to determine how the effect of the application of the “Health Belief Model” in the Prevention and Health Care of Chronic Disease in the Elderly, which was carried out with a total sample of 100 respondents. The research design used Quasi Experiment with a pre-test and post-test approach with a control group design, a knowledge questionnaire about chronic disease, disease prevention, and health care including pre-test and post-test, used Paired T-Test with knowledge result $p\text{-value } 0.000 < \alpha$ ($\alpha = 0.05$) and health prevention and maintenance $p\text{-value } 0.000 < \alpha$ ($\alpha = 0.05$) so it can be concluded that there is an effect of implementing the “Health Belief Model” in the prevention and maintenance of chronic disease health in the elderly.

Introduction

Chronic disease is a non-communicable disease and is categorized as a long-term disease because it undergoes physiological changes in the body (Ribeiro et al., 2014). Chronic illness can cause job loss, experience physical dependence, and require treatment assistance (Gonzalez, Maria, Roth, Gelehrter, & Lopes, n.d.). Indonesia has 20.24 million people in the elderly category, equivalent to 8.03% of the total population (Yulianti, Baroya, & Ririanty, 2014). The number has not been matched by good health. The elderly morbidity rate in Indonesia is calculated at 25.05%, meaning that out of every 100, there are 25 sick elderly. The morbidity rate of the elderly is moderate due to chronic diseases in the highest order, such as hypertension, arthritis, stroke, COPD, DM, cancer, coronary heart disease, kidney stones, heart failure, and kidney failure (Sudarmaja, Swastika, & Ariwati, 2020).

Chronic diseases generally attack the elderly, and this condition requires treatment

until the end of life (Periyakoil, Neri, & Kraemer, 2016). The increasing population of chronic diseases affecting the elderly poses challenges for social care and health care. They experience the aging process, so they have a health burden. The decline in health functions prevents the elderly from being independent and participating in social activities (Perdamaian, Manus, Periska, & Steffiasih, 2020). The incidence of elderly people with chronic diseases requires long-term care and increases the cost of health care. In addition, chronic conditions cause the elderly to experience an inability to perform activities independently due to aging, disease conditions, and cognitive abilities that can make them dependent on care providers and require health services (Ondiege & Clarke, 2017).

The elderly with chronic diseases require long-term treatment. Treatment compliance is vital for them. Compliance is affected by several factors. Like medication, patient, physician, system-based factors, etc. Low medication compliance usually leads to poor

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HEALTH RESEARCH ETHICS COMMITTEE
FAKULTAS KESEHATAN MASYARAKAT UNIVERSITAS DIPONEGORO
FACULTY OF PUBLIC HEALTH DIPONEGORO UNIVERSITY**

**KETERANGAN LOLOS KAJI ETIK
DESCRIPTION OF ETHICAL APPROVAL
"ETHICAL APPROVAL"**

No : 71/EA/KEPK-FKM/2021

Protokol penelitian yang diusulkan oleh :
The research protocol proposed by

Peneliti utama : Dr. dr. Sutopo Patria Jati, MM, M.Kes
Principle Investigator

Nama Institusi : Universitas Diponegoro
Name of the Institution

Anggota Peneliti : 1. Dr. Budiyo, SKM., M.Kes. 5. Nikie Astorina Yunita D, SKM, M. Kes
Member 2. Dr. Dra. Ayun Sriatmi, M.Kes. 6. dr. Rani Tiya Budiyan, M.H
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4. Dr. Drs. Syamsulhuda BM, M. Kes 8. Nissa Kusarjana, SKM, M. Si

Dengan judul :
Title

"PERENCANAAN TERPADU DALAM RANGKA PERCEPATAN PENURUNAN ANGKA KEMATIAN IBU DAN BAYI"

**"INTEGRATED PLANNING IN THE CONTEXT OF ACCELERATING THE DECREASE
IN MATERNAL AND INFANT MORTALITY RATES"**

Dinyatakan layak etik sesuai 7 (tujuh) Standart WHO 2011, yaitu 1) Nilai Sosial, 2) Nilai Ilmiah, 3) Pemerataan Beban dan Manfaat, 4) Risiko, 5) Bujukan/Eksploitasi, 6) Kerahasiaan dan Privacy, dan 7) Persetujuan Setelah Penjelasan, yang merujuk pada Pedoman CIOMS 2016. Hal ini seperti yang ditunjukkan oleh terpenuhinya indikator setiap standar.

Declared to be ethically appropriate in accordance to 7 (seven) WHO 2011 Standards, 1) Social Values, 2) Scientific Values, 3) Equitable Assessment And Benefits, 4) Risks, 5) Persuasion/Exploitation, 6) Confidentiality and Privacy, and 7) Informed Consent, referring to the 2016 CIOMS Guidelines. This is as indicated by the fulfillment of the indicators of each standard.

Pernyataan Laik Etik ini berlaku selama kurun waktu tanggal 22 March 2021 sampai dengan tanggal 22 March 2022

This declaration of ethics applies during the period March, 22th 2021 until March, 22th 2022

Semarang, 22 March 2021
Professor and Chairperson,



dr. M. Sakundarno Adi, M. Sc, Ph.D.
NIP. 196401101990011001

Stakeholder Perception of Health Resources and Village-Funds Optimizing for Maternal and Child Health Program

by Ayun Sariatmi

Submission date: 24-Jun-2022 09:03AM (UTC+0700)

Submission ID: 1862072437

File name: llage-Funds_Optimizing_for_Maternal_and_Child_Health_Program.pdf (265.23K)

Word count: 6894

Character count: 37451



Stakeholder Perception of Health Resources and ¹Village-Funds Optimizing for Maternal and Child Health Program

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Article Info

Article History: ¹⁸
Submitted January 2022
Accepted March 2022
Published April 2022

Keywords:

MCH programs; stakeholder groups; village funds

DOI

<https://doi.org/10.15294/kemas.v17i4.34334>

Abstract

The low support on cross-sectoral commitment of village stakeholders to health programs was one of factors contributed maternal and infant mortality in Tegal Regency. Although village funds have been rolled out since 2015, its implementation hadn't been optimal due to orientation focus on infrastructure development. The study aims to analyze perceptions and attitudes of village stakeholders towards village level resources and optimizing village funds for MCH programs based on 3 groups stakeholder (Decision Maker, Provider and Clients-Representatives). It's quantitative research, population of all village level stakeholders with 300 people as samples from 30 selected villages. Data collected with interview using questionnaire and being analyzed with frequency distribution and statistically using Kruskal-Wallis test. Most of three group stakeholders had good perception of their health resources and positive attitude towards MCH programs, but different results were seen for attitudes towards optimizing village funds. Decision Maker group and Clients-Representatives group showed tendency refusing, while Provider group tend to agree on village funds optimizing for MCH programs. Statistically, there were differences in attitudes towards optimizing village funds for MCH program between three groups. Attitude differences was mainly due to lack of understanding from external health stakeholders about health programs, especially village's MCH program.

Introduction

The high Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR) were still major health problems in developing countries (Geller et al., 2018; Zureick-Brown et al., 2013). The main causes of maternal death were pregnancy complications, childbirth complications and medical history (Bauserman et al., 2015). Infant mortality was mainly due to asphyxia, respiratory disorders, ¹⁴maturity and low birth weight (Abdullah et al., 2016; Anggondowati et al., 2017; O'Hare

et al., 2013). The MMR and IMR reflected health development level and quality of life of community (Ignacio Ruiz et al., 2015) and at the same time as means to monitor and evaluate health programs and policies (Yugistiyowati, 2020). One of determinants that affected difficulty reducing maternal and infant mortality was the low stakeholder support, especially for cross-sectoral commitments even though ¹⁵their involvement has increased (Harbianto et al., 2016; Jati et al., 2020; Nurani; et al., 2018), in addition of socioeconomic

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factors (poverty), inequity and unfairness access of services (Abbasi & Younas, 2015; Ignacio Ruiz et al., 2015).

The stakeholder role is important in successful health programs implementation, including MCH program (Ignacio Ruiz et al., 2015; Sombie et al., 2017). Through tiered collaboration from center to village level, it is necessary to strive for strengthening stakeholder role in a comprehensive network. The stakeholder roles are very varied in form of policy support, facilities and financing, as well as in community mobilizing for using health services and supporting their active role in UKBM (Posyandu, Poskesdes, etc.), as well as support in form of guidance and counselling, including support for facilitation of infrastructure. The form of stakeholder support covers many aspects, from policy, managerial to operational aspects, including monitoring and evaluation mechanism (Douthard et al., 2021).

Study of Harbianto et-al showed one of capacities that must be improved in reducing maternal and child mortality at regional level was through strengthening cross-sectoral planning and budgeting. It was proven that failure achieving targets of MCH program was due to blockage of unsystematic planning mechanism (Harbianto et al., 2016). Through Law No. 6 of 2014 concerning Villages, national government had allocated village funds as source of financing and implementation of local village-scale activity programs. The aim is not only equalizing financial capacity between villages, but also improving rural community welfare and quality of life of community, as well as efforts reducing poverty. Villages had authority to regulate its finances according to needs of local area and in preparing program plans and budgeting involving all relevant sectors. Improved rural health infrastructure could increase the demand and utilization of ANC services for poor families in India (Gupta et al., 2017).

Legal Regency is one of 35 regencies in Central Java province that have been affected by Covid-19 pandemic. In last three years there has been increasing in cases of maternal and infant mortality. In 2019 there were 12 cases of

maternal death, increasing to 28 cases in 2020 and until November 2021 were 27 cases. The main causes of death were eclampsia by 46% (in 2020) and due to Covid-19 by 44.4% in 2021. From 27 maternal deaths, 13 cases (48.2%) occurred during postpartum period, 10 cases (37%) during pregnancy and 4 cases (14.8%) during delivery. The IMR also increased from 5.95 per 1000 KH (in 2019) to 6.9 per 1000 KH (in 2020) with 152 deaths. Until October 2021 were 113 cases of infant mortality. Total 61.9% of infant deaths occurred at age of 0-6 days, 20.9% at age of 7-28 days and 17.2% at age of 29 days-11 months. Asphyxia, LBW and ARI (acute respiratory infection) were main causes of infant mortality.

Although village funds have been rolled out by national government since 2015, the implementation in health programs was still not optimal (Suarsih et al., 2017). So far, focus of village fund financing have been on infrastructure development, although starting in 2019 it had begun to be directed at strengthening community empowerment. Study by Tumaji & Putro provided evidence of low utilization of village funds for health in Pasuruan and Sampang districts, which was on average 4.17% and was mostly used for infrastructure and non-health development (Tumaji & Putro, 2018). It was recognized that policy actor, especially Village Head and village officials had important role in every development process in village including in village funds managerial, because they were the compilers and implementers of development in village. Suarsih et al. stated that low level of health development was due to village government's assumption that the responsibility for health development was the Health Office and PHC (Suarsih et al., 2017). On the other hand, study of Ismawati et-al showed the role of Village Head as a decision maker, although he often did not understand the program technically because it tends not to involve integrated service post (Posyandu) cadres in preparation of village budget (Ismawati et al., 2017).

Based on description above, this study aims to analyze perceptions and attitudes of

village level stakeholders towards village level health resources and village funds optimizing for maternal and child health programs based on different three stakeholder categories, include Decision Maker (DM) group, Providers (P) and Clients & Representatives (CR). Regarding ethical feasibility, this research had been declared having passed ethical review from Commission of Health Research Ethics (KEPK) from Public Health Faculty, Diponegoro University with Number: 71/EA/KEPK-FKM/2021.

Meth²⁰

This study uses a quantitative survey research with cross-sectional approach. Population were all village level stakeholders related to MCH programs implementation in village, including: Village Head, Village Secretary, BPD, other village officials, FKD/FKK, PKK/Pokja-4, regional apparatus (RT/RW/Dukuh/Dusun), religious leaders, community leaders, youth organizations, village associations, village midwives, health cadres and so on. Sampling determination was carried out by purposive sampling technique based on villages criteria that had cases of maternal and child mortality in last year so 30 villages were selected. Total respondents were 300 people because 10 stakeholders were taken from each village and they divided into three categories of roles, namely; Decision Maker include: Village Head, Secretary and other village officials, BPD and FKD. Provider group include: Village Midwives and Health Cadres, and group of Client & Representatives were sub local officer, religious leaders, community leaders, PKK/Pokja-4, Youth Organizations, community organizations and village associations.

Data was collected by interview using structured questionnaire. Because it was still in pandemic situation, interview was carried out

while still complying with "health protocols" after previously respondent stated willing to be interviewed²¹ and making an appointment in advance. Validity and reliability tests have been carried out and the results were valid and reliable. The research variables include: perceptions of village health resources, attitudes towards MCH program and attitudes towards optimizing village funds for MCH. Analysis was carried out descriptively and statistically. Based on results of Kolmogorov-Smirnov test, it is known that data was not normally distributed, so variable categorization uses median value as cut off point. If score value < median was declared unfavorable, if score ≥ median was declared good. Furthermore, data were analyzed univariately with frequency distribution and analysis¹⁰ of the difference test for three groups using Kruskal Wallis test which was non-parametric test. If p value < 0.05 on the statistical test results, it could be concluded there was significant differences.

Result and Discussion

From 300 respondents, based on their role in village, 135 people (45%) belonged to Decision Makers group, 60 people (20%) to Providers group and 105 people (35%) to Clients and Representatives group. Table 1 showed characteristics of respondents based on stakeholder groups were dominated by adults at age range 31-60 years old. In DM group, the largest proportion was in age range 41-50 years old (45.9%), male sex (70.4%), while CR group of 43.8% was in age range 41-50 years old and 16% male gender (50.5%). For P group, as 36.7% were in age range of 31-40 years old, followed by age range 41-50 years old (35%), with the largest proportion being female (93.3%). Most of respondents have middle level education with the largest proportion being passed high-school/equivalent for all stakeholder groups.

Table 1. Distribution of Respondents' Characteristics Based on Village Stakeholder Groups in Tegal Regency

| Characteristic | Category | Decision Maker | | Provider | | Client & Representatives | |
|----------------|----------------------------------|----------------|------|----------|------|--------------------------|------|
| | | n | % | n | % | n | % |
| Age | a. 21-30 years old | 7 | 5.2 | 4 | 6.7 | 2 | 1.9 |
| | b. 31-40 years old | 22 | 16.3 | 22 | 36.7 | 30 | 28.6 |
| | c. 41-50 years old | 62 | 45.9 | 21 | 35.0 | 46 | 43.8 |
| | d. 51-60 years old | 37 | 27.4 | 12 | 20.0 | 20 | 19.0 |
| | e. > 60 years old | 7 | 5.2 | 1 | 1.7 | 7 | 6.7 |
| Gender | a. Male | 95 | 70.4 | 4 | 6.7 | 53 | 50.5 |
| | b. Female | 40 | 29.6 | 56 | 93.3 | 52 | 49.5 |
| Education | a. Elementary/equivalent | 1 | 0.7 | 2 | 3.3 | 6 | 5.7 |
| | b. Junior high school/equivalent | 11 | 8.1 | 9 | 15.0 | 19 | 18.1 |
| | c. Senior high school/equivalent | 74 | 54.8 | 28 | 46.7 | 55 | 52.4 |
| | d. Academy/Diploma-3 | 14 | 10.4 | 20 | 33.3 | 9 | 8.6 |
| | e. Undergraduate (S1) | 35 | 25.9 | 1 | 1.7 | 16 | 17.3 |
| Total | | 135 | 45.0 | 60 | 20.0 | 105 | 35.0 |

Source: Primary Data, 2021

Total of 54.2% of respondents from all stakeholder groups stated that their village had no maternal deaths in last 3 years, 19.3% said there were deaths and 26% said they did not know. For infant mortality in last 3 years, 39% said they had never, 29.7% said they had and 31.3% said they did not know. Table 2 described stakeholders' understanding of health resources available in their villages and most of three stakeholder groups stated their villages were Siaga Village and UCI Village (Universal Coverage of Immunization), although there were still did not know what Siaga Village was, as many as 11.9% from DM group, 16.7% from Provider group and 11.4% from CR group. For stakeholders who didn't know what UCI Village was, 33.3% were from DM group, 25% from Provider group and 38.1% from CR group.

Table 2 also showed that most of respondents from all groups stated that their village currently did not have a village ambulance, although there was small proportion who state that they have a village ambulance in form of loan cars belonging to local residents. Most of respondents from all groups stated their village had many Posyandu (>5) and health cadres that numbered >20 people and they were very active. Most of respondents also stated that their village already had Village Health Unit (Poskesdes), although there were 13.4% respondents from Provider group who stated that they did not know and did not have Poskesdes. This description showed all stakeholder groups generally had positive perceptions and understandings regarding health village resources.

Table 2. Distribution of Village Stakeholder Perception about Village Health Resources in Tegal Regency

| Health Village Resources | Category | Decision Maker | | Provider | | Client & Representatives | |
|------------------------------------|--------------------------|----------------|------|----------|------|--------------------------|------|
| | | n | % | n | % | n | % |
| Siaga village | a. Do not know | 16 | 11.9 | 10 | 16.7 | 12 | 11.4 |
| | b. No | 22 | 16.3 | 8 | 13.3 | 18 | 17.1 |
| | c. Yes | 97 | 71.9 | 42 | 70.0 | 75 | 71.4 |
| UCI village | a. Do not know | 45 | 33.3 | 15 | 25.0 | 40 | 38.1 |
| | b. No | 29 | 21.5 | 7 | 11.7 | 15 | 14.3 |
| | c. Yes | 61 | 45.2 | 38 | 63.3 | 50 | 47.6 |
| Village ambulance | a. Do not know | 8 | 5.9 | 5 | 8.3 | 6 | 5.7 |
| | b. Do not have | 80 | 59.3 | 35 | 58.3 | 60 | 57.1 |
| | c. Have but borrow a car | 3 | 2.2 | 4 | 6.7 | 1 | 1.0 |
| | d. Have own ambulance | 44 | 32.6 | 16 | 26.7 | 38 | 36.2 |
| Integrated Service Post (Posyandu) | a. Do not know | 0 | 0 | 0 | 0 | 4 | 3.8 |
| | b. Have (≤ 5) | 44 | 32.6 | 19 | 31.7 | 29 | 27.6 |
| | c. Have (> 5) | 91 | 67.4 | 41 | 68.3 | 72 | 68.6 |
| Number of health cadres | a. Do not know | 0 | 0 | 3 | 5.0 | 6 | 5.7 |
| | b. Have (≤ 20) | 2 | 1.5 | 0 | 0 | 3 | 2.9 |
| | c. Have (> 20) | 133 | 98.5 | 57 | 95.0 | 95 | 90.5 |
| Number of active health cadres | a. All cadres inactive | 1 | 0.7 | 0 | 0 | 3 | 2.9 |
| | b. Few cadres active | 0 | 0 | 0 | 0 | 1 | 1.0 |
| | c. Most cadres active | 24 | 17.8 | 14 | 23.3 | 18 | 17.1 |
| | d. All cadres active | 110 | 81.5 | 46 | 76.7 | 83 | 79.0 |
| Health Village Post (Poskesdes) | a. Do not know | 0 | 0 | 4 | 6.7 | 4 | 3.8 |
| | b. Do not have | 3 | 2.2 | 4 | 6.7 | 3 | 2.9 |
| | c. Have | 132 | 97.8 | 52 | 86.7 | 98 | 93.3 |

Source: Primary Data, 2021

Table 3 showed the frequency distribution of stakeholder groups attitudes about MCH program, where the largest percentage of DM group was in poor category (57%) and this was greater than Provider group which was also in poor category (50%). The results were different in CR group because the proportion in good category was greater (55.2%). Regarding attitudes about optimizing village funds for MCH program, the DM and CR groups both indicated that proportion of those with poor perception was greater than those with good perceptions. As many as 63% of respondents from DM group and 53.3% from CR group. On the other hand, from Provider group, the

largest percentage had a good perception of optimizing village funds for MCH program (61.7%). There was a tendency for lack support in optimizing village funds for MCH program in village, especially in DM and CR groups. Strong support comes from the service provider group (P). Furthermore, regarding perception of health resources, three groups showed linear result, where most of them had a good perception and understanding of health resources currently owned by their village, although it was recognized that the proportion of the Provider group was higher than other two groups, namely 60% versus 56.3% and 52.4%.

Table 3 Distribution of Attitudes and Understandings Based on Differences in Village Stakeholder Groups in Tegal Regency

| Research variables | Category | Decision Maker | | Provider | | Clients & Representatives | |
|--|----------|----------------|------|----------|------|---------------------------|------|
| | | n | % | n | % | n | % |
| Perception of Village Health Resources | a. Poor | 59 | 43.7 | 24 | 40.0 | 50 | 47.6 |
| | b. Good | 76 | 56.3 | 36 | 60.0 | 55 | 52.4 |
| Attitude to MCH Program | a. Poor | 77 | 57.0 | 30 | 50.0 | 47 | 44.8 |
| | b. Good | 58 | 43.0 | 30 | 50.0 | 58 | 55.2 |
| Attitude to Village Funds Optimizing | a. Poor | 85 | 63.0 | 23 | 38.3 | 56 | 53.3 |
| | b. Good | 50 | 37.0 | 37 | 61.7 | 49 | 46.7 |

Source: Primary Data, 2021

Table 4. Difference Analysis of Attitudes and Understanding Based on Village Stakeholder Groups in Tegal Regency

| Research variables | Decision Maker (DM) | | Provider (P) | | Client & Reprv (CR) | | Sig. (p-value) |
|--|---------------------|-----------|--------------|-----------|---------------------|-----------|----------------|
| | n | Mean rank | n | Mean rank | n | Mean rank | |
| Perception of Village Health Resources | 135 | 152.36 | 60 | 153.22 | 105 | 146.56 | 0.841 |
| Attitude to MCH Program | 135 | 138.88 | 60 | 162.93 | 105 | 158.34 | 0.102 |
| Attitude to Village Funds Optimizing | 135 | 135.94 | 60 | 178.93 | 105 | 152.98 | 0.005* |

*Significant at $p < 0.05$ in *Kruskal Wallis* non-parametric test

Source: Primary Data, 2021

Because data was abnormal and wanted to know difference between >2 groups, so *Kruskal Wallis* non-parametric test was used. Table 4 showed attitude variable towards village funds optimizing was statistically proven to be different between three stakeholder groups because of $p\text{-value}=0.005$ was far below the threshold $p < 0.05$ while for attitude variable towards MCH program and perception of village health resources there was no difference between groups. The DM group was more likely disagree with optimizing village funds for MCH program, while the Provider group was very supportive. Meanwhile, the CR groups were divided in almost equal proportions between those who agree and disagree. These results also proved that an understanding of MCH program, especially in rural areas would determine their attitude towards the program. Understanding of MCH program influenced the attitudes and perceptions of stakeholders' roles towards these program (Chol et al., 2018; George & Branchini, 2017).

Village funds were funds sourced from APBN that were regulated by national government to villages and were mandated by Law No. 6 of 2014 concerning Villages. Increasing village income through village funds was aimed at improving community service facilities in meeting basic needs, strengthening village institutions and empowering communities. The allocation and distribution of using village funds was decided through Village Musrenbang which sees all stakeholders at village level. In accordance with the provisions, 70% allocation of village funds was used for community empowerment in form of developing village economic infrastructure, empowerment in fields of education, health

and village economic empowerment according to village potential. Optimizing local potential had been proven to improve nutritional status in community which at the same time indicated effectiveness criteria of nutrition program was 60% as study by Handayani et-al (Handayani et al., 2018). Priority of financing village funds was implementing local scale programs and activities with the aim of improving community welfare and quality of life.

It must be admitted that the use of village funds had not been effective because of insufficient capacity and capability of village government, nor had active involvement of community in managing village funds been optimal (Azizi, 2016). In addition, quality of activity planning was still considered low and weaknesses of Health Office advocacy. In some areas, it's proven that allocation of village funds for health sector was often not a top priority (Tumaji & Putro, 2018) and even allocation of village funds for community empowerment in health sector does not even exist (Hill et al., 2014). According to Tumaji & Putro, for villages that do not yet have health facilities in village such as Poskesdes/Polindes or when Posyandu and Posbindu activities were not running optimal, village funds should be prioritized for the construction and development of health service facilities, including for maternal and child health programs (Tumaji & Putro, 2018).

With regard to management of development budget, study of Harbianto et-al. proved that involvement of relevant cross-sectors in planning and budgeting of MCH program had positive impact on the workplan and budgeting. His study in Papua showed increasing in allocation of funds for MCH

sector through strengthening the increasingly positive role of Local government revenue agency (BAPPEDA) (Harbianto et al., 2016). This condition could be implemented in management of village funds too, where all village stakeholders must be involved and their roles strengthened so the allocation for health programs funding and village community empowerment for health was also getting better through indicators of increasing budget allocations provided by village. Conceptually it was understood that each stakeholder had different influences and interests, so how to unite the same perception and understanding becomes a very crucial need (Kumar et al., 2018) which also includes multi-sectoral collaboration (Das et al., 2018). Study in Ethiopia proved strengthening health system's roles in multisectoral approach affected its success in achieving MDGs targets (Assefa et al., 2017). Study on nutrition program in Bangladesh also gave the same result (Kar, 2014).

Different characters of stakeholders made different contributions, including their different perspectives on health problems in their village. The study conducted by Sriatmi et-al regarding the role of stakeholders in the nutrition strengthening program in 1000 HPK (first day of life) illustrate that Decision Making group had power to influence programs, but did not really understand health programs. Stakeholders belonging to Provider group or service providers had better ability handling technical problems, but could not build collaboration with other stakeholders. On the other hand, it turns out that Client and Representatives (CR) group tend to be passive in building cooperation and did not regard this movement as important and tends to be ignored. The impact occur from different perspectives on each stakeholder would creating gaps in program implementation (Sriatmi et al., 2021), including to ensure its sustainability (Chol et al., 2018; Teychenne et al., 2021).

Another study by Buccini et-al which aim to map the influence of stakeholders involved in breastfeeding promotion policies and programs in Mexico and identify opportunities for strengthening breastfeeding-friendly environment could identify four important influence domains for stakeholders

include: instruction, dissemination, funding and assistance technical, where strongest factor was dissemination aspect (Buccini et al., 2020). Each stakeholder will look at these four elements when faced with their role in various programs, including health programs. These results indicate that perception and strengthening of stakeholder role could be improved through how dissemination of program was carried out, through socialization and a clear, structured and routine communication mechanism. Furthermore, how technical assistance was provided through a model of assistance by related parties and local governments. Regulatory support and clear work system were the third important elements that must be considered, including finance ability. This result in line with study by Yugistiyowati et-al which stated that facilitation to all stakeholders was needed through effective communication in order to accelerate neonatal health targets achievement, while increasing participatory empowerment principal (Yugistiyowati, 2020).

Generally, this study showed perception of village stakeholders regarding sustainability of MCH program was quite good, although there were some things that need to be improved because as many as 35.5% of respondents apparently consider the MCH program fully the Public health center responsibility. This perception was not completely wrong when they did not understand the program. Although they were willing to be involved and participate in its implementation, it was only limited to supporting it. One of these conditions was evidenced by lacking of village ambulances as a form of village government facilitation support. This result in line with Suarsih's study in Malinau Regency which showed that village government considered that responsibility for health development rests was the Health Office and Public health center (Suarsih et al., 2017). Iswarno et-al study also showed that local government's political commitment to MCH program was still low, as evidenced by the minimal budget allocation MCH program (Iswarno et al., 2013).

Regarding to optimizing of village funds, it was known by this research that although most stakeholders support and agree on the need to optimize village funds for maternal and

child health programs, there were still some who said otherwise. It was known that 21.3% tend to agree that village funds were prioritized for village infrastructure development because the results were faster and clearly visible to community. As many as 15.3% respondents thought that Integrated Healthcare Center and Antenatal Class activities could not be financed from the village funds because it was government responsibility. As many as 54% respondents turned out to agree that village funds budgeted for health sector allocator were maximum 5% of total village fund budget and that was very good and was considered more than sufficient. Totally 13.7% also tend state all rules and regulations related to mechanism for budgeting health programs for villages were unclear and had not been properly understood by village officials. These results proved that there were different perceptions commitment among respondents about MCH program in their area. Different points of view will produce different dimensions of understanding. Differences of perceptions between stakeholders have an impact on not optimal coordination and program failure as Meutia & Yuliyanti study which proved one of weaknesses intervention strategy for reduction stunting due to low capacity of cooperation among stakeholders (Meutia & Yulianti, 2019). Lack of perception and attitude affected how they implemented their roles (Memon et al., 2015).

The lack of decision maker commitment in village related to efforts village funds optimizing for strengthening maternal and child health programs could be influenced by several factors, especially their lack of knowledge and understanding regarding the benefits and interests of program for community health status and performance indicators in the health sector. In addition, the ignorance factor of village-level decision makers in describing and developing potential indicators in concept of strengthening community empowerment as stipulated in regulations issued by Ministry of Villages related to allocation of village funds. Based on commitment and active role of various stakeholder components in fostering and assisting community elements in various implementation processes and activities related

to efforts reducing maternal and infant mortality, it was expected to increase understanding, capability, as well as facilitation support for optimizing the utilization of all village potentials, including village funds. The study of Jati et al showed the commitment of local governments, private sector and other sectors was related to success of achieving minimum service standards (MSS) for health, especially maternal and child health (Jati et al., 2020). Continuous strengthening of accountability and advocacy at all governmental levels through civil society involvement played an important role achieving the success of MCH programs (Hoope-Bender et al., 2016). Collaboration and partnership between public and private sectors were key indicators, as studies result in Hawaii (Hayes et al., 2016) and California (Main et al., 2018).

One of key factors for this weakness was mainly because of the low stakeholder role and their involvement in planning and budgeting mechanism for village fund allocations had not been optimal. Coordination of village government officials with stakeholders was not going well so there were often differences in understanding and opinions about the program. Weak coordination between stakeholders had proven to be an obstacle in planning financing for maternal and child health programs in Central Lombok district (Erpan et al., 2012). On the other hand, external stakeholders generally also tend to be passive and leave decisions entirely in the hands of Village Head and its officials who were considered having authority to decide, even though they were technically not understanding program. It was accordance with the results study which proved there were significant differences in attitudes from DM group, Provider group and CR group towards their perceptions of optimizing village funds for maternal and child health, where the DM group tends to disagree and the P group tends to agree. The CR group was relatively equally divided between those who agree and those who disagree. Although all stakeholders agree and support MCH program, there were still different opinion regarding the optimization of village funds for budgeting MCH program in village. Differences of opinion could occur due to the low involvement of health technical sector (health cadres) in planning and budgeting

process in the village as studied by Ismawati et al in Blitar Regency (Ismawati et al., 2017).

This description indicate that village stakeholders tend to be seen only as supporting elements for implementation of various health programs. These result in line with study of Namazzi et al in Uganda that supporting of district and community level stakeholders was very high in intervention of care for pregnant women, mothers in labor and newborns, but they were not a driving factor. High support was illustrated by their opinion that intervention provides positive benefits for community (Namazzi et al., 2013). One of efforts that could be done overcoming these obstacles was through strengthening collaboration between stakeholders which was proven to be still quite weak at this time. The practice of collaboration in health services emphasizes optimizing multi-stakeholder role and joint responsibility to overcome various health problems (Ramswamy et al., 2016). It must be admitted that the role and involvement of stakeholders in implementation of health programs was still relatively weak, especially the local government stakeholders even though their attitudes and perceptions were positive and supportive (Iswarno et al., 2013). Need a comprehensive policy that was able strengthening proactive health system and could policies design according to regional needs through leadership roles at local, regional and national levels, as studies in Bangladesh (Islam & Biswas, 2014), Ethiopia (Assefa et al., 2017), Pakistan (Abbasi & Younas, 2015) and China (Liu et al., 2020). Therefore the commitment of all stakeholders was critical aspects to gain successfully (Hlongwane et al., 2021).

Conclusion

The three village stakeholder groups had relatively same perception of village health resources and attitudes towards maternal and child health programs, but different results were seen for attitudes towards optimizing village funds. The Decision Maker group and Clients & Representatives group showed tendency to refuse, although the proportion of rejection was greater in the Decision Maker group, while the Provider group tended to agree on the need to optimize village funds

for maternal and child health particularly. The difference in attitude was mainly due to a lack of understanding from external health stakeholders about health programs, especially maternal and child health at village level. It was necessary to actively involve all stakeholders in every stage of village level health program activities, including the planning and budgeting mechanisms. Strengthening coordination also need to be done through clarity of form and time of scheduled regular meetings, as well as improving interpersonal communication to improve understanding and positive attitudes towards health programs, including maternal and child health.

Acknowledgments

This research gets funded allocation from self-management cooperation activities at 2021 between Faculty of Public Health Diponegoro University with Directorate of Maternal and Child Health, Ministry of Health Republic of Indonesia.

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