

RESEARCH ARTICLE

The Availability of Health Resources on the Performance of Maternal and Child Health Policy Implementation in East Nusa Tenggara

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Abstract

Maternal and child health problems continue to be priority health issues in Indonesia, especially in East Nusa Tenggara (NTT). The maternal mortality rate in NTT has reached 159/100,000 live births, while infant and under-five mortality rates have reached 32/1000 live births and 40/1,000 live births, respectively above the national value of 23/1000 live births and 32/1,000 live births. It indicates that the health and maternal and child health policies in NTT have not been maximally implemented. One of the causes is the lack of available health worker resources that provide health services. The research objective is to identify the effect of health resources' availability on the performance of maternal and child health policy implementation in NTT. A quantitative research method for data collection was carried out in 11 districts in NTT and 104 public health centers (*pusat kesehatan masyarakat*, *puskesmas*) towards 235 health workers from August to December 2019. The results show that the health workers were categorized as insufficient/not available (mean value of 2.64), and puskesmas did not have doctors, midwives, and nurses conforming to standards. There was also inadequacy in some aspects such as budget (average value of 2.45), medical devices (average value of 2.75), medicines and medical supplies, buildings, and transport. A correlation was found between resources and the performance of maternal and child health policies ($p=0.00$) with a coefficient correlation of 0.546. It indicates a strong and positive correlation, which means that if there is an increase in resources, maternal and child health policy implementation will also. Partial linear regression tests showed $t_{\text{arithmetik}}=13.304 > t_{\text{table}} 1.97$, which means that H_0 was rejected. It suggests a significant effect between resources and the performance of maternal and child health policy implementation in NTT. In conclusion, resources had a positively impact on the performance of maternal and child health policy in NTT.

Keywords: Implementation, maternal and child health, performance, policies, resources

Pengaruh Ketersediaan Sumber Daya Kesehatan terhadap Kinerja Implementasi Kebijakan Kesehatan Ibu dan Anak di Nusa Tenggara Timur

Abstrak

Permasalahan kesehatan ibu dan anak (KIA) terus menjadi prioritas masalah kesehatan di Indonesia khususnya di Nusa Tenggara Timur (NTT). Angka kematian ibu di NTT mencapai 159/100.000 kelahiran hidup (KH), sedangkan angka kematian bayi dan balita mencapai 32/1.000 KH dan 40/1.000 KH yang masing-masing di atas nilai nasional, yaitu 23/1.000 KH dan 32/1.000 KH. Kondisi tersebut mengindikasikan bahwa penerapan kebijakan KIA di NTT belum dilaksanakan secara maksimal. Salah satu penyebabnya adalah sumber daya manusia kesehatan yang memberikan pelayanan kesehatan kurang tersedia. Tujuan penelitian adalah mengidentifikasi pengaruh ketersediaan sumber daya manusia kesehatan terhadap kinerja penerapan kebijakan KIA di NTT. Metode penelitian adalah kuantitatif. Pengumpulan data dilakukan di 11 kabupaten dan 104 pusat kesehatan masyarakat (*puskesmas*) pada 235 tenaga kesehatan dari bulan Agustus hingga Desember 2019. Hasil penelitian menunjukkan bahwa tenaga kesehatan dikategorikan tidak cukup/tidak tersedia (nilai rerata 2,64) dan puskesmas tidak memiliki dokter, bidan, dan perawat sesuai standar. Selain itu, terdapat juga kekurangan di beberapa aspek seperti anggaran biaya (nilai rerata 2,45), alat kesehatan (nilai rerata 2,75), obat dan perbekalan kesehatan, alat medis, bangunan, serta alat transportasi. Korelasi ditemukan antara sumber daya dan kinerja penerapan kebijakan KIA ($p=0,00$) dengan koefisien korelasi 0,546. Hal ini berarti korelasi cukup kuat dan positif, artinya jika sumber daya ditingkatkan maka kinerja implementasi kebijakan KIA juga meningkat. Uji regresi linier parsial menunjukkan $t_{\text{hitung}}=13,304 > t_{\text{tabel}} 1,97$ yang bermakna H_0 ditolak. Hal ini menunjukkan pengaruh yang signifikan antara sumber daya dan kinerja penerapan kebijakan KIA di Provinsi NTT. Simpulan, sumber daya berpengaruh positif terhadap kinerja penerapan kebijakan KIA di NTT.

Kata kunci: Implementasi, kebijakan, kesehatan ibu dan anak, kinerja, sumber daya

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Introduction

Maternal and child health (MCH) is still a significant health problem in Indonesia, particularly in East Nusa Tenggara (NTT). Based on data, deliveries at health facilities were up to 86.9%, and those assisted by health workers were 86.63%. The maternal mortality rate (MMR) was 179/100,000 live births in 2013, 159/100,000 live births in 2014, and 102/100,000 live births in 2015.¹⁻³ The national target in Indonesia is 153/100,000 live births. Meanwhile, the infant and under-five mortality rates were 32/1,000 live births in 2013 and 40/1,000 live births in 2014, with the national target of 23/1,000 live births and 32/1,000 live births, respectively. It shows the failure to implement maternal and child health policies in NTT that directly impacted the human development index in NTT. NTT ranked the 32nd out of 34 provinces, ranging from 68.77.^{1,2,4}

In 2012, the local government targeted 80% of deliveries to be carried out in health facilities, but surprisingly the figures slightly exceeded 81%. On the contrary, in 2013, only 86% of deliveries were successfully met out of 90% of the target. The targeted number of deliveries assisted by health workers in 2012 was 94%, but only 81% were reached. While in 2013, only 86% were reached out of 96% of the target. The achievement indicators of maternal and child health as opposed to national targets refers to the percentage of fourth antenatal care visit (K4) coverage (61.78% vs 85.63%), obstetric complication management (46.5% vs 73.3%), low birth weight babies (15.5% vs 10.01%), neonatal treatment outcomes (15.34% vs 41.47%), first neonatal visit outcomes (75.51% vs 92.33%), infants service coverage (69.38% vs 87.77%), complete basic immunisation coverage in infants (69.9% vs 89.86%), and prevalence of undernutrition children (33% vs 19.6%).⁴⁻⁶

The failure in implementing the maternal and child health policies in NTT is allegedly due to the limited health resources available.⁵⁻⁷ They also point out six obstacles and stimulants of the program implementation from Van Metter and Van Horn: policy measurement and objectives,^{8,9} resources, characters of the implementing agency, attitudes/tendency of implementers,^{9,10} communication between organizations and implementation activities, and economic, social, and political environment.^{11,12}

Ngambut and Sila¹³ reported that in Renda

village, Satar Mesa district, Manggarai regency, NTT, many women have their deliveries attended by a traditional birth attendant (*dukun*) and delivering at home. Health workers and the community have not appropriately utilized the village maternity hut (*polindes*). Gae Dopo¹⁴ concludes that there has been a significant increase in numbers since the mother and child health revolution program. However, this number has not been sufficient for fulfilling the needs of health workers in Soa subdistrict, Ngada regency, NTT.

This study aims to determinant the effect of the availability of resources on the performance of maternal and child health policy implementation in NTT. This study's results are expected to provide recommendations to the government in improving maternal and child health policy programs to decrease the mortality rate of mothers and children in the future.

Methods

This research used quantitative methods, and it needed six months to collect the data from August to December 2019. The research was carried out in 12 regencies, specifically in 104 public health centers (*puskesmas*) throughout NTT. This study's target population was all actors implementing maternal and child health policies at the *puskesmas* level. The total number of the target population was 3,372 people, and the population reached (i.e., implementing maternal and child health services) was 2,233 people.

The sampling technique used was the multistage random sampling technique, and the number of samples obtained was 235 people. The dependent variable is maternal and child health policy implementation in NTT and the independent variable is health resources. Health resources are the availability of power resources to implement policies that cover human and non-human resources, including financial resources. Performance of policy implementation is the on-target result or impact of policies. Data collection was carried out using a questionnaire that employed the first validity, and the reliability test was performed on 20 respondents. The test results show that the instrument was valid and reliable because most items had an average calculation value of $r_{table} = 0.43166$, which was smaller than $r_{arithmetic}$.

Regarding measurement, this study used

a Likert scale and ordinal scale. Moreover, a univariate analysis was carried out to determine the distribution of data descriptively, followed by a bivariate analysis to see the relationship between the independent variable and the dependent variable using a simple linear regression tool. The study has obtained research ethics permit from the Health Research Ethics Committee of the Politeknik Kesehatan Kemenkes Kupang with the registration number LB.02.03/1/0070/2019. All respondents were asked for their consent before data collection.

Results

The research was conducted in 12 regencies in NTT province. The results of the study were analyzed in a number of stages starting from univariate, bivariate, and multivariate analyses towards all variables. The characteristics of the samples are depicted in Table 1, with the largest number of samples coming from Kupang regency and North Central Timor.

The health variables include the availability of human resources, budget, and health service tools/facilities. The availability of personnel in quantity, quality, and distribution is focused on doctors, midwives, and nurses. In contrast, budget resources' availability is concentrated on maternal and child health services at the *puskesmas* level. This budget comprises adequacy funds from the provincial budget, regional budget, national budget, public funds, referral costs, and procurement budget for facilities, infrastructure, and medicines. In comparison, the availability of equipment/facility resources includes decent infrastructure, medical devices, medicines, transportation, maternity waiting homes, and equipment following maternal and child health service standards. The results of the average assessment of resource indicators in implementing the maternal and child health policy in 2017 in NTT are shown in Table 2.

Table 2 shows that the availability of human resources in implementing maternal and child health policy in NTT is in the category of insufficient/not available (average value of 2.64). The budget availability is also seen as inadequate for policy implementation (average 2.45), which means that the government's budget has not been sufficient for policy implementation. The availability of health equipment is also categorized as inadequate with an average value

of 2.75. Overall, the resource variable is in the category of inadequate standing at an average value of 2.61.

The performance of maternal and child health policy implementation is the extent to which policy targets' achievement is following the policy standards. This study uses a statement that shows the implementation of activities that describe the specified achievement. The calculation of the average value of performance achievement indicators in implementing MCH policy in NTT province in 2019 is shown in Table 3.

Table 3 elaborates the average value of maternal and child health policy implementation in NTT with 3.36. It means that maternal and child health service targets have been created but not maximally implemented yet. Overall, the score for all question items is less than 4.0, and the lowest score is in questions related to the patient referral fees charged to the local government and blood donor fees. The highest value on maternal and child health services was antenatal check-up services at least four times during pregnancy.

According to the method of Van Meter and Van Horn, the availability of resources precedes attitudes.^{9,10} It refers to the availability of human resources that will influence the implementers' attitudes and subsequently affect the performance of the policy implementation. The resource shown in Table 4 is based on the performance of the MCH policy in NTT.

Table 4 shows the conformity between resources and the performance of policy implementation. It also suggests that the category of available human resources is not sufficient to

Table 1 Characteristics of Samples

No.	Regency	n=235	%
1	Manggarai	22	9.36
2	East Manggarai	24	10.21
3	Sikka	25	10.64
4	East Flores	21	8.94
5	Lembata	10	4.26
6	Alor	26	11.06
7	North Central Timor	27	11.49
8	Kupang regency	27	11.49
9	Rote Ndao	13	5.53
10	Sabu Raijua	6	2.55
11	West Sumba	10	4.26
12	East Sumba	24	10.21

Table 2 Average Indicator Value of Resources in Maternal and Child Health Policy Implementation in NTT in 2017

Availability of Resources in Maternal and Child Health Policy Implementation in NTT	Average Value
Availability of human resources	2.64
Health workers (doctors, midwives, nurses).	2.83
Supporting health workers.	2.83
Administration staff.	2.25
Doctors, midwives, and nurses who have been trained according to maternal and child health needs.	2.69
Human resources residing in maternal and child health policy.	2.62
Availability of budget	2.45
Adequate costs and budget.	2.7
Incentives for the policy implementers.	2.4
Community funds.	1.8
Costs and budget from the district government (APBD II).	2.6
Costs and budget from the provincial government (APBD I).	2.3
Referral costs.	2.7
Funds for facility, infrastructure and medical devices.	2.7
Availability of tools	2.75
Medical devices according to the policy standards.	2.8
Buildings and rooms according to the policy standards.	2.7
Facilities (buildings, delivery rooms, treatment rooms) according to the policy standards.	2.7
Medicines and supplies according to the standards	2.8
Transport for the policy implementation.	2.8
Maternity waiting homes for pregnant women and their families.	2.6
Office stationery and formats.	3.0
Variable average value	2.61

indicate implementation performance. On the contrary, the category of sufficiently available human resources shows good performance of the implementation. It means that the policy's good performance is following human resources availability, whereas poor policy performance corresponds with the insufficiency of human resources.

For a further review, a statistical analysis of the relationship between human resources availability and the performance of maternal and child policy implementation can be seen in Table 5.

Table 5 shows the correlation between health resource variables and the performance of maternal and child health policy implementation ($p=0.00$). The correlation is quite strong, with the correlation coefficient standing at 0.546. This means that if the resources increase or are added, the policy implementation's performance

will improve too. A partial linear regression test (t test) was performed to assess resource variables' effect on policy performance. It is then found that $t \text{ count}=13.304 > t \text{ table } 1.97$, which means that H_0 was rejected. It can also refer to a significant effect of resources on maternal and child policy implementation in NTT.

Discussion

Data analysis results show that the availability of human resources in implementing maternal and child health policies in NTT province is not sufficient/not available (value 2.64). The available doctors, midwives, and nurses are not according to public health service centers' standards. Costs and budget are also insufficient (value 2.45), and medical tools such as medicines, medical devices, buildings, and health facilities are categorized inadequate (value 2.75). Resources, including

Table 3 Performance Scores for Implementing Maternal and Child Health Service Policies

Indicators	Average Value
Health services for pregnant women, childbirth, postpartum, and infants aged 0–28 days born normal or with complications.	3.8
<i>Puskesmas</i> provide antenatal services at least 4 times.	4.0
Antenatal care is attended by trained obstetric and neonatal emergency staff.	3.7
Maternity assistance is attended by midwives, general practitioners, obstetricians.	3.8
<i>Puskesmas</i> prioritise infection prevention, delivery assistance according to standards, giving referrals, encouraging early initiation of breastfeeding, preventing complications.	3.8
Postpartum care at least 3 times: (KF-1) 6 hours after delivery up to 3 days; (KF-2) day 8 to day 14 after delivery; (KF-3) day 36 to day 42 after delivery.	3.8
Neonatal services at least 3 times (KN-1), (KN-2), (KN-3).	3.8
Obstetric and complication services for pregnant women, delivery rooms and childbirth.	3.8
Availability of tools and medicines, manuals and managerial guidance, delivery rooms, at least 2 beds, clean water, bathroom/toilet.	3.3
Sources of funds for delivery assistance services and handling complications, and referrals from the government.	3.5
All labour costs are borne by the government or local government.	3.4
Availability of maternity waiting homes for pregnant women with complications of pregnancy and childbirth.	3.0
The transport cost of blood donors is borne by the government.	2.9
All referral costs for pregnant women and childbirth are borne by the government.	3.3
Pregnant women with complications stay at maternity waiting homes for 2 weeks before giving birth and 1 week postpartum.	3.0
Average value	3.36

human resources, financial resources, and equipment resources, play an essential role in policy implementation.¹⁵ Human resources are a variable that determines the success or failure of policy implementation.¹⁶

Human resources, including doctors, midwives, and nurses, are the primary providers

of health services.¹⁷ Data collection results show that most of the public health centers for health workers did not meet the standards. According to standards, the availability of health workers was found in 371 health centers throughout NTT with 40.70% of doctors according to national standards, 54.72% of midwives, and 58.76% of

Table 4 Resources based on Performance of Policy Implementation

Health Resources	Performance of Policy Implementation				Total
	Poor	Fair	Good	Very Good	
Not available	4	1	2	0	7
Fair	15	61	22	0	98
Sufficiently available	3	30	61	6	100
Available as needed	0	3	20	7	30
Total	22	95	105	13	235

Table 5 Relationship between Resources and Performance of Policy Implementation

			Performance of Policy Implementation	Health Resources
Spearman rho	Performance of Policy Implementation	Correlation coefficient Sig (2-tailed)	1.000	0.546**
		n	235	235
	Health Resources	Correlation coefficient Sig (2-tailed)	0.546**	1.000
		n	235	235

Note: **significant correlation at level 0.01 (2-tailed)

nurses. According to *puskesmas* data in 2016, 41.78% of *puskesmas* did not have doctors, 18.33% did not have nurses according to standards, and 25.07% did not have midwives according to standards. As much as 72.51% of *puskesmas* did not have five supporting health workers such as pharmacy, public health, sanitation, nutrition, and medical analysts.

Pujowati⁸ concludes that actors involved in the implementation of cross-sectoral health services perform their roles in different ways. Some efforts to raise public awareness to create healthy life behaviors are challenging because socioeconomic factors do not adequately support them. Indeed, the contributing factor to the implementation of this policy is the imposing of regulations as legal protection.

Paruntu et al.,¹⁸ point out that human health resources in the health department and *puskesmas* are not based on the same perception of methods or measuring instruments. The problems seem to lack communication and coordination. Apart from the fact that there is no scheduled planning for human health resources, monthly or yearly health worker maintenance, and career development for health workers.

Health human resources are currently inadequate due to the low ratio of health workers compared to the population. Some efforts have been attempted to meet the health needs of human resources by placing health workers throughout Indonesia. However, it is still seen insufficient in terms of types and quality of health workers able to achieve the highest health status following the legal mandate. The low level of human resources is one of the weaknesses in the implementation of maternal and child health policies. Permatasari et al.,¹⁹ point out that

despite the fulfillment of decent facilities and the regulation of fund resources in budget planning and budgeting, human resources are still seen as inadequate. Meanwhile, the inhibiting factor in the implementation of PONEK is the lack of human resources, and some PONEK team members have not performed their duties based on their primary tasks and functions.

The insufficiency of cost and budget resources (value 2.45) illustrates that the government has not prepared the budget optimally, even though Indonesia's health financing comes from the government and the community. According to Adisasmito,²⁰ budget allocations and expenditures originating from the Indonesian government always receive a meager portion, with the national average not reaching 5% of the total government budget. It shows that the health sector is not fundamentally prioritized. Substantively, health development is an investment in improving human resources quality that plays an essential role in increasing economic growth and reducing poverty and unemployment.

Human resources' quality is closely related to skills, dedication, professionalism, and competence in the fields. At the same time, the quantity is associated with the number of human resources, despite not having reached all the targeted groups in implementing policies. Indeed, budgetary resources are needed to ensure that the implementation of public policies can be run effectively in achieving standards and objectives. Also, the availability of decent facilities and infrastructures like buildings, land, office equipment, and other supporting facilities affect the program's success.

This study's findings indicate that the performance of the maternal and child health

policy implementation in NTT was in category 3.36, which implies that although there are still many targets that have not been achieved, the current results of the implementation are rated good.

The performance of public policy implementation evaluates policy efficiency by comparing the inputs and outputs. At the same time, the effectiveness of policies can be seen from the outputs and impacted outcomes. According to Anderson,²¹ the dimensions of impact in the state policy are: (1) the expected and unexpected impacts of policies on society; (2) waste of policy for situations or people who are not the main target of the policy; (3) the impact of the policy can occur in the present or future conditions; (4) the impact of the policy affects the direct and indirect costs experienced by community members.

Most of all, health service output indicators have increased, but unfortunately, they are still below the national target. In comparison to national figures, the achievement of health service output indicators is still meager. Therefore, it is necessary to optimize the role of various society components and intensify cooperation among related sectors.²²

The policy implementation's success depends on using available resources, particularly human resources, as the most critical asset. Each stage of implementation requires a higher quality of human resources.^{23,24} Even though the policy is delivered accurately, clearly, and consistently, the implementation will not be effective if the implementer lacks resources.²⁵

The ability and competence of the implementers are immensely needed to ensure public policy implementation improvement.^{17,26} Management of human resources is seen as one primary strategy that aims to increase the workers' productivity and contribution to organizational goals.²⁷ Since human resources are the aspect of determining policy implementation's effectiveness, they must possess the skills and capability needed to carry out their duties and functions.^{23,28}

Anggraeni and Muazaroh in Kusbandiyah,²⁷ in line with Van Meter and Van Horn theory, stated a relationship between resources and policy implementation. The availability of sustainable resources such as human resources, funds, facilities, and infrastructure will generate positive results and successful policies. Adequate resources that are not accompanied by a positive

attitude from the organizers will result in suboptimal implementation.^{27,29} For example, providing maternal and child health services requires qualified human health resources.^{22,30} In fact, to date, the number of health workers has not been sufficient because the ratio of health workers to the total population is still low.^{24,31}

Conclusions

The availability of health resources (human resources, financial resources, and health equipment/medical devices) in implementing maternal and child health policies in NTT is categorized as inadequate. Performance of maternal and child health policy implementation is satisfying, although some service targets have not been implemented maximally. Human resources have a significant and positive effect on maternal and child health policy implementation in NTT.

Conflict of Interest

There was no conflict of interest or, in other words, this research was conducted without commercial or financial relations, which could be interpreted as a potential conflict of interest.

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