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

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Article Info

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, prematurity 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 (Yugistyowati, 2020). One of determinants that affected difficulty reducing maternal and infant mortality was the low stakeholder support, especially for cross-sectoral commitments even though their involvement has increased (Harbianto et al., 2016; Jati et al., 2020; Nurani; et al., 2018), in addition of socioeconomic

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 increases the demand and utilization of ANC services for poor families in India (Gupta et al., 2017).

Tegal 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 of 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.

Method

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 interviewed 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 analysis 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 was male gender (50.5%). For P group, as 36.7% were in age range 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/	74	54.8	28	46.7	55	52.4
		equivalent	14	10.4	20	33.3	9	8.6
	d.	Academy/Diploma-3	35	25.9	1	1.7	16	17.3
	e.	Undergraduate (S1)						
		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-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 given 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 Yugistyowati 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 (Yugistyowati, 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 stakeholder 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 (Ramaswamy 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

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