FINAL REPORT

ROAD MAP FOR REDUCING MATERNAL MORTALITY

IN SEMARANG CITY

REGIONAL DEVELOPMENT PLANNING AGENCY OF SEMARANG CITY 2018

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CHAPTER I
INTRODUCTION

A. Situation Analysis

On global commitment through *the Sustainability Developments Goals* (SDGs), maternal mortality is the third goal, namely health improved. For this purpose, the target to be achieved is Guarantee healthy lives and promote well-being for everyone in all ages, with targets related to maternal and infant mortality, namely reducing the maternal mortality rate is below 70 per 100,000 live births and ending infant/neonatal deaths of up to 12 per 1000 live births as well ending the under-five mortality rate 25 per 1000 live births.

Health development in the 2015-2019 period is a program Healthy Indonesia with the target of increasing health status and nutritional status community through health efforts and community empowerment supported by financial protection and equal distribution of health services. The main targets of the 2015-2019 RPJMN are: (1) improving health status and maternal and child nutrition; (2) increased disease control; (3) increasing access and quality of basic and referral health services especially in remote, underdeveloped and border areas; (4) increasing universal health service coverage through the Healthy Indonesia Card and quality of SJSN Health management, (5) meeting personnel needs health, medicine and vaccines; and (6) increasing system responsiveness health.

Maternal and child health is a priority in developmentHealth in Indonesia is caused by the Maternal Mortality Rate (MMR) in Indonesia ranks highest in ASEAN, namely 359 per 100,000 births lives, in other words more than 18,000 mothers every year or two mothers every hour died of cause related to pregnancy, childbirth, and postpartum (BPS, BKKBN, Ministry of Health-MOH, & International, 2013). Death Rate Mothers in Indonesia when compared with the *Sustainability Developments* target *Goals* (SDGs), are still far from expectations of 70 per 100,000 births life. Improving the level of public health is a responsibility together for both the Government and Society. Good and bad indicators The degree of public health can be seen by increasing age expectancy community life which is calculated based on population death regression.The death of the population is caused by accidental death, death illness and death in childbirth.

The maternal mortality rate in Central Java Province shows a significant decrease from 2015, 2016 and 2017 amounting to 111.16 per 100,000 KH in 2015, 109.65 per 100,000 KH in 2016 and 88.58 per 100,000 KH in 2017. Meanwhile, the development The Infant Mortality Rate also showed a decline, namely 10 per 1000 KH in 2015, 9.99 per 1000 KH in 2016 and 8.93 per 1000 KH in 2017. Commitment to efforts to reduce maternal and infant mortality rates in Central Java Province is also supported through the Provincial Governor program Central Java is the Central Java Program for Pregnant Women (5NG) Save Mother and Child.

Overview of infant mortality in Semarang City in 2017 as many as 197 cases, which is a decrease from 2016 of 201 cases and still occupies the sixth highest position in infant mortality in Java Province Middle. The number of cases of under-five deaths in Semarang City in 2017 was recorded amounting to 228 cases. This figure has also decreased in comparison in 2016 there were 232 cases. The hope is that the city of Semarang will be in 10th place at the Central Java Province level in 2022.

An overview of the number of maternal deaths in the city of Semarang there were 23 cases of maternal death in 2017. This number is decreasing from the previous year there were 32 cases of maternal death in 2016 and 35 cases of maternal death in 2015. Efforts to reduce death cases Mothers in Semarang City are also strongly supported by the issuance of the Regulation Semarang City Region Number 2 of 2015 concerning Maternal Safety Children through the concept of *a Continuum Of Care* approach where safety mothers start with care and services before pregnancy begins from newborns, toddlers, school age children, teenagers, adult up to old age. This is in line with the Governor's policy Central Java through the Jateng Gayeng Nginceng Program for Pregnant Women (5 NG) Save Mother and Child starting from the pre-pregnancy phase, phase pregnancy, labor phase up to the postpartum phase.

The highest cause of maternal death in 2017 was in Semarang City namely eclampsia, bleeding and disease. Semarang city occupied ranked 3rd (three) in Central Java Province. Meanwhile, the cause is not Maternal death is directly caused by a lack of information about social issues economy/poverty, education, women's role position, social culture and transportation affected in 3 Too Late and 4 Too: Too Late recognize danger signs/risks and make decisions, too late to reach a health service facility, it is too late to get help health services. And 4 is too young to have children (age< 20 years), too many births (> 3 children), too close together birth (< 2 years), and too old (> 35 years). Based on the results of the study, the maternal mortality rate in Semarang City In 2017, it was discovered that the highest presentation of maternal death cases occurred at ages 20-35 year 66.7%. Next, looking at the level of education, percentage

The highest cases of maternal death occur in mothers with higher levels of education middle, namely 51.4%. The mother's low level of education can increases the risk of maternal death. Proportion of maternal deaths The highest occurred in mothers with less than 3 children, namely 85.71%. The number of parities or the number of children more than 3 is a high risk complications in pregnancy, childbirth and postpartum women. Meanwhile, disease presentation suffered before pregnancy and during pregnancy, namely hypertension. The highest proportion of maternal deaths occurs in mothers with a history of abortion 80%. The highest proportion of maternal deaths also occurs in mothers with complications in previous births, namely bleeding before gave birth to 8.57%.Apart from that, the results of a study regarding the maternal mortality rate in Semarang City 2017 regarding *Ante Natal Care* services also shows the proportion The average incidence of maternal death occurs in mothers with a history of number antenatal care visits 5.9 times (6 times). This amount corresponds to The minimum number of visits during pregnancy is 4 times. Proportion of events The highest maternal mortality occurred in mothers with a history of antenatal visits care at specialist obstetrician clinics is 48%. Proportion of eventsThe highest maternal mortality occurs in mothers at high risk of experiencing systolic blood pressure more than 140 mmHg and diastole more than 90 mmHg during pregnancy. The highest incidence of maternal death occurs in mothers with complications of preeclampsia or eclampsia during pregnancy, namely by 40%. The highest proportion of maternal deaths occurred in death after giving birth with 28 incidents at the hospital, 2 incidents at home, and 1 incident on the trip. The research results also show that most midwives who practice independent midwifery have not carried out activities The quality of Ante Natal Care 10 T's services in full is still great things that midwives should do but have not done, such as measuring TB, providing health education/providing information health, measuring lila, and carrying out recording and reporting in books KIA.

The results of other studies also show that the proportion of incidents The highest maternal deaths occur with specialist birth attendants content is 80%. Based on a visit to the hospital, the patient arrived in hospital in serious condition, the patient was referred without stabilization, and referral delay. However, things that need attention are: there are still cases of death with untrained shaman assistants 2.86%, because in Semarang City mothers should carry out antenatal care care, delivery and postpartum care in health facilities. This too supported by a preliminary study conducted on one of the cadres

in the Semarang City sub-district area regarding cases of maternal death stated that in his area there were several cases of mothers not giving birth in a health care facility but gave birth alone at home, however when further confirmed the cause was due to a KTD incident (Unwanted Pregnancy) in mothers who are still of school age ultimately leading to the death of the newborn baby. Number of maternal deaths during the postpartum period in Semarang City in 2018, 2017, most occurred during the postpartum period from 3 days to 28 days with The causes of death during the postpartum period are pre-eclampsia and eclampsia by 38%, bleeding 19% and heart disease 19%. Death event The highest rate for mothers occurs in the history of postpartum visits with a doctor's help obstetrics specialist, namely 42.86%. Postpartum examination services have been provided according to service standards by checking the perineal sutures on normal delivery, blood pressure check, fundal height check uterus, vital signs examination, post caesarean section wound examination in surgical delivery to other supporting examinations. Based on the data, it is known that the number of cases of maternal death in Semarang City is based on the area with the most cases the period January to June 2018, namely in the District Pedurungan (4 cases), Gayamsari District (2 cases) and District Tembalang (1 case). The number of cases of maternal death for the period July to In August there were 3 cases of maternal death, one of which was a case Maternal death occurred in the postpartum phase on the 17th day and 2 cases of maternal death occurred outside the administrative area of Semarang but was recorded as deaths in the city of Semarang due to adjustments to KTP ownership registered as a resident of Semarang City.

Meanwhile, the highest cases of infant mortality were at perinatal age at 71%, The most common cause of infant death is due to the weight of the baby Low birth weight (LBW), asphyxia and congenital abnormalities. Based on place of birth, most cases of infant death are in hospitals with birth attendant specialist in obstetrics and gynecology. Case Infant deaths occur mostly in mothers with educational characteristics middle or high school. Then the case of infant death was related to the action stabilization before referral as many as 67% said they did not know, 21% stated that stabilization was not carried out and 12% stated that it was carried out stabilization. Regarding health service facilities, the research results state that the number of community health centers that can provide PONED services is as large as 6 community health centers spread throughout the Semarang City area (Puskesmas Ngesrep, Halmahera Health Center, Bangetayu Health Center, Mijen Health Center, Mangkang Community Health Center and Gunungpati Community Health Center) and 7 hospitals

PONEK (Dr. Karyadi Hospital, Telogorejo Hospital, Elisabeth Hospital, Sultan Hospital Agung, KRMT Wongsonegoro Hospital, Tugurejo Hospital and Panti Wilasa Hospital Citarum). In the Obstetric and Emergency Referral Service Flow Neonatal, PONED Health Center is able to provide direct services against pregnant women, mothers in labor and postpartum mothers with certain complications according to the level of authority and ability or performance referral to PONEK Hospital. Meanwhile, non-PONED Community

Health Centers must be capable carry out stabilization of patients with obstetric and neonatal emergencies before making a referral.

Other research on MMR studies in Semarang City shows that almost all hospitals already provide these facilities Main for examination of pregnancy, childbirth and newborns. The existence of supporting facilities for pregnancy and childbirth services in The hospitals are all filled. But there is one facility support that is still weak is the existence of a blood donor list and also list of blood availability at PMI. The existence of this blood donor list is very important important if a birth or postpartum emergency occurs labor. So for hospitals that do not have unit facilities blood transfusion / Blood banks are recommended to collaborate with provider of these facilities.

Apart from that, an overview of cases of toddler deaths in Semarang City occupies the 5th highest position in Central Java Province with 228 cases in 2017. Nutritional problems among toddlers in Semarang City too related to malnutrition (BB/TB) as many as 12 cases.

Based on the description of maternal and infant death cases above Several maternal characteristics were found to be at risk, including maternal death and babies occur in mothers with junior high school education and high school education, which indicates that they are still in school age and adolescence. By Therefore, the approach to maternal and child health services is through approach *Continuum of Care* is also related to health services at age schools and teenagers. This is also in accordance with the preparation phase beforehand pregnant in the 5 NG program of the Governor of Central Java Province. Service health in school-aged children related to BIAS (Children's Immunization Month Schools) and health screening including nutrition case assessments clinical signs of anemia and vital signs of blood pressure as a form of effort preventing the occurrence of anemia and comorbidities when pregnancy period. TT immunization coverage in the Semarang City BIAS program in 2016 it was 98.3% with a target of 98% considered to have achieved the target.

Meanwhile, regarding health services in the productive age group aged 15-59 years through health screening according to standards incl services for teenagers, women of childbearing age and couples of childbearing age. Improving nutrition for teenagers and prospective brides and grooms as well as health education reproduction is also one of the programs provided in the period or the phase before pregnancy. *The continuum of care* approach is a start-up approach upstream to downstream with complete services in one life cycle humans including old age. In this study it will also be Analyze various problems in old age because they are related to degenerative diseases.

Efforts that have been carried out by the City of Semarang so far order to reduce maternal mortality rates and infant mortality rates including, through the Joint SANPIISAN (Healthy Mother and Child Movement) is an innovation program for the City of Semarang through strategy efforts to reduce MMR in Semarang City, namely:

1. Health Service at Community Level (UHC program, utilization jampersal, Great Ambulance, Ambulance Standby, Mother's Assistance Pregnant and Postpartum Mothers by Health Worker Pregnant Women via PKK) Optimization of mentoring
2. Health Service with Professional Organizations (in collaboration with IBI through Independent Practice Midwife meetings and giving punishment to BPM who carry out services that do not meet standards competence as well as cooperation with POGI in providing training for obstetrician specialist doctors.)
3. Health Service with Community Health Center (Health Service carries out facilitative supervision, coaching of the PONED Community Health Center by the PONEK Hospital

which is carried out every 3 months starting from 2014 and coaching to the coordinating midwife)

4. Health Service and Hospital (MOU/mutual agreement with 18 RSU and RSB Directors in 2012 in decline maternal mortality rate, MOU of PONEK Hospital, clinical assessment of PONEK Hospital by EMAS and hospital construction).

Health and safety of mothers, newborns and toddlers is one of the main factors for family life, because of the degree and family health status measured by maternal mortality, infant mortality, morbidity and nutritional status of the family. It must be recognized that pregnant women and babies Newborns are among the groups most vulnerable to death, considering his very weak condition both physically, mentally, socially and psychological. Every process of pregnancy and childbirth will cause big health risk, including for women/mothers who don't have previous health problems. Formulation of the problem raised in this study is formulating selected intervention programs in maternal and child health efforts through a *Continuum of Care* approach in Semarang City.

B. Legal Basis

Legal basis for preparing the Death Rate Reduction Roadmap Plan The capital city of Semarang is as follows:

1. Law Number 29 of 2004 concerning Medical Practice (State Gazette of the Republic of Indonesia 2004 Number 116, Supplement State Gazette of the Republic of Indonesia Number 4431);

2. Law Number 36 of 2009 concerning Health (Sheet

3. Republic of Indonesia Year 2009 Number 144, Supplement State Gazette of the Republic of Indonesia Number 5063);
4. Law Number 23 of 2014 concerning Regional Government
5. (State Gazette of the Republic of Indonesia 2014 Number 244, Supplement State Gazette of the Republic of Indonesia Number 5587);
6. Law Number 9 of 2015 concerning the Second Amendment Law Number 23 of 2014 concerning Regional Government (State Gazette of the Republic of Indonesia 2015 Number 58)
7. Government Regulation Number 18 of 2016 concerning Regional Apparatus (State Gazette of the Republic of Indonesia 2016 Number 114, Supplement State Gazette of the Republic of Indonesia Number 5887);
8. Presidential Regulation of the Republic of Indonesia Number 72 of 2012 concerning National Health System (State Gazette of the Republic of Indonesia
9. 2012 Number 193);

10. Presidential Regulation of the Republic of Indonesia Number 153 of 2014 *Grand* Population Development *Design* (State Gazette of the Republic Indonesia 2014 Number 310)

11. Presidential Regulation of the Republic of Indonesia Number 59 of 2017 concerning Implementation of the Achievement of Sustainable Development Goals (Sheet Republic of Indonesia Year 2017 Number 136);

12. Regulation of the Minister of Health of the Republic of Indonesia Number 39 of 2016 Regarding Guidelines for Implementing the Healthy Indonesia Program with Family Approach (State Gazette of the Republic of Indonesia 2016 Number 1223)

13. Regulation of the Minister of Health of the Republic of Indonesia Number 43 of 2016 Concerning Minimum Service Standards for the Health Sector (State Gazette Republic of Indonesia Year 2016 Number 1475)

14. Semarang City Regional Regulation Number 2 of 2015 concerning Safety of Mothers and Children (Semarang City Regional Gazette Year 2015 Number 2, Supplement to Semarang City Regional Gazette Number 97).

C. Aims and Objectives

1. **Purpose of Preparing a Road Map for Reducing Maternal Mortality Rates** Compiling a Road Map for Reducing Mortality Rates in the Capital City of Semarang to serve as a guide for steps to implement commitments Regional Government in order to achieve quality improvement goals population health sector through reducing maternal mortality rates improving maternal and child health by analyzing blockages strategy for each intervention program in the target group (pregnant women, mothers maternity, postpartum mothers, newborns, toddlers, school age children, ages productive and elderly).

2. **Purpose of Preparing a Road Map for Reducing Maternal Mortality Rates**

   a. Identify bottlenecks in coverage, quality of service as well recording reporting on maternal health programs during the pregnancy phase.
   b. Identify bottlenecks in coverage, service quality, recording reporting and managing referrals effectively maternal health program during the maternity phase
   c. Identify bottlenecks in coverage, service quality and recording and monitoring maternal health programs in the postpartum phase.
   d. Analyze the coverage, quality of service and handling newborn complications.
   e. Analyze the coverage and quality of health services for children under five.
   f. Analyze the coverage and quality of health services for children elementary school age.
   g. Identify bottlenecks in service coverage and qualityhealth at productive age through appropriate health screening with standards in the pre-pregnancy phase.
   h. Analyze the coverage and quality of health services at age continue through health screening according to standards.
   i. Identifying the need for maternal and child health programs through a *continuum of care approach.*

BAB II

LITERATURE REVIEW AND METHODOLOGY FOR PREPARING A ROAD MAP

A. Semarang City SANPIISAN (Healthy Mother and Child Movement) Program

The SANPIISAN (Healthy Mothers and Children Movement) program together with Health Worker became Semarang City innovation program through the 4 Friends strategy in an effort The decline in MMR in Semarang City is:

1. Health Service at Community Level (UHC program, utilization jampersal, Great Ambulance Ambulance Standby, Assistance for Pregnant Women and Postpartum Mothers by Health Worker via PKK). Optimizing assistance to pregnant women
2. Health Service with Professional Organizations (in collaboration with IBI through Independent Practice Midwife meeting and giving punishment to BPM those who carry out services do not comply with competency standards as well Collaboration with POGI in providing training for specialist doctors Obgsgyn.)
3. Health Service with Community Health Center (Health Service carries out supervision Facilitative, coaching of the PONED Community Health Center by the PONEK Hospital was carried out every 3 months starting from 2014 and providing guidance to midwives coordinator)
4. Health Service and Hospital (MOU / Mutual agreement with 18 Directors of RSU and RSB in 2012 in reducing the death rate mother, MOU of PONEK Hospital, clinical assessment of PONEK Hospital by EMAS and hospital construction).The SANPIISAN program is a systematic and systematic action or step plans carried out together to reduce maternal mortality and babies and create healthy mothers and children. SANPIISAN has 5 (five) steps or 5 M namely:
   a) Collect data and report pregnant women, postpartum mothers and newborn babies in the area each of them well by Health Worker cadres and health workers.
   b) Accompanying pregnant women, postpartum mothers and newborn babies.
   c) Provide counseling to groups of pregnant women and postpartum mothers in class pregnant women, posyandu, PKK, FKK, and community meetings, as well as giving counseling for pregnant women or postpartum women who need attention special.
   d) Motivate referrals to pregnant women, postpartum mothers and newborns high risk that requires immediate action at the hospital.
   e) Self-awareness, namely pregnant women, their families and the surrounding community are able to see, understand or know the health condition of yourself and your family. One of the efforts carried out by the Semarang City Health Service is: reducing MMR and IMR through the SANPIISAN Program is the formation of Officers Health Surveillance, Legal Basis for the Establishment of Gasurkes is Law No. 36 of 2009 about health, Law No. 36 of 2014 concerning health workers, Semarang City Regional Regulation No. 2 of 2014 2015 concerning maternal and child safety. Based on the Decree of the Head of Service Semarang City Health Semarang City 2016 Number 440/6322 concerning Changes to the Decision of the Head of the Semarang City Health Service Number 440/3434 concerning the Appointment of Maternal and Health Surveillance Officers Children (KIA) Semarang City In 2016-2018, Surveillance Officers were formed Maternal and Child Health (GASURKESKIA) which focuses on

reduction efforts deaths of mothers and children in Semarang City. HEALTH WORKER is a power- Competent personnel are taken based on a strict recruitment process and quality. Before carrying out the task, HEALTH WORKER is given provision in the form of material about pregnancy, maternity, postpartum and babies as well counseling practices and classes for pregnant women by SPOG doctors and trained midwives.

B. *Continuum Of Care* Approach

In order to achieve success in reducing maternal mortality and death babies, the health development process must be based on good "evidence". especially from community elements so that development priorities are obtained appropriate, quality, equitable and sustainable health. Approac. The most appropriate method to use to achieve these goals and expectations is "life-cycle" approach or life cycle starting from babies, toddlers, ages. schools, teenagers, productive age, pregnant women and the elderly/elderly. Through This life cycle approach brings about various health programs and interventions can be managed evenly, comprehensively and sustainably.

Figure 1. Continuum Of Care Approach

The " *continuum of care* " concept approach has been emerged as a new paradigm for addressing maternal, infant and child mortality. Apart from that, the concept of continuum of care is also very important for combating maternal, infant and child mortality. The first dimension of the continuum This care is the time from before pregnancy, through pregnancy, delivery and days of years of life. The second dimension of this continuum of care is a place that connects various levels of home and community facilities and health. The continuum for maternal, infant and child health is usually referred to on the continuity of individual care. Continuity of care required throughout the life cycle (adolescence, pregnancy, childbirth, period post natal, and

childhood) and also between places of care (including household and community, outpatient and service outreach, clinical care).

The concept of *"continuum of care"* in maternal, infant, child and health services toddlers starts from the service cycle for couples of childbearing age and women of childbearing age (before pregnancy), pregnancy examination services, services childbirth (including postpartum and neonatal), services for babies, services for toddlers, services for elementary school children and services for school children Middle School / High School as well as teenagers. Efforts fulfillment of the rights to health and safety of pregnant women, newborns and children minors found in the underlying regulations are necessary adopting the "continuum of care" paradigm as one step approach to combating maternal, infant and under-five child mortality rates by paying attention to the entire life cycle in individual care.

Guidelines for implementing the Healthy Indonesia Program with an Approach Family in the Minister of Health of the Republic of Indonesia Number 39 of 2016 which consists of three main pillars, namely :

(1) implementation of a healthy paradigm,
(2) strengthening health services, and
(3) implementing national health insurance

(JKN). The application of the healthy paradigm is carried out with a mainstreaming strategy health in development, strengthening promotive and preventive efforts, as well as community empowerment. Strengthening health services is carried out by strategies for increasing access to health services, optimizing referral systems, and quality improvement using *a continuum of care* and intervention approach health risk based.

The importance of a family approach is also mandated in the Strategic Plan Ministry of Health 2015 – 2019. In the Strategic Plan it is stated that One of the references for the Ministry of Health's policy direction is implementation an integrated and sustainable health service approach *(continuum of care).* This means that health services must be provided towards all stages of the human life cycle, from an early age womb, until birth becomes a baby, grows into a toddler, aged child school, teenagers, young adults (productive age), and finally old adults or advanced age (see figure 6). To be able to provide health services which is sustainable for all stages of the human life cycle, then the focus of health services must be on the family. Provision of health services Individuals must be seen and treated as part of their family.

In order to implement the Healthy Indonesia Program, it has been agreed There are twelve main indicators to mark a health status family. The twelve main indicators are as follows:

1. The family participates in the Family Planning (KB) program
2. The mother gives birth in a health facility
3. Babies receive complete basic immunization
4. Babies get exclusive breast milk (ASI).
5. Toddlers get growth monitoring
6. Pulmonary tuberculosis sufferers receive treatment according to standards
7. Hypertension sufferers take regular medication
8. People with mental disorders receive treatment and do not abandoned
9. None of the family members smoke
10. The family is already a member of the National Health Insurance (JKN)

11. Families have access to clean water facilities

12. The family has access to or uses a healthy toilet Based on these indicators, the Family Index is calculated Health (IKS) of each family, while the condition of each indicator reflects the PHBS condition of the family concerned.

An outline description of the activities carried out in each The priority area for the Healthy Indonesia program is efforts to reduce numbers Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), intervention activities carried out following the human life cycle as follows:

a. Pregnant and Childbearing Mothers:
   1. Strive for integrated quality assurance of Ante Natal Care (ANC).
   2. Increasing the number of Birth Waiting Homes (RTK).
   3. Increasing deliveries in health facilities.
   4. Organizing Early Breastfeeding Initiation and post-family planning counseling labor.
   5. Increasing the supply and use of KIA books.

b. Babies and Breastfeeding Mothers:
   1. Strive for complete quality assurance of neonatal visits.
   2. Organizing exclusive breast milk (ASI) counseling.
   3. Organizing post-natal family planning services.
   4. Organizing activities to provide complementary foods for breast milk (MP BUT).

c. News:
   1. Carrying out revitalization of Posyandu.
   2. Strengthening the Posyandu Pokjanal institution.
   3. Increasing the transformation of KMS into KIA Books.
   4. Strengthening Posyandu cadres.
   5. Organizing Supplementary Feeding (PMT) for Toddlers.

d. School Age Children:
   1. Revitalizing the School Health Business (UKS).
   2. Strengthen the institutions of the UKS Advisory Team.
   3. Organizing the School Children's Nutrition Program (PROGAS).
   4. Developing the use of health report cards.
   5. Strengthening Community Health Center human resources.

e. Remaja:
   1. Organizing the administration of Blood Supplement Tablets (TTD).
   2. Organizing reproductive health education in secondary schools
   3. Increase the number of Community Health Centers providing services Adolescent Health Care (PKPR).
   4. Striving to delay the age of marriage

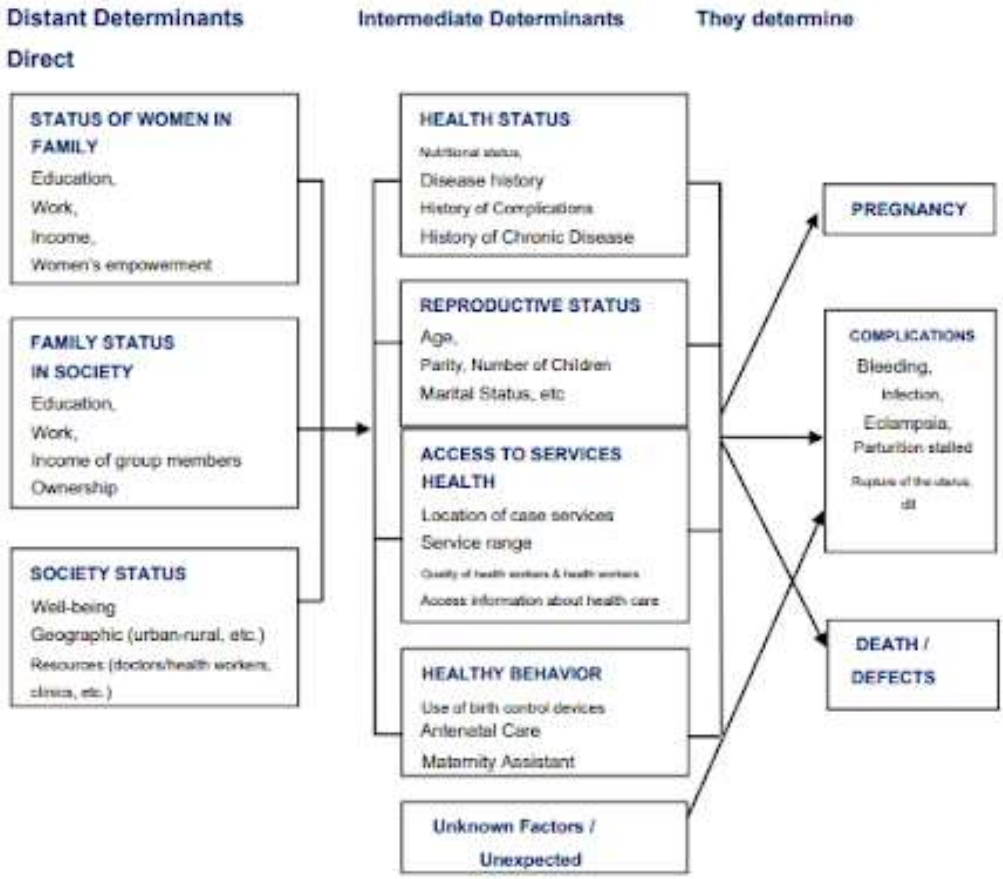
f. Young Adult:
   1. Organizing premarital counseling.

2. Organizing a movement for healthy, productive women workers (GP2SP) for working women.
3. Organizing the provision of immunizations and TTD.
4. Organizing premarital family planning counseling.
5. Organizing balanced nutrition counseling.

C. Determinants of Illness, Death of Maternity Mothers, Infants and Toddlers

In the determinant model of maternal death (Mc Carthy & Maine, 1992) explained that maternal death and disability (mortality and morbidity) caused by 3 (three) determinants, namely direct determinants *(proximate determinants),* determine antara *(intermediate determinants)* give determine far *(contextual determinants).* Including the direct determinant, namely pregnancy and pregnancy complications that can directly result in death include: bleeding, infection, eclampsia, obstructed labor, uterine rupture and etc. In othe words, the potential for death is greater for the mother with complicated (high risk) pregnancies compared to risk pregnant women low.

Based on Mc Carthy & Maine's determinant model, it is understood that Various efforts and strategies to reduce maternal mortality will not be successful if only handed over and become the responsibility of the health sector alone. Sector health is basically only capable and authorized to overcome factors direct determinants *(proximate determinants),* while for determinants intermediate and distant determinants are the responsibility and authority of the sector other related (multisector). Cross-sector roles and responsibilities and multi-sector is very crucial, so as to achieve success in reducing MMR requires very strong political commitment and support *(political will).* government, both central and regional government.



Furthermore, it is known that the pregnancy status and complications that occur influenced by several factors including intermediate determinants, namely: status and maternal health history, reproductive status, access to health services and mother's behavior in maintaining her pregnancy. However, there are complications Pregnancy can still occur despite all intermediate determinant component in good condition. Therefore, it must be acknowledged that there are other causes that are not expected. Intermediate determinants are influenced by contextual determinants, namely status women in the family, the status of the family in society and the status of that society Alone.

Based on the delay theory framework of McCharty and Maine (2002) factors that influence maternal mortality are grouped as follows :

1. Near determinant

The process that is closest to the occurrence of maternal death is pregnancy itself and complications in pregnancy, childbirth and period postpartum.

a. Pregnancy complications

Pregnancy complications are a direct cause of death maternal. Frequent pregnancy complications include bleeding, preeclampsia/eclampsia, and infections.

b. Bleeding

The causes of bleeding play an important role in causes of maternal death during pregnancy are bleeding, whether it occurs at a young gestational age / first trimester, ie bleeding due to abortion (including abortion provocateur due to unwanted pregnancy) and bleeding due to disrupted ectopic pregnancy (KET), or bleeding occurs in late pregnancy due to antepartum hemorrhage. Reason Antepartum hemorrhage in general is placenta previa and solution placenta.

c. Preeclampsia / eclampsia

Pregnancy can cause hypertension in women who before pregnancy had normal blood pressure (normotension) or can aggravate pre-existing hypertension. Hypertension in pregnancy is a condition during pregnancy The most common ones are preeclampsia and eclampsia. Severe preeclampsia and especially eclampsia is a serious condition because it can resulting in maternal and fetal death. Mild preeclampsia can be easy turns into severe preeclampsia, and easy severe preeclampsia eclampsia with seizures. If preeclampsia / eclampsia If not treated quickly, loss of consciousness and loss of consciousness will occur maternal death due to heart failure, kidney failure, failure liver and brain inflammation.

d. Infection

Infection in pregnancy is an infection of the birth canal during pregnancy pregnancy, both in young and old pregnancies. Infection may occur by direct causes related to young pregnancy is birth canal infections that occur at less than 20 – 22 weeks of gestation Sunday. The most frequent cause is abortion infected. Birth canal infection in late pregnancy is an infection that occurs in the second and third trimesters of pregnancy. This uterine tube infection can occur due to premature rupture of membranes, tract infections urination, or due to systemic disease. This situation is dangerous because can result in sepsis, which may cause maternal death.

2. **Childbirth** and postpartum complications

Complications that arise during childbirth and the postpartum period are direct cause of maternal death. Complications that occur ahead childbirth, during and after delivery, especially bleeding, parturition obstruction or prolonged labor and infection due to trauma during childbirth.

a. Bleeding

Bleeding especially postpartum hemorrhage gives contributes 25% to maternal deaths, especially if the mother suffers anemia due to malnutrition or malaria infection.

This bleeding occurs suddenly and blood loss can occur quickly become death in a state where there is none Initial treatment to control bleeding includes medication,

uterine massage to stimulate contractions, and transfusion blood if needed. Postpartum hemorrhage is bleeding occurs after the child is born and the amount exceeds 500 ml and bleeding This can happen before, during or after the placenta comes out.

b. Long Parturition Prolonged labor can endanger the lives of the mother and fetus. Long parturition is labor that lasts more than 18 hours from birth. This situation is often caused by cephalopelvic disproportion and in abnormal location. Disproportion occurs more often when circumstances exist endemic malnutrition, especially in populations that still adhere to it taboos and traditions that regulate food for girls or adult female. This situation gets worse when girls get married young and expected to have children soon, whereas their growth is not optimal.

c. Postpartum Infection

Childbirth infection is an all-encompassing condition inflammation caused by the entry of germs inside genital organs during childbirth and postpartum. Germs that cause infection can enter the genital tract in various ways, for example through the hands of dressing assistants are not clean or the use of instruments the dirty one. Postpartum infections cause morbidity and mortality for mothers postpartum. Death occurs due to various complications, incl shock, kidney failure, day failure and anemia.

3. Intermediate determinants

a. Maternal health status

A mother's health that influences maternal events includes nutritional status, anemia, diseases suffered by the mother, and history complications in previous pregnancies and childbirth.

1) Nutritional Status

The nutritional status of pregnant women can be seen from the results of measurements of upper arm circumference (LILA). LILA measurements aim to detect whether pregnant women fall into the category of chronic energy deficiency (KEK) or not. Mothers with poor nutritional status are at risk for the occurrence of bleeding and infection during the puerperium. State of malnutrition before and during pregnancy contributes to poor maternal health, problems in childbirth and problems in a newborn baby.

2) Anemia

Anemia is an important problem that must be considered during pregnancy. According to WHO, a mother is said to be hamul suffer from anemia if the hemoglobin (Hb) level is less than 11 g/dl. Anemia can be caused by various causes, which can be mutual related, namely inadequate *intake* , parasitic infections, malaria, deficiencies of iron, folic acid and vitamin A. Women who suffer. Severe anemia will make you more susceptible to infections during pregnancy and childbirth, will increase the risk of death due to bleeding and There will be a risk of operative complications if needed cesarean section delivery.

3) The disease suffered

Other important indirect causes of maternal death including malaria, hepatitis, HIV / AIDS , diabetes mellitus bronchopneumonia. a pattern of disease that results in death General matters in Indonesia have experienced changes, due to the transition epidemiology. Degenerative diseases are more common, while diseases Infections and parasites also still play a role. Pregnancy with Tuberculosis is still high, but has a good prognosisif treated early.

4) History of complications from previous pregnancy and childbirth Poor obstetric history such as surgical delivery, bleeding, prolonged labor, previous caesarean section will affect maternal death. All surgical births have risks, both mother and baby. Some risks arise due to nature of the actions performed, partly due to other procedures that accompanying, such as anesthesia and blood transfusions, and some consequences pregnancy complications that force action, aside Therefore, complications can also arise, including bleeding and infection heavy.

b. Reproductive Status

Reproductive status plays an important role in maternal events are the age of the pregnant woman, number of births, birth interval and status mother's marriage.

1) Age

Ages under 20 years and over 35 years are age risk for pregnancy and childbirth. Complications that often arise in pregnancy at a young age are anemia, premature labor, and stalled parturition. Pregnancy over the age of 35 years causes women exposed to medical and obstetric complications, such as the risk of occurrence pregnancy hypertension, diabetes, cardiovascular disease, kidney disease and impaired lung function.

2) Parity

Parity 2 -3 is the safest parity in terms of angle maternal death. Parity less than 1 (never gave birth /just gave birth for the first time) and a parity of more than 4 has a number high maternal mortality. Parity less than 1 and young people are at risk because the mother is not ready medically or mentally, meanwhile parity above 4 and old age, the mother physically declines to undergo pregnancy. In the second or third pregnancy if pregnancy occurs in unexpected circumstances (failed birth control, the economy is not good, the interval is too short) may increase the risk maternal death.

3) Pregnancy spacing

Too close a distance between pregnancies (less than 2 years) can increase the ratio of maternal deaths. Labor with intervals of less than 24 months (too often) nationally by 15%, and is a high risk group for bleeding postpartum, maternal morbidity and mortality. The distance between pregnancies generally recommended is at least two years, for allows a woman's body to recover from the extra demands on pregnancy and lactation.

4) Marital status

Marital status that supports material death is the status of not being married. This status is an indicator of something unexpected or planned pregnancy. Woman with Unmarried marital status generally tends to be less Pay attention to the health of yourself and your fetus during pregnancy not having an antenatal check-up, which resulted in no detection of abnormalities that could result in complications.

5) Access to health services

This includes, among other things, the affordability of the location of the service location health, where the service location is not strategic / difficult achieved by mothers causes reduced access of pregnant women to health services, the type and quality of services available and accessibility to information. Access to service locations Health can be seen from several factors, such as the location where the mother is obtaining contraceptives, antenatal check-ups, health services primary or referral health services available in the community.

c. Location affordability

Geographical constraints in the field result in many houses referral illness cannot be reached within two hours, which is maximum time required to save the mother with bleeding from the birth canal. Difficulty obtaining transportation is closely related to the affordability aspect of this location.

d. Availability of human resources and infrastructure

Often mothers have to wait for several hours at the center referral health due to poor staff management, policies advance medical payments, or difficulty in obtaining blood for transfusion needs, lack of equipment and also lack of medicine essential medicines and a room for surgery or an ICU room.

1) Diversity of types and quality of service

   Completeness of services available and quality of service is one of the factors that influences where to refer patients.This is related to the patient's tastes/desires. Someone with A high economy will prioritize this aspect because it will influencing patient satisfaction with the quality of service. Different with low economic patients, they will not pay attention to this aspect.

2) Availability of information

   Availability of information, both counseling and counseling It is important that mothers know the dangers that can occur in pregnancy, childbirth and the postpartum period, as well as efforts to avoid it that problem. It was identified that there was still a lack of information and counseling from health workers to mothers. Most officers focus on providing information/counseling, but not doing enough counseling to help mothers solve problems.. Apart from that empowering means of communication, information and education (KIE) regarding maternal health is still very poor, remote villages not yet familiar with radio and television.

3) Behavior in using health service facilities

   Behavioral use of health services includes, among others: behavior of using contraceptives, where mothers who participate in the program family planning (KB) will give birth less often than with mothers who do not use family planning, antenatal check-up behavior, where the mother who carry out regular antenatal check-ups will be detected health problems and complications, birth attendant, where is the mother Those who are helped by shamans are at greater risk of suffering death compared to mothers who gave birth assisted by energy health, as well as the place of birth, where the birth takes place at home will hinder access to online referral services quickly when needed.

e. Familiy Planing Program

   Family planning programs have the potential to save mothers' lives, i.e by enabling women to plan pregnancy in such a way that it can avoid pregnancy at that age certain or the number of births that bring additional danger, by reducing fertility levels in general, namely by reduce the number of pregnancies.

f. Antenatal examination

   Antenatal examination is a pregnancy examination performed to periodically check the condition of the mother and her fetus, followed by efforts to correct the deviations found. Antenatal examinations are carried out by health workers trained and educated in the field of midwifery, namely midwives, doctors, and trained nurses. The goal is to keep the mother Pregnant women can go through pregnancy, childbirth and postpartum well and safe. Antenatal examinations are carried out 4 times a year pregnancy with the provision of one first trimester (gestational age before 14 weeks), once during the second trimester (between 14 to by 28 weeks), and twice during the third trimester (between 28 up to 36 weeks and after 36 weeks).

g. Labor assistants

Most obstetric complications occur during delivery taking place. For this reason, professional staff are needed who can quickly recognize complications that can threaten the mother's life while providing timely treatment to save lives mother Trained dressing assistants are one of them the most important technique in reducing maternal mortality. Handling of childbirth by doctors, midwives and nurses is a factor important in reducing the maternal mortality rate. There are many factors that cause only some to give birth assisted by trained energy among others is lack of energy who are trained and the lack of distribution of these workers in regions.

3. Remote Determinants

1Although this determinant does not directly influence maternal death, but socio cultural factors, economic, religious, and other factors also need to be considered and integrated in implementation of interventions for handling maternal deaths.

a. Socio-cultural

Included in the distant determinants are social and cultural ones related to the status of women in the family and society, which includes educational level, where women are highly educated tend to pay more attention to the health of themselves and their families, wherea women with a low level of education, causing a lack their understanding of the dangers that can befall pregnant women and women the baby, especially in the event of pregnancy and childbirth emergencies.

Mothers, especially in rural or remote areas with low education, level of independence to take the result is low. Decision making is still based on a culture of “negotiating” which results in delays in referring. Low knowledge of mothers and families about danger signs in pregnancy underlies the underutilization of the referral system.

b. Socioeconomic

The distant determinants also include socio-economic ones related to the mother's work, where the state of pregnancy is not significant changing the daily work activity patterns of pregnant women. This is related with the family's economic situation, the mother's own lack of knowledge, or local customary factors. Poverty could be the cause of the low community participation in health efforts. Maternal deaths are frequent occurs in poor, uneducated, local groups remote, and they have no ability to fight for it his own life.

Whereas Infant death is the death experienced by a new baby born at the age of 1 year (12 months) or before his first birthday. The classification of infant deaths is perinatal death and neonatal death. Perinatal death is the death of a baby at 22 weeks of gestation complete / 154 days to 7 days after birth. Neonatal death is the death of a baby after birth to the age of 28 days. Death Neonatal itself is divided into two, namely early neonatal deaths that occur within the 7 day period after birth and late neonatal deaths that occur at the age of 8 to 28 days.

Newborn deaths generally occur at home without any assistance skilled handler. Most deaths are related to pregnancy, childbirth and infections that occur. Various data also shows that around 40%-80% of deaths are related to the birth weight of the baby low. Other facts also show that infant mortality is the lowest in mothers aged 20-30 years.

If the mother's age is < 20 years or > 30 years, the infant mortality rate tends to increase. Infant mortality urban areas are lower than in rural areas. The higher the level of education mother, the lower the infant mortality rate. The better the quality of housing,

the lower the infant & child mortality rate. Distance from birth to birth less than (<) 24 months, tends to increase the risk infant death.

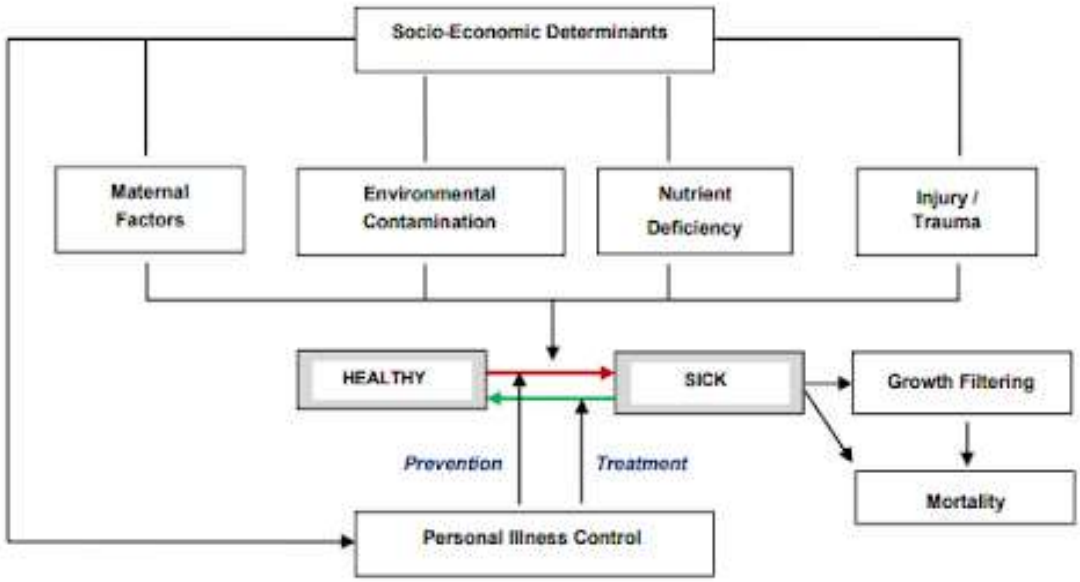


Figure 3: Proxy Determinants of Infant & Toddler Mortality (Mosley & Chen, 1985)

Mosley & Chen (1983) developed a proxy determinant model of mortality infants and toddlers which includes various interrelated factors, namely maternal factors (age, parity, and birth spacing), environmental contamination factors (water, skin, soil, insecticides, etc.), nutrient deficiency factors (calories, protein, vitamins & minerals), accident (trauma) factors experienced by the baby and control factors / individual attention to disease (in prevention and treatment efforts disease). To further explain the model, see Figure the. Policy implementation is an inseparable part of infants and toddlers which includes various interrelated factors, namely maternal factors Mosley & Chen (1983) developed a proxy determinant model of mortality Policy Implementation soil, insecticides, etc.), nutrient deficiency factors (calories, protein, vitamins & how a policy design is able to comprehensively formulate aspects (age, parity, and birth spacing), environmental contamination factors (water, skin, individual attention to disease (in prevention and treatment efforts policy planning. Implementation success is greatly influenced by the lower the infant & child mortality rate. Distance from birth to birth must be emphasized so that in the implementation and evaluation of policies later it will be minerals), accident (trauma) factors experienced by the baby and control factors / implementation as well as evaluation methods that will be implemented. This understanding must be emphasized so that in the implementation and evaluation of policies later it will be a process flow occurs and can be evaluated properly at end of the process. Hence the duties of an analyst or policy advisor

The public also includes providing identification of various things found on implementation stages, problems encountered, and also what strategies are possible carried out so that policy implementation can run well. There are several factors that influence the success of implementation policies both internal and external. According to Howlet and Ramesh, stated that policy implementation is influenced by:

a. The starting point of the problem

   If the starting point of the problem is clear, then public policy will be implemented will go smoothly. This means that by recognizing what The starting point is in the social, political,

economic or cultural domain make it easier to implement policies in implementing policies the.

b. The level of severity of the problems faced by the government The more acute the problem faced by a policy, the more it takes longer to complete and sacrifices resources more and more power.

c. Target group size
The smaller the targeted groups aimed at by a public policy, the of course it will be easier to manage than a large target group and has a wide scope.

d. Expected behavioral impact
If the desired impact is purely quantitative, it will be more it is easier to handle than if the desired impact is dimensional qualitative which takes a long time. Apart from several factors that influence the success of implementation in above, there are also conditions that influence the success of implementation a public policy. In their book Badjuri and Yuwono state that There are several conditions that influence the success of an implementation policy, namely:

1) Whether or not there are severe external limitations, meaning if there is great resistance from external circles of public organizations, then it is clear that policy implementation will fail. Therefore it is necessary constructive efforts so that external constraints can be minimized.
2) Availability of sufficient time and resources. If implementation policies are not supported by the availability of time and resources (people and money) enough, then don't expect much
3) successful implementation of a policy.
4) There is support for various combinations of sufficient resources in each policy implementation stage. This means there is continuity of source support resources in each implementation stage that are well prepared and type.
5) Causality analysis will greatly influence success in implementation of a policy.
6) The need for a coordinating institution is needed to be more dominant managing the stages of policy implementation. If there is no institution coordinator, then it is clear that there is no accountability and continuity mechanism continuity of a public policy implementation process.
7) In the early stages of implementation, there must be clarity and agreement regarding goals and objectives. This is very important for clarity and unity of movement and steps from each institution involved.
8) There is a clear division of work in each implementation stage, so that produce clarity on the rights and responsibilities of each institution policy implementer.
9) There is good coordination, communication and cooperation between institutions policy implementer.
10) There is compliance with the agreements and objectives that have been set in coordinating implementation. This has a lot to do with consistency and commitment between what is written and what is implemented in it stages of policy implementation.

F. Service Blockage Analysis (Bottleneck Analysis)

Approach to conducting bottle neck analysis especially using the model introduced by Tanahashi as well used by the Indonesian Ministry of Health, especially in making program plans KIA. The model analyzes blockages in maternal health programs child with 6 variables.

These 6 variables, through special studies, have been considered to represent common blockages that occur in the program health. This variable is divided into 2 analysis groups, namely from side Supply (service provider) and Demand side (service recipient). So that the analysis will become more focused. With this model it will be seen, Do the blockages occur more from the service provider's side or? precisely from the side of the service recipient.

Figure 2.1 Blockage Analysis Framework Model Chart

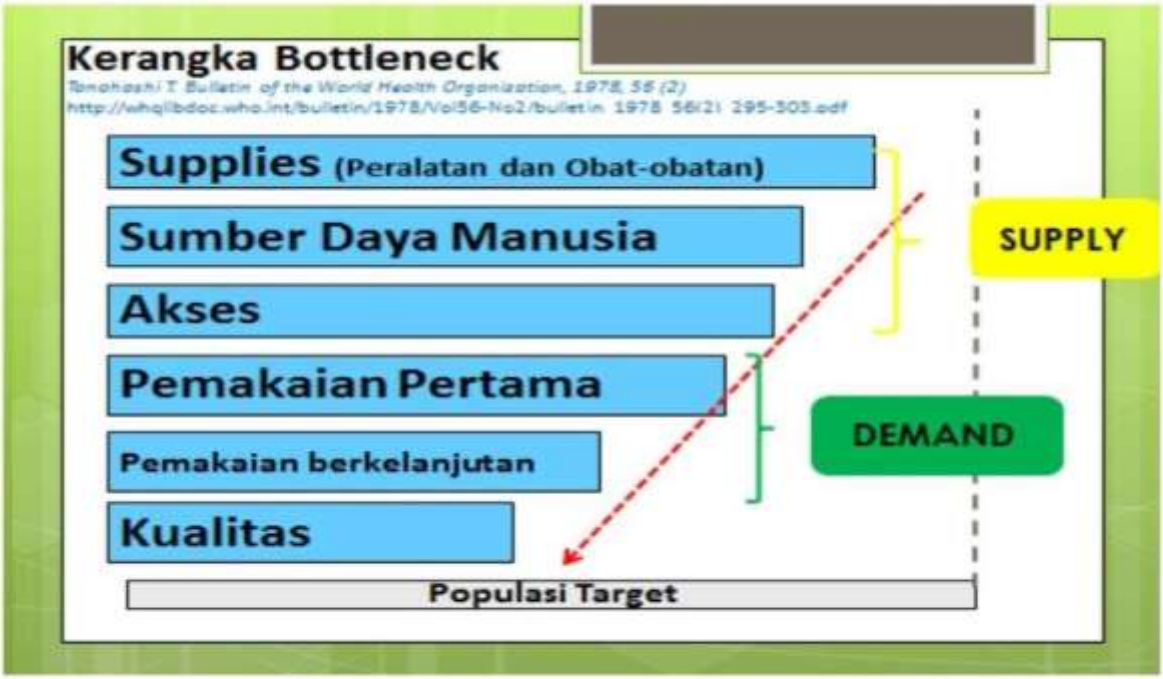


Figure 4: (Bottleneck framework) Source: Tanahashi (1978),

UNICEF, UNDIP, UGM, KIA Evidence Based Planning (2014)

The failure of a program does not only depend on the "side". bad" not only the program, but also supply and demand factors. Part Large supply shortages will cause the program to fail achieve the desired target. But there is another side, namely the demand side, where the service recipient himself does not want to use the service
available as recommended. For example: low coverage immunization, can be analyzed with this approach, whether because it is from in terms of the number of vaccines, the number and quality of human resources for immunization, or the distance taken to reach difficult target communities, or even from the part of society that is reluctant to immunize due to various factors certain social and religious beliefs. With this model the government can precisely shoot targets that become blockages in the process health planning, especially MCH. This model approach is felt more precise targets and speeds up the blockage analysis process This blockage analysis approach must be preceded by selecting priority interventions that will be used as strategic choices.

Next from The intervention was carried out blockage analysis using 6 variables namely:

1. Availability of human resources (HR). This HR study includes:
   amount, type of personnel associated with the intervention, which includes adequacy, quality/competence and distribution.

2. Availability of facilities, infrastructure, medical equipment, consumables, vaccines, reagents and drugs. The study includes adequacy, distribution, function equipment and facilities (are they still functioning), distribution and what? there is a stock out of medicine/reagent.
3. Access to quality health services. Calculating levels affordability of health service facilities (geographical) by the community (for example % of people who can access health facilities within 2 hours), distribution of health service facilities and level of transportation difficulty. This variable also includes influential social and cultural factors on community acceptance of MCH health services, for example: (a) health service costs (including non-service costs health: transportation costs, costs for companions and others included membership in BPJS, issues related to injustice gender.
4. First Service Coverage (First Contact). Utilization rate health services by the community, for example K1 antenatal coverage, coverage of neonatal health services
5. Complete Service Coverage (Continuity). Sustainability level utilization of health services by the community, for example coverage Antenatal K4, KF3, KN Complete, Exclusive Breastfeeding, Complete Basic Immunization, Toddler Health Services, Booster Immunizations for Toddlers
6. Service effectiveness. Analysis is carried out on effectiveness or quality from a service, for example K4 according to standard (10 T) or KN 1 according The standard uses the MTBM algorithm or Diarrhea treatment with ORS and Zinc.

G. Definition of Maternal Death

Maternal deaths according to the limits of The Tent Revision of The International Classification of Diseases (ICD – 10) is female mortality occurring during pregnancy, or within 42 days after its termination pregnancy, regardless of the length and location of the pregnancy, is caused by anything related to pregnancy, or aggravated by the pregnancy or its management, but not the death caused by accident or chance. This 42 day limit is subject to change, as is known With the existence of new procedures and technology, this occurs Death can be prolonged and delayed, so ICD – 10 also includes it a new category called late maternal death death) is the death of a woman due to direct or indirect obstetric causes directly occurring more than 42 days but less than a year after end of pregnancy. Maternal deaths can be divided into two groups, namely:

1. Direct obstetric death, namely death arise as a result of complications of pregnancy, childbirth and postpartum, which caused by acts, omissions, inaccuracies in handling, or from chain of events arising from the above conditions. These complications include bleeding, both bleeding antepartum and postpartum, preeclampsia / eclampsia, infection, obstructed labor and death in young pregnancies.
2. Indirect obstetric death, namely death caused by an illness that occurred before pregnancy or childbirth or illnesses arising during pregnancy that are not related to direct obstetric causes, but exacerbated by physiological influence due to pregnancy, so that the sufferer's condition worsens bad. These indirect obstetric deaths are caused, for example, by hypertension, heart disease, diabetes, hepatitis, anemia, malaria, tuberculosis, HIV / AIDS and others.

H. Definition of Infant Death

Infant mortality is death that occurs when a baby is born to one the day before his first birthday. In terms of causes, infant death

differentiated by endogenous factors and exogenous factors. Endogenous infant mortality (Neonatal death) is a death event that occurs in the first month since the baby was born, generally caused by factors carried since born, inherited by parents at conception or acquired from the mother during pregnancy. Meanwhile, exogenous death (post natal death) is infant deaths that occur between the ages of one month and up to one year caused by factors related to environmental influences.

I. Continuum of Care Approach in Minimum Service Standards for Sector Health in Minister of Health Regulation Number 43 of 2014

Minimum Service Standards (SPM) in the Health Sector is a reference for Regency/City Regional Government in providing health services

which every citizen is entitled to at a minimum. Division of affairs between Central Government and Regional Government in Law Number 23 of 2014, which states that health is one of six concurrent affairs (together) which is mandatory. SPM is a minimum requirement implemented by the regional government for its people, with SPM targets must be 100% every year. The following are SPM indicators the health sector in this study is in accordance with the *continuum of* approach *care* in this research as follows.

1. Pregnant Women's Health Services

   Every pregnant woman receives standard antenatal care including data collection activities on pregnant women. Antenatal care given to pregnant women at least 4 times during pregnancy with schedule once in the first trimester, once in the second trimester and twice in the third trimester performed by Midwives and or Good doctors and/or obstetricians who work at government and private health service facilities that have Registration Certificate (STR). The standard of antenatal care is services provided to pregnant women that meet the criteria The 10 Ts are:

   a) Weighing and measuring height;
   b) Measure blood pressure;
   c) Nutritional status value (Measure Upper Arm Circumference/LILA)
   d) Measure the height of the top of the uterus (fundus uteri);
   e) Determine fetal presentation and Fetal Heart Rate (DJJ);
   f) Screening for tetanus immunization status and provide Tetanus Toxoid (TT) immunization if necessary;
   g) Giving minimum 90 blood supplement tablets during pregnancy;
   h) Test laboratory: pregnancy test, blood hemoglobin (Hb) examination, blood type test (if it has never been done before),
   i) urine protein examination (if indicated); which is a gift Services are adjusted to the trimester of pregnancy.
   j) Management/handling of cases according to authority;
   k) Interview (counseling)

2. Maternal Health Services

   Delivery services according to standards are deliveries that are carried out by Midwives and/or Doctors and/or Obstetric Specialists work in government and private health service facilities have a Registration Certificate (STR) for both normal and/or births birth with

complications. Health service facilities include: Polindes, Poskesdes, Puskesmas, private practice midwives, pratama clinics, main clinic, maternity clinic, maternal and child health center, hospital government and private. Normal delivery service standards follow the normal birth care guidelines listed in Minister of Health Regulation Number 97 of 2014 concerning Services Health Before Pregnancy, Pregnancy, Childbirth, and Period After Childbirth, Providing Contraception Services, And Sexual Health Services. As for giving birth with complications follow the references from the Maternal Health Services Pocket Book in Referral Health Facilities.

3. Newborn Health Service

   Newborn health services according to standards are services that given to babies aged 0-28 days and refers to the Service Essential Neonatal as stated in the Ministerial Regulation Health Number 25 of 2014 concerning Child Health Efforts, carried out by Midwives and/or nurses and/or Doctors and/or Doctors Pediatric Specialist who has a Registration Certificate (STR). Service carried out in health service facilities (Polindes, Poskesdes Community health centers, private practice midwives, primary clinics, main clinics, clinics maternity, maternal and child health centers, government hospitals and private sector), Posyandu and/or home visits

4. Toddler Health Services

   Health services for toddlers according to standards are health services which is given to children aged 0-59 months and is performed by midwives and/or Nurse and/or Doctor/DLP and/or Pediatrician who has a Registration Certificate (STR) and is given at the facility government and private health, and UKBM. Health services, includes:

   a. Weighing at least 8 times a year, measuring body length/height at least 2 times a year
   b. Giving vitamin A capsules 2 times a year.
   c. Providing complete basic immunization.

5. Health services at primary education age

   Primary education age health services are health screening given to children of primary education age, at least once class 1 and class 7 conducted by the Community Health Center. Service standard Health screening is a service that includes:

   a) Assessment nutritional status (height, weight, clinical signs of anemia);
   b) Assessment vital signs (blood pressure, pulse and respiratory rate);
   c) Assessment dental and oral health;
   d) Assessment of visual acuity with snellen posters;
   e) Assessment of the sharpness of the sense of hearing with tuning fork.

6. Health services at productive age

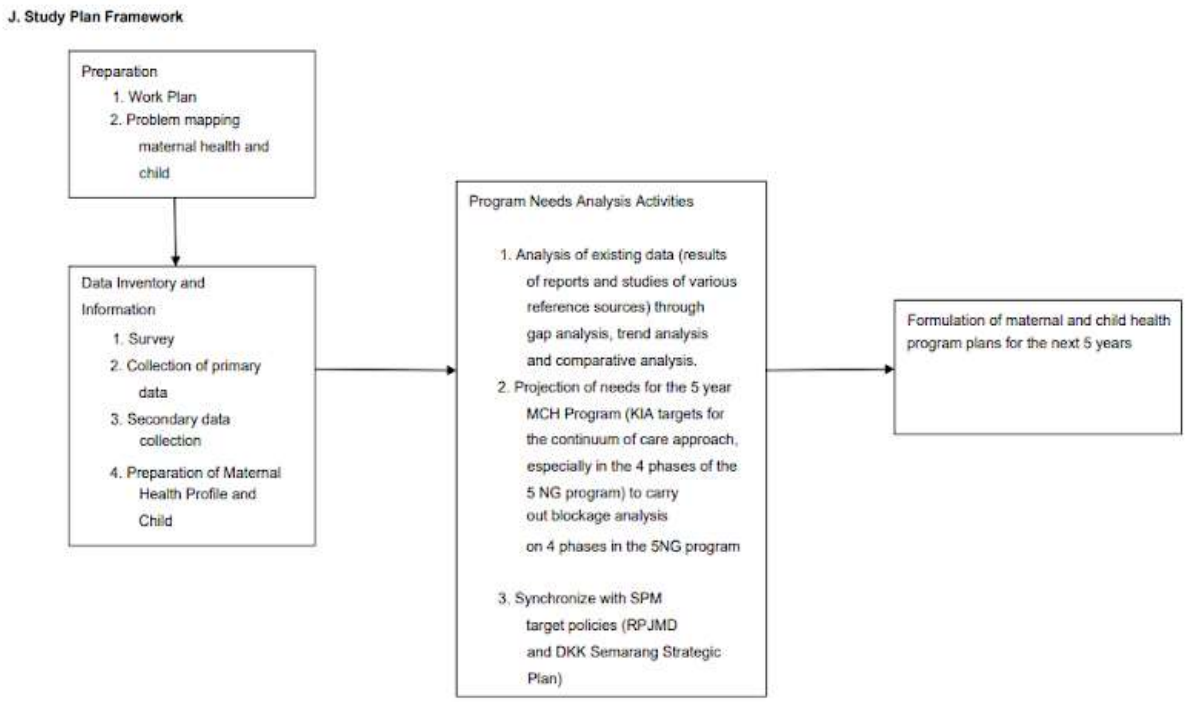
   At least one health screening service for ages 15–59 years is carried out once a year. Health screening services aged 15–59 years include:

   (1) Detection of possible obesity is done by checking body height and body weight and abdominal circumference.

(2) Detect hypertension with checking blood pressure as primary prevention.
(3) Detection possible diabetes mellitus using a rapid blood sugar test.
(4) Detection of mental emotional and behavioral disorders.
(5) Inspection visual acuity
(6) Hearing acuity test
(7) Early detection of cancer is done through clinical breast examination and VIA examination specifically for women aged 30–59 years. Visitors Those found to be suffering from disorders must be treated or referred to health service facilities capable of handling it.

7. Health services for the elderly
   Health screening services are carried out at least once a year. Scope screening is as follows: (1) Detection of hypertension by measuring blood pressure. (2) Detect diabetes mellitus by checking levels blood sugar. (3) Detection of cholesterol levels in the blood (4) Detection mental emotional and behavioral disorders, including dementia using Mini Cog or Mini Mental Status Examination (MMSE)/Mini Mental Test or Abbreviated Mental Test (AMT) and Geriatric Depression Scale (GDS). Visitors found to have risk factors require early intervention. Visitors who found to be suffering from an illness must be treated or referred to a facility health services capable of handling it.

J. Study Plan Framework



K. The approach method used in this study consists of:

1. Analysis of existing data (results of reports and studies of various reference sources) through Gap analysis, Trend and comparative analysis. Gap Analysis is carried out to carry

out gap analysis of target indicators achievement of programs related to maternal and child health with service standards minimum in the health sector in accordance with Government Regulation No. 2 of 2018 regarding Minimum Service Standards (SPM) especially in the health sector and also Minister of Health Regulation Number 43 of 2016 and refers to Minister of Health Regulation Number 39 of 2016 concerning guidelines for implementing the program Healthy Indonesia with a family approach focusing on priority area activities decrease in maternal and infant mortality. Trend analysis is carried out to see trends in cases or target indicators program achievements based on data from related supporting reports maternal and child health program. While comparative analysis is done to compare with various studies from supporting references.

2. Projection of needs for the 5 year MCH Program (KIA target approach *continuum of care* , especially in the 4 phases of the 5 NG program) was analyzed blockages in the 4 phases of the 5NG program. The approach to carrying out *bottle neck analysis* especially using the model introduced by Tanahashi is also used by The Indonesian Ministry of Health, especially in making plans for the KIA program. Model The study analyzes blockages in maternal and child health programs with 6 variable. These 6 variables, through special studies, have been considered representative Common blockages that occur in health programs. This variable divided into 2 analysis groups, namely from the Supply side (service provider) and Demand side (service recipient).

Next, from this intervention, a blockage analysis was carried out using using 6 variables, namely:

1) Availability of human resources (HR).
2) Availability of facilities, infrastructure, medical equipment, consumables, vaccines, reagents and drus,
3) Access to quality health services,
4) Coverage First Service (First Contact),
5) Complete Service Coverage (Continuity),
6) Service effectiveness.

These 6 variables are analyzed to see the problems that exist in the future then (at least 3 years later), and then set a target 5 next year, which includes the availability and achievement of meeting needs based on obstacles;

1. Availability of facilities, basic and supporting infrastructure, medicine and food supplies health, from the current position, the past (3 years ago) and 5 year projections forward, gradually.
2. The current number of health workers, considering conditions 3 years ago to prepare projections for the next 5 years.

3. Access to health services. This access can contain elements of access conditions physically (roads, means of transportation and time; to and from health facilities) or access non-physical, such as the availability of guaranteed health services to targets, the present, past perspectives, and stages for the next 5 years.
4. First Service Coverage (First Contact), used for viewing use of health programs that have been implemented within the framework improving

maternal and child health services. This coverage is coverage basics that must be present in every maternal and child health program indicator.

5. Complete Service Coverage and Continuity of services (Continuity), which will look at the strategy for the next 5 years in terms of coverage sustainability of services that have an effective and efficient impact on in order to achieve maternal and child health development targets.
6. Service effectiveness in order to achieve quality services and achieving the targets of strategies, interventions, programs and activities become a problem in the field of maternal and child health.

Synchronize with SPM target policies

Synchronization of various programs related to maternal and child health efforts which is especially the 5 NG program (Jateng Gayeng Nginceng Wong Meneng) and Semarang City SANPIISAN program with various SPM indicator target policies through a *continuum of care* approach with target groups starting from mothers pregnant, maternity mothers, postpartum mothers, newborns, toddlers, children of primary education age, productive age to old age.

Implementation Schedule

Table 1. Implementation Schedule

L. Implementation Schedule
Table 1. Implementation Schedule

Activity No		Strategic target	Indicator Success	Time Allocation (moon) 1 2 3 4 5 6 7 8 9 10 11 12 13 14	Information
1	Preparation Coordination: a. Work Plan b. Problem mapping using Gap analysis (achievement indicators with target analysis. Trend/Tendency Comparative Analysis. SPM), and	Tim RoadMap KIA, Bappeda and Health Department Semarang city	Preparation of work plan schedules and secondary data collection at DKK Semarang		Weeks 3- and 4 Months August 2018
2	Data and Information Collection: a. Survey preparation b. Collection of Primary Data and Secondary Data c. Problem Mapping d. Preparation of Mother and Child Health Profiles for Semarang City	Stakeholders involved in the MMR reduction strategy	a. Arrangement of instruments b. Collection of primary and secondary data c. Compilation of Mother and Child Health Profiles for Semarang City		Weeks 1, 2 and 3 Months September
3	Activities to analyze needs for programs to reduce MMR / maternal and child health programs: a.Data Analysis (program report and several study results) b. Projection of the Need for Efforts to Reduce MMR (continuum of care approach in the 5 NG program.	Bappeda, DKK Semarang, Relevant stakeholders and Team Roadmap KIA	a.Situation analysis b. Draft report temporary c. Formulation of projections for efforts to reduce MMR		Week 4 of the month October, 1st week and 2 November 2018
4	Plan Formulation Activities	Bappeda, DKK Semarang , along with the KIA RoadMap Team	Formulation of plan 5 next year in the form of a RoadMap/ Plan. Strtegis Program KIA DKK		Weeks 3 and 4 Months November 2018

CHAPTER III

GENERAL DESCRIPTION OF SEMARANG CITY REGIONAL CONDITIONS

A. Geographical and Demographic Aspects

Semarang city is the capital of Central Java province. Located in a coastal area the North coast of Java with an area of 373.70 km², part of which is a hilly area (especially in the western and southern regions) and areas lowlands and coasts, especially in the northern regions. As the provincial capital, the city Semarang is considered very strategic as a central government city trade, industry and economy. Geographically, Semarang City is located between 6° 50' – 7° 10' South Latitude (LS) and 109° 50' – 110° 35' East Longitude (BT). The eastern boundary of Semarang City borders the Regency Demak, south with Semarang Regency, west with Regency Kendal and to the north the Java Sea with a coastline length of 13.6 kilometer.

Administratively, Semarang City is divided into 16 and 177 sub-districts sub-districts, with varying sub-district and sub-district areas. Amount The population of Semarang City in 2016 was 1,651,279 people, with a percentage The female population is slightly more than male, namely 50.28% (830,218 people) and men 49.72% (821,061 people). Population growth rate The city of Semarang tends to decline every year. Central Statistics Agency (BPS) data Semarang City (2017) shows a population growth rate in 2016 of 0.47 decreased from the previous year, namely 0.59% (2015) and 0.97% (2014). Subdistrict Pedurungan has the densest population (187,938 people), followed by District Tembalang (171,993 people), while Tugu District is the district with the least amount of population (32,873 people).

Semarang residents are generally Javanese and use the language Javanese as mother and everyday language. Viewed based on the Index indicator Human Development (HDI) or Human Development Index (HDI), achievement status Semarang City's HDI tends to increase every year, namely 81.19 in 2016 which increased compared to the HDI in 2012 of 78.04. Semarang city is the region with the second largest population in Central Java after Brebes Regency. Semarang City's HDI is the second highest HDI in Java Middle. Likewise with the rate of economic growth, Semarang City has the fifth highest economic growth in Central Java after the Regency Blora, Tegal Regency, Banyumas Regency and Sragen Regency.

Life expectancy also tends to continue to increase, namely 77.18 years (2014), 77.20 years (2015) and 77.21 years (2016) and 77.21 years (2017). Number This is much higher than the 2016 Central Java HDI figure, which was 69.98

Semarang City Administrative Area Map (Source : Wikipedia.com)

Information :

1. Central Semarang District
2. North Semarang District
3. East Semarang District
4. Gayamsari District
5. Genuk District
6. Pedurungan District
7. South Semarang District
8. Candisari District
9. Gajahmungkur District
10. Tembalang District
11. Banyumanik District
12. Gunungpati District
13. West Semarang District
14. Ngaliyan District
15. Mijen District
16. Tugu District

Based on health status characteristics, the city of Semarang has 37 Community health centers are spread evenly in all areas of the region, including 12 community health centers with treatment and 25 non-treatment health centers. Apart from that, it also has 35 supporting health centers (Pustu) and 41 mobile health centers. Means other health services, namely 7 government hospitals, 14 private hospitals, 1 mental hospital and 3 hospitals Mother and Child, as well as various clinics and other general medical centers.

Number of Posyandu as many as 1,559 in 2013, increasing slightly to 1,561 Posyandu in 2014. There will also be no implementation of health efforts for the community run well if it is not supported by the availability of human resources quality health. For this reason, the deployment and regulation of health workers evenly is also absolutely necessary. Based on 2014 data, the number is known all specialist doctors in Semarang City are 1,079 people; general practitioner 388 people, Dentists & Specialists 172 people; Midwives 571 people; Nurses 4,641 people

B. Community Welfare Aspects

By expenditure group, more than 40 percent of the City's population Semarang has expenditures above 1 million rupiah per month. Per capita expenditure the smallest is less than Rp. 200,000 which covers 0.04 percent of the population. The total per capita expenditure per month in Semarang City is IDR. 1,362,348 Yang consisting of food expenditure of Rp. 526,309 and non-food expenses amounting to Rp. 836,039. Economic growth can also have an impact on increasing per capita income, in the end will also affect income Economic growth is shown by GDP figures at constant prices 2010 is one indicator to see the success of development. On In 2016, Semarang city's economic growth was slightly experienced at 5.69% a decrease compared to 2015 of 5.80%.

Semarang city is the region with the second largest population in Java Middle after Brebes Regency. Semarang City's HDI is the highest HDI second in Central Java. Likewise with the city's economic growth rate Semarang has the fifth highest economic growth in Central Java after Blora Regency, Tegal Regency, Banyumas Regency and Sragen Regency. Meanwhile, Semarang City's inflation rate is in the first position of smallest for all provincial capitals in Central Java, amounting to 8.19 percent in 2016. Inflation is a measure of economicstability.

Table 3. Inflation rate per month for Semarang City, 2012-2016

2012	2013	2014	2015	2016
5.18	7.99	8.21	2.55	2.30

Source: BPS Semarang City

CHAPTER IV

ANALYSIS OF MOTHER AND BABY DEATH CONDITIONS IN SEMARANG CITY

A. Description of the Achievement of Minimum Service Standards Indicator Coverage in the Semarang City Health Sector

Achievement of Semarang City Minimum Service Standards (SPM) indicators in 2017 semester 1 and semester 2 can be seen in the following table wit compare the achievement of indicators with the 2017 Health Service targets and National targets are in accordance with the mandate of Minister of Health Regulation Number 43 of 2016.

Table 4. Achievement of SPM Indicators in the Health Sector for Semarang City

	Indicator	Th. Achievements 2017	Target Th 2017	Target In the	GAP SMT I	GAP SMT II
		SMT I SMT II	%	%	% %	
1	Maternal health services pregnant	43,20 % 97,57%	98	100	56,	2,43
2	Maternal health services giving birth	43,00 % 99,56%	98	100	57	0,02
3	Baby Health Services Newborn	42,72 % 95,03%	96	100	57,	4,97
4	Toddler health services	21,14 % 95,01%	95	100	78,	4,99
5	Health Services On Primary Education Age	0,00 % 99,54%	100	100	100	0,46
6	Health Services On Productive age	4,17 % 36,46%	100	100	95,	63,54
7	Health Services On Elderly	56,68 % 102,96%	75	100	40,32	Exceed target
8	Service Health Hypertension sufferers	3,29 % 24,75%	100	100	96,	75,25
9	Service Health Diabetes Mellitus Sufferers	16,58 % 50,64%	100	100	83,	49,36

	Indicator	Th. Achievements 2017		Target Th 2017	Target In the	GAP SMT I	GAP SMT II
		SMT I	SMT II	%	%	% %	
	(DM)						
10	People's Health Services With Mental Disorders (ODGJ) Heavy	0.00 %	100.00%	100	100	100	Reach target
11	People's Health Services with Tuberculosis (TB)	49,05 %	104.52%	100	100	50,	Exceed target
12	People's Health Services with the risk of infection HIV	40,96 %	89.55%	100	100	59,	10,45

Source: Semarang City Health Service, 2017

Based on this table, it can be seen that the SPM achievement indicators in Several indicators in the city of Semarang have not reached the national target or targets Semarang City Health Service and there are indicators that have reached even exceeding the SPM target in semester II such as the Human Health Services indicator With Tuberculosis, Health Services for People with Mental Disorders, and Health Services for the Elderly. Meanwhile, the achievement of SPM indicators in In the first semester, it seems that there still tends to be quite a high gap between realization achievements with the latest SPM targets. This happens because of a transition from the old SPM to the latest SPM. If seen from the gap analysis between the achievements of SPM indicators in the semester II with the national SPM target, shows quite high gaps in some areas indicators in accordance with the continuum of care approach , namely, health services at productive age, toddler health services and newborn health services. Meanwhile, the indicators for maternal health services in the second semester are compared with the SPM target there is still a gap even though the value is quite small in comparison Other indicators still need attention. In terms of health service indicators for productive age in semester I and The second semester has a fairly high gap compared to the SPM target In addition, indicators for toddler health services, newborn health services, maternity health services and pregnant women's health services in the first semester 2017 also shows a fairly high gap when compared with .target SPM. In accordance with the concept of "continuum of care" in health services for mothers, babies, children and toddlers start from the service cycle for couples of childbearing age and women of childbearing age (before pregnancy), pregnancy check-up services, delivery services (including postpartum and neonatal), services for babies, services for toddlers, services for elementary school children and services for middle school children First / Senior High School and teenagers. The concept of "continuum of care" as one of the steps of the approach to combating maternal, infant, and child mortality toddlers by paying attention to the entire life cycle in individual care.

In order to achieve success in reducing maternal and infant mortality, The health development process must be based on good "evidence" primarily from community elements

so that appropriate health development priorities are obtained, from community elements so that appropriate health development priorities are obtained, quality, equitable and sustainable. The most appropriate approach to use To achieve these goals and hopes is a *"life-cycle"* approach life starting from babies, toddlers, school age, teenagers, productive age, pregnant women and elderly/elderly.

Strengthening health services is carried out with strategies to increase access health services, optimizing the referral system, and improving the quality of use *continuum of care approaches* and health risk-based interventions are wrong one pillar in the Healthy Indonesia Program with a Family Approach. Approach families are also mandated in the 2015 – 2019 Ministry of Health Strategic Plan. In the Strategic Plan, it is stated that it is one of the references for the Ministry's policy direction Health is the application of an integrated and health service approach continuous *(continuum of care).* If the achievement of SPM indicators is in accordance with the concept *of continuum of care* and compared with the Central Java 5NG governor's program in the previous phase pregnancy, pregnancy phase, postpartum phase and delivery phase, there are still gaps between Each service cycle listed in the table above is:

1. Pre-pregnancy phase: starting from health services at productive (age related to couples of childbearing age and women of childbearing age), health services at school age (middle school/high school/ teenagers)
2. Pregnancy phase: there are still gaps in health services for pregnant women in the 1st semester.
3. Maternity phase: includes delivery services including services There is still a gap in the health of newborn babies in the first semester which is quite high and in the 2nd semester.
4. Postnatal phase: includes postnatal care services including services The health of children under five also still has a fairly high gap in semester 1.

B. Maternal Death and Causes of Maternal Death

There were 23 cases of maternal death in the city of Semarang this year 2017. This number decreased from the previous year of 32 cases of maternal death in 2016 and 35 cases of maternal death in 2015. Meanwhile, according to distribution of areas where there are cases of maternal death and the number of cases of maternal death highest per sub-district in Semarang City from 2014 to June in 2018, namely in the districts of Pedurungan, Ngaliyan, Genuk, North Semarang and Tembalang.

Table 5. Distribution of Maternal Death Cases Per City Subdistrict Area

Semarang 2014 to June 2018

Subdistrict	Number of Cases Mother's Death
Central Semarang	5
North Semarang	11
East Semarang	4
South Semarang	3
West Semarang	5
Gayamsari	8
Candisari	3
Gajahmungkur	3
Genuk	13
Protection	21
Tembalang	10
Banyumanik	8

Subdistrict	Number of Cases Mother's Death
Gunungpati	5
Mijen	6
Over and over	16
monument	8

Data source: Semarang City Health Service

The proportion of maternal deaths occurring during the postpartum period is 70% and during pregnancy pregnant by 30%. The causes of maternal death in general are mostly caused by pre-eclampsia and eclampsia, others, comorbidities and bleeding. These other causes include DOA, CVA, amniotic fluid embolism, peritonitis perforation ec Curretage, Acute Fatt Liver, liver disorders.

The proportion of maternal deaths during postpartum occurred on the day of postpartum between 3 up to 28 days (KF II) as much as 44%. The cause of death when postpartum occurs, caused mostly by pre-eclampsia and eclampsia, heart disease, bleeding, amniotic fluid embolism, tuberculosis and others. Meanwhile, based on place The majority of cases of

maternal death occurred in hospitals (78%) with time of death in hospital, namely the majority of cases occur in less time time of death in hospital, namely the majority of cases occur in less time than 48 hours in Hospital.

Based on Mc Carthy & Maine's determinant model, it is understood that various Efforts and strategies to reduce maternal mortality will not be successful if only handed over and become the responsibility of the health sector alone. Health sector on Basically, they are only capable and competent in dealing with direct determinant factors *(proximate determinants),* while for intermediate determinants and distant determinants is the responsibility and authority of other related sectors (multisector). Following These are various causes of maternal death according to Mc Carthy's determinant model and Maine:

1. Remote Determinant Factors (including women's status in the family, family status in society and community status and the availability of health workers)

   Based on the results of the study, it shows that the level of education, percentage of cases The highest maternal mortality occurs in mothers with secondary education levels, namely 51.4%. The mother's low level of education can increase the risk of incident maternal deaths, but in 2015 the highest proportion of maternal deaths occurred occurs in mothers with secondary education. Relationship between levels education with the incidence of maternal death is not direct which is distant determinant. Education is one factor that will influence mindset, increasing social status, mother's position in society.

   The highest proportion of maternal deaths occurs in mothers who do not work 57.1%. This relates to housewives who are busy with business domestic household will have relatively little time for get adequate information about their health. That too related to the family's economic situation, the mother's own lack of knowledge. Mother who are not working or housewives are economically very dependent on her husband's income and has no extra income that can be used to obtain needs during pregnancy, childbirth and postpartum.

   Viewed from the welfare aspect, Semarang City is an area with The second largest population in Central Java after Brebes Regency. City HDI Semarang has the second highest HDI in Central Java. Likewise with The rate of economic growth, the city of Semarang has economic growth fifth highest in Central Java. Economic growth will affect mothers in accessing or reaching health services.

2. Intermediate Determinant Factors (including reproductive status, health status, access to health services, healthy behavior and unknown/unexpected causes.)

   Reproductive status shows the mother's age when pregnant, parity, number of children. Based on the results of the study, looking at reproductive status, it shows that The highest presentation of maternal death cases occurred at the age of 20-35 years, 66.7%. On age > 35 years total 25.7%. There are things that can be seen in this phenomenon the incidence of maternal death at age < 20 years is 5.7%. There needs to be an assessment unmetneed. Unmeetneed is a group of women of childbearing age (WUS) who are married, still menstruating, don't want children or want to delay the birth of children, but don't use contraception.

Unmet need data for Semarang City in 2016 shows a decrease compared to the previous year, namely 10.45% in 2016 and 10.97 in 2015. The proportion of maternal deaths The highest occurred in mothers with less than 3 children, namely 85.71%. Amount The highest occurred in mothers with less than 3 children, namely 85.71%. Amount parity or the number of children more than 3 is a high risk of complications for the mother pregnancy, childbirth and postpartum. Socially and economically the number of children is more than 3 influence the fulfillment of the mother's needs during pregnancy, childbirth and postpartum.

Health status shows the mother's history of previous illnesses pregnancy including history of abortion and history of complications. Based on studies if Judging from the health status of pregnant women, it shows the presentation of the disease suffered before pregnancy, namely other diseases by 20% and hypertension by 14.29%. Comorbidities suffered by the mother before pregnancy will increase the risk of maternal death, or pregnancy will aggravate the complications suffered by the mother. There is a need to provide understanding to pregnant women about the disease experienced so that the treatment of the disease can be resolved and not disturbed the process of pregnancy, childbirth and postpartum. Health workers need to implement early detection of diseases suffered by the mother before pregnancy in order to provide earlier and more comprehensive therapy. Apart from that, the proportion of maternal deaths complications in previous births, in order to minimize complications (Pustu) 35 units and Mobile Health Centers 41 units. Other health facilities are 7 Judging from the health status of pregnant women, it shows the presentation of the disease The highest occurs in mothers with a history of abortion of 80%. History of abortion in Previous pregnancies indicate poor uterine condition and maternal health not well, which will increase the risk of complications and death maternal. There needs to be a special treatment plan for patients with a history bad obstetrics, one of which is a history of abortion. The results of the study also show The highest incidence of maternal death occurs in mothers with complications during childbirth The previous one was bleeding before giving birth, 8.57%. Health workers preferably can dig up information and detect early risks of complications through information complications in previous births, in order to minimize complications can arise during pregnancy, labor and postpartum.

Access to health services includes location of health services, quality health services, information about health services and coverage service. Location of health services and reach of health services can be seen from the availability of health services in the city of Semarang equipped with 6 PONED Community Health Centers and 7 PONEK Hospitals, 37 Community Health Centers spread evenly in all areas of the region, covering 12 health centers with care and 25 non-nursing health centers. Apart from that, it also has a supporting community health center (Pustu) 35 units and Mobile Health Centers 41 units. Other health facilities are 7 government hospitals, 14 private hospitals, 1 mental hospital and 3 maternal and child hospitals, as well various clinics and other general medical centers.

Regarding access to information based on study results, the incidence of maternal death is the highest occurred at the first postpartum visit (KF1), which was

37.14%, which was several This incident was caused by factors that the mother and family did not have understanding and information regarding the importance of postpartum visits and danger signs emergencies during the postpartum period.

In terms of quality of inspection services pregnancy (ANC) and postpartum examination, it is known that the examination service Postpartum is in accordance with service standards by checking the perineal sutures on normal delivery, blood pressure check, uterine fundal height check, examination of vital signs, examination of post caesarean section wounds delivery through surgery to other supporting examinations. Whereas Judging from the aspect of pregnancy checks, it was found that most of the midwives were carrying out independent midwife practice and not yet carrying out 10 T activities regularly Overall, there are still many things that midwives should do but haven't carried out, such as measuring TB, providing health education/providing health information, measuring health, and carrying out recording and reporting on KIA book. The birth and postpartum assistance provided by BPM is good, although there are still several things that need to be improved in quality, for example use of a partograph and application of the 58 step birth aid method normal.

The quality of service at the PONED Community Health Center is known to be that the number of midwives trained Poned very little. Likewise, the number of APN-trained midwives is lacking From 5 years the number is very small, that there are community health centers that have midwives those without APN training for less than five years. APN training is important for midwives to be able to provide maximum service, be healthy and safe, comply with service standards that have been set and always improve their performance. The existence of PONED Community Health Center facilities is not known to all community health centers has the main facilities for birth assistance. Main aid room This delivery does not have, for example, obstetric surgery room, emergency room or complications, mother's recovery room after giving birth, new baby care room born. Apart from that, it was also found that the availability of medical supplies was incomplete, only around 65% of community health centers have fairly complete medical supplies. Meanwhile there are other main facilities such as mother and child examination equipment, childbirth sets, heacting sets, and essential medicines can be fulfilled. Seen from the existence of supporting facilities for delivery services at community health centers was discovered that the availability of blood donor lists and relations with the Red Cross Indonesia (PMI) is still very weak, only around 50% of community health centers have them blood donor list. Information about the list of donors and also relationships with PMI is very important, even though the community health center does not handle transfusions one of the program efforts undertaken to facilitate referral cases Awareness of the importance of antenatal care is influenced by several factors, namely information, and awareness of patients and families hinder the process blood, but if the community health center already has a list of donors then treatment blood transfusion for emergencies at the next referral service will be possible handled more quickly.

Good supporting facilities include communication tools, directories service lines that can be contacted for obstetric referrals are embedded in place which is easy

to see clearly, ambulance, budget for purchasing fuel and there are delivery personnel prepared for relief cases labor. The availability of the Great Ambulance and the Standby Ambulance is wrong one of the program efforts undertaken to facilitate referral cases patient.

Related to healthy behavior, showing a history of pregnancy checks or anti-natal care performed by pregnant women. Based on the results of the study known that the incidence of maternal death on average occurs in mothers with a history of number antenatal care visits 5.9 times (6 times). Minimum number of visits during 4 pregnancies. It is necessary to evaluate the visit and the results maternal antenatal care visits, which include understanding and awareness of pregnant women about the condition so that it influences the decision-making process. Awareness of the importance of antenatal care is influenced by several factors, namely experience, knowledge, social problems and assistance during antenatal care.

3. Direct Determining Factors (includes complications during pregnancy)

Based on the results of the study, it was found that the highest incidence of maternal death occurred in mothers at high risk of experiencing systolic blood pressure of more than 140 mmHg and diastole more than 90 mmHg during pregnancy. On early detection when if you are known to have high blood pressure, treatment should be possible provided more comprehensively, but several things such as lack of understanding, information, and awareness of patients and families hinder the process management. The highest proportion of maternal deaths occurs in mothers with complications of preeclampsia or eclampsia during pregnancy are 40%.

B. Analysis of coverage, quality of service and recording of reporting based on each target group using a Continuum of CareApproach.

1. Analysis of coverage, service quality and program reporting recordsmaternal health during pregnancy.

The following are the achievements of the program efforts in maternal health services the pregnancy phase in the 5 NG program is a phase that can, in the data, be reported systemically through information technology where pregnant mothers are recorded by midwivesvillage, with a coordinating midwife (Bikor) or Gasurkes (health surveillance officer) as regional coordinator, escorted or examined by health workers (minimum 1 time by a doctor) and the risk factors can be known or recognized. Mother pregnant with high risk factors (risti) are given a sign. In accordance with the SPM thatIn this indicator, every pregnant woman receives standard antenatal care including data collection activities on pregnant women according to the 5 NG program. PWS KIA Semarang City data shows K1 coverage in 2017Coverage is 100% (28,758 visits), and coverage in Q4 2017 was 97.57% (28,060 visits). City health service indicators for pregnant womenSemarang in the second semester was 97.57%, when compared with The national SPM target is 100%, this figure has not yet reached the target. The results of studies using this blockage analysis approach must be preceded bychoose intervention priorities that will be used as strategic choices.

Next fromThis intervention carried out a blockage analysis using 6 variables namely: Non-HR supply, Availability of human resources (HR), Access toquality health

services, First Service Coverage (First Contact), Complete Service Coverage (Continuity), and Service Effectiveness.Related to health services during the pregnancy phase through programsin accordance with PIS-PK and SPM priorities which consist of ANC examinations according to standards. The results of the study showed that there was a blockage in the ANC examination namely those with a larger scope, namely non-HR supplies and availability of human resources, as well as access to services by the community. Non-HR supplies This includes the availability of KIT midwives, medicines, etc. This happened, because there are obstacles in procuring medicines, especially for medicines for cases pre-eclampsia and high blood pressure. This is because the Community Health Center is still feel difficulties with the e-catalog system. Blockages in tht availability of human resources related to the shortage of trained midwives because currently community health centers are assisted midwives who are still apprentices and because the work area of the puskesmas is very largewide. Meanwhile, blockages in services by the community are related to the region the extensive work of community health centers and the existence of "elite" areas whose residents do not want them check her pregnancy at the Community Health Center and prefer to do sopregnancy check-up at a hospital or specialist doctor. In Program 5 NG This phase is also not limited to providing ANC services and data collection

they can plan and prepare good delivery facilities, including the availability of personnel health (general practitioner, anesthesiologist, nurse, midwife), medication and stocking of health supplies, preparation of delivery rooms and operating rooms if needed, and so on. Regarding the performance of the KIA Gasurkes, based on the results of the study, it is known that not yet implementation of appropriate support for pregnant women and postpartum mothers with the provisions, the target achievement of accompanied pregnant women is still less than The target that has been set is a standard of around 27 health care visits every mother. However, data collection on pregnant women, the discovery of pregnant women who are pregnant, Cohort filling, integrated ANC and delivery bags run more optimally. The knowledge Gasurkes has regarding KIA to provide assistance course and regarding factors of high risk pregnant women. A must skill Health Worker has, among others, communication, coordination, filling in cohorts and delivery bag and data collection and assistance skills. Extension facilities such as leaflets, feedback sheets and materials are still not provided to Gasurkes. The following is the flow of assistance carried out by gasurkes

Table 6. Coverage of Data Collection on Pregnant and Postpartum Women by Health Worker in 2017

Table 6. Coverage of Data Collection on Pregnant and Postpartum Women by Gasurkes KIA in 2017

Status	January – June 2017			January – June 2018		
	Target/year	Realization of Achievements		Target/year	Realization of Achievements	
Mother Pregnant	28.721	14.320	49,85%	29.174	15.133	51,87%
Mother Postpartum	27.414	7.741	28,25%	27.874	9.229	33,10%

Source: Semarang City Health Service, 2017

Based on table 6, it shows that data collection achievements have not yet been achieved The target/goal with the obstacles faced by KIA health care workers is pregnant women do not want to be accompanied, and pregnant women who work are difficult to find. Working area too big and lots of pregnant women. Other obstacles faced are: several mothers visited were not given an MCH book by the examining doctor and there was something that was not filled in by the examining doctor, mothers who lived in housing luxury is difficult to accompany, working mothers are difficult to find and do assistance, there are pregnant women who have been registered but were not found when they arrived region (immigrants), difficulties in continuing assistance for mothers who move out city. In accordance with the SANPIISAN Program, HEALTH WORKER is a workforce Competent candidates are taken based on a strict and quality recruitment process. Before carrying out their duties, HEALTH WORKER is given good training in the form of: material about pregnancy, childbirth, postpartum and babies as well as counseling and class practices pregnant women by SPOG doctors and trained midwive but have not included the material related to communication, coordination and mentoring. Currently the number of health care workers The number of KIA in 2018 was 180 people, with 400 being needed person. Apart from that, the city of Semarang received an award from the innovation program in the KIA field through the SANPIISAN Program in 2018. Regarding assistance to pregnant women, Semarang City has a Health Forum The sub-district where one of the focuses of its activities is assisting pregnant women and mothers high risk postpartum and facilitating classes for pregnant women through FKK cadres with FKK funds per sub-district are IDR. 50,000,000,-. The results of the study found that Maternal participation or involvement in classes for pregnant women is still low and participation It is felt that FKK is still less active. Apart from that, there is various coverage related to health programs for pregnant women as follows. The results of the study show that when giving Fe tablets to mothers Suboptimal pregnancy is caused by the mother's disobedient Fe consumption behavior and nutritional factors/adequate nutrition that must be met by pregnant women.

2. Analysis of coverage, service quality, reporting and recording management of effective referrals to maternal health programs in phase giving birth

Achievement of maternal health services during the maternity phase in the 5 NG program is the phase when a pregnant mother who is about to give birth is accompanied by an escort. Mother with normal births are delivered in standard basic health facilities, while mothers high-risk pregnant women are referred to the Hospital and monitored by PKK/ Dasa Wisma and Community and referral process through the SIJARI system GOLD. In accordance with the SPM, every pregnant woman gets this indicator Antenatal services according to standards including appropriate data collection activities for pregnant women 5 NG program. According to the SPM, delivery services according to standards are childbirth carried out by Midwives and/or Doctors and/or Obstetric Specialists who work in government and private health service facilities have a Registration Certificate (STR) for both normal labor and/or childbirth with complications. PWS KIA Semarang City data shows that the coverage of childbirth is assisted by health workers in 2017 reached 99.98% (26,148). If compared to the national SPM target of 100%, this achievement figure has not yet achieved the target, however, when compared with the previous year's achievements there was a significant increase

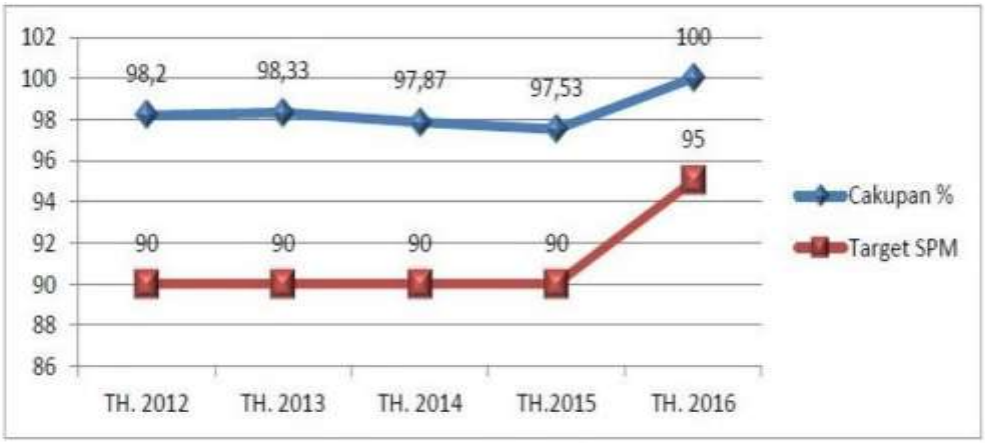


Figure 9. Trends in coverage of delivery assistance by health workers in the City Semarang from 2012 to 2016.

Sumber : Seksi Pdu Bidang Kesga

Maternity services in Semarang City already provide ambulances Great and Ambulance Siaga, health insurance program (Universal Health Coverage) and JAMPERSAL, as well as the birth waiting house. Great Ambulance is one of the free services provided by The Semarang City Government is under the supervision of the Semarang City Health Service one of which provides maternal emergency services which are equipped with skilled medical personnel, tools and emergency medicine. Great Ambulance is spread across 5 points in the city of Semarang. The five points consist of the City Health Service Office (DKK) Semarang as the coordination center, Bangetayu Health Center for the region East Semarang, Karangmalang Health Center for the West Semarang region, Srondol Health Center for the South Semarang area and Halmahera Health Center for the North Semarang area. Meanwhile, Ambulance Siaga is also wrong one free service in addition to the Great ambulance which is available at 8 points in the City Semarang. Great ambulances have call centers, telephone and WhatsApp can be contacted by the public.

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The results of the study regarding the use of the Great Ambulance by BPM show some independent practice midwives have not been socialized about the Great Ambulance, So far, most of the information BPM has obtained has only been through advertising and advertising a small part through outreach by the Health Service. Study results too shows that the majority of midwives have experienced emergency casesmaternal neonate, and most BPMs also make patient referrals so The use of this great ambulance is very important in terms of handling emergencies and patient referrals. Apart from that, the ambulance response time is great the location point is stated to be reached by the majority of BPMs but there are a small numberwho said it was not achieved. If we look at the needs, most of them are BPM stated that they needed Great Ambulance services even though there were a small number of them who stated that they did not need and did not perceive ambulance services great not good. Then, interest in using the ambulance service is still greatsome showed low interest even though most of the BPM felt

Medium and high interest in using this service. UHC or Universal Health Coverage is a health insurance program comprehensive for Semarang City residents who collaborate with BPJS Health including providing delivery services or the health of pregnant women. Besides that, JAMPERSAL also provides a budget used for accommodation costsfor birth waiting homes, examination services, care and assistance childbirth for poor pregnant women, mobility rental fees (already throughgreat ambulance), and transportation of delivery health workers (no utilized). Family planning services are not guaranteed through JAMPERSAL but through

KIA health services, namely RTK approaching Tugurejo Hospital, RTK approaching KRMT Regional Hospital Wongsonegoro, RTK approached the Citarum orphanage, Dr. Cipto and Kusuma Hospital, and RTK approached Banyumanik Hospital and Hermina Banyumanik Hospital. Accommodation costsfood and drink as well as the rental of the house waiting for the birth are guaranteed through JAMPERSAL, but in reality it is not absorbed because:

1. The geographical location of the hospital in Semarang City is easy to reach from all areas so that patients are reluctant to stay in RTK or are not used preferablystay at home because hospital transportation is easy to reach.
2. Culture and culture of the people of Semarang City who choose to stay at home.
3. Pregnant women choose to only stay temporarily at RTK because
   Waiting for the hospital inpatient room to be empty, and when you get a treatment room hospitalization tends to make patients unwilling to return to RTK.

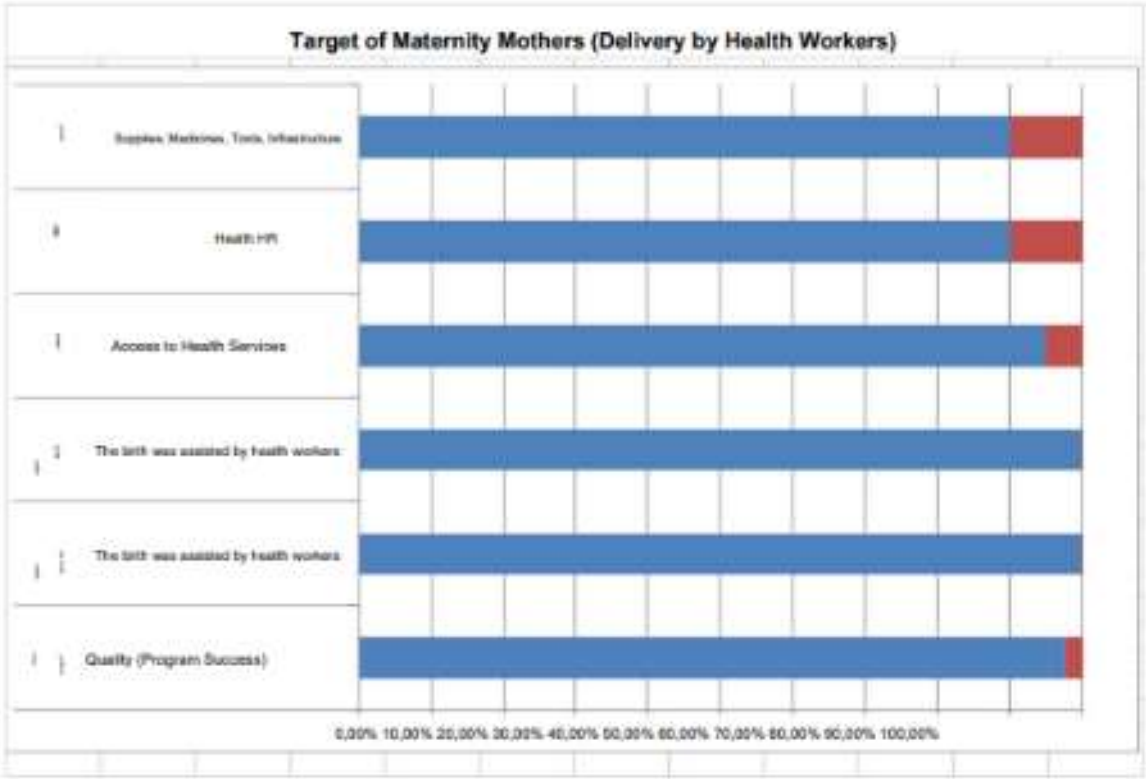

Figure 10: Analysis of blockages in childbirth by health workers in Semarang City

The quality of delivery services meets the standards carried out by the staffhealth so far from various study results found observed in BPM from observations of 10 births that not all BPMs did physical examination properly and record it in the partograph. Inspectionphysical and use of a partograph is very important in assisting childbirth. A partograph is a graphic record of the progress of labor to monitor the situation mother and fetus, discover abnormalities during delivery. The intended use Partography is observation, early detection of the possibility of parturition long because this is the most important part of the decision-making process clinic in the first stage of labor, so that there is enough time at the health service centerto take action until *a well born baby and well health mother is achieved.*

It is still found that several services are still inadequate service standards, for example not all birth attendants carry out deliveriesbaby properly (with 58 Steps for Normal Childbirth Care). As well during postpartum services, it was found that not all showed practice Property infection prevention after delivery and not all do postnatal physical examination. Meanwhile for other services already meet standards, for example initial assessment at the time of contact, ensuring the environmentwhich is supportive, safe and comfortable for giving birth, delivering the placenta with appropriate and AMTSL management, providing immediate care to newborns, ensuring a safe environment during the postpartum period, as well as assessing the mother's healthand newborns to prepare for homecoming.The results of the study also found that the existence of supporting facilities for Pregnancy and childbirth services at the hospital are all available. However, there is one supporting facility that is still weak, namely the existence of a listblood donors and also a list of blood availability at PMI. Existence of donor list This blood is very important if a birth or postpartum emergency occurs labor.

So for hospitals that do not have transfusion unit facilities blood / Blood banks are recommended to collaborate with facility providersthe. In health services for newborns, obstacles were found SOPs for childbirth and handling of newborns do not yet exist in some facilitieshealth.

There are still obstacles in maternal health services, namely: There are a limited number of PONED Health Centers, health facilities providing services limited maternal emergencies (limited ponek hospitals), as well as independent practice midwives not all of them have facilities that meet standards. Related study results PONED Health Center is based on *lean healthcare management* at the Community Health CenterHalmahera also found *waste* identification through VAA *(Value Added Assessment)* obtained the ratio between *Value added* and *Non Value Added* activities amounting to 36.36%: 63, 64%, meaning that the patient referral flow for PONED services inHalmahera Community Health Center is not yet *Lean.* Waste, or waste is everything activities that do not represent assistance in the healing process towards patient. All waste must be eliminated or at least reduced in order to achieve this reducing costs, increasing patient satisfaction and improving safety patients and employees.

This study found 5 types of waste in the service flow, namely *unnecessarytransportation, motion, defect, waiting* dan *underutilized abilities of people,* explained as follows:

1. In unnecessary transportation, it was found that it occurred in the process
2. PONED patient services which include the distance from the ER to the delivery room or VK is quite far away or feels ineffective.
3. In motion it was found that in the process of serving PONED patients It was found that midwives' work methods/SOPs were inconsistent methods) is shown by the work methods of one midwife with another others are different.
4. The defect was found to be an incapable process (inappropriate work SPO), absence of standard operating procedures, rework (repetitive work due to wrong processes), customer dissatisfaction (dissatisfaction and patient discomfort due to suboptimal service).
5. Waiting was found in PONED patient services at the Community Health Center Halmahera, namely when the patient has to wait for the delivery room door to be opened,
6. When processing referral administration, call the hospital and Sijariemas as well call the ambulance driver.
7. In the underutilized abilities of people, it was found that the competence of midwives should have the same competence at work but cannot yet work independently (always need assistance).
8. The cause of the waste found was the layout of the room (distance ER and delivery room quite far away), midwife competency (always needed assistance from senior midwives), weak leadership supervision, absence of SOP PONED patient flow (fixed referral flow procedure), work commitment and honorary status in ambulance drivers, midwife work division system.

Regarding health service facilities, the research results state that The number of puskesmas that can provide PONED services is 6 puskesmas or 22.5% of the 37 community health centers spread throughout the city Semarang. In the Obstetric and Neonatal Emergency Referral Service Flow,

PONED Community Health Center is able to provide direct services to pregnant women, maternity and postpartum mothers with certain complications according to the level authority and ability or

make a referral to PONEK Hospital. Meanwhile, non-PONED Community Health Centers must be able to stabilize patients with obstetric and neonatal emergencies before making a referral. The SANPIISAN program in Semarang City has one of its pillars strategy, namely the Health Service with the Community Health Center (the Health Service carries out Facilitative supervision, coaching of the PONED Community Health Center by the PONEK Hospital is carried out every 3 months starting from 2014 and providing guidance to coordinating midwives). The obstacle found based on the results of the study was the perceived coaching time The Puskesmas is taking too long and there are still limited teaching aids at the Puskesmasdoes not match what is in RS so often during the construction of para The instructors from the PONEK Hospital cannot operate the equipment at the Puskesmas. The results of the study also found that a Maternal Audit had been carried outPerinatal if a death occurs, an audit is carried out by an internal team appointed by the Health Service, with the final result being a good recommendationto hospitals, health centers, BPM and health workers. Energy development health that is found to be inconsistent with procedures in the form of internship in the hospital and under monitoring by the Health Service for 6 months. Auditing internally is also carried out at the hospital. The problem that occurs is that some hospitals do not submit internal audit reports. In this case there have been administrative effortswrite a letter to the hospital owner or director. Then, there are also maternity services family planning services which are the results of coaching active family planning participants during 2016 amounting to 203,751 with the following contraceptive mix. The image shows that during 2016, injections were still ongoing is the contraceptive method most widely used by the people of the city Semarang because it is practical and also fast to obtain his service. When compared with 2015 data, injectable contraception also still occupies the highest ranking, while male contraception is the least used is MOP. This is because many husbands still assumes that only the wife has the obligation to use it contraception as an effort to control birth. Coverage figures for active family planning participants in 2016 it was 77.4%, this figure has increased slightly from year to year 2015, namely 76.2%.

3. Analysis of coverage, quality of service and recording and monitoring maternal health program in the postpartum phase.

Achievement of maternal health services in the postpartum phase in the 5 NG programis the phase where postpartum mothers are provided with good postpartum nursing care by doctors/midwives/nurses and monitored by PKK/Dasa Wisma and the Community. System This fourth phase records and monitors postpartum mothers and babies for up to 1000 days First Birth. If there is a case of death of a mother or baby, it is recorded system through SIKIB (Information system for mapping maternal and infant mortality cases). PWS KIA Semarang City data shows the coverage of postpartum visits, namelythat KF3 coverage has increased from 2012 to 2012 2016 but still below the target (90%). KF1 and KF3 coverage since 2012up to 2016 tends to increase, this shows Increasing public awareness of the importance of doing examination during the postpartum period. Apart from that, there is an increase in KF coverage due to visits by Community Health Center officers using BOK funds and assistance to pregnant women by Gasurkes and health cadres. In 2017

Data on the number of maternal deaths during the postpartum period in Semarang City in 2017 Most occur during the postpartum period from 3 days to 28 days with causes deaths during the postpartum period, namely pre-eclampsia and eclampsia, were 38%,bleeding 19% and heart disease 19%. Based on the results of other research stated that the highest incidence of maternal death occurred during the visit historychildbirth with the help of a specialist obstetrician is 42.86%.

Based on the results of studies in several Community Health Centers, it was found that there were blockages quite high in the supply of non-HR in the Postpartum Visit Program.This is due to problems in procuring medicines, especially for medicines for cases of pre-eclampsia and high blood pressure. The blockage is quite high It was also found that the supply of human resources was still insufficient. This number was still insufficient because it is an Inpatient Health Center with 2 (two) Assistant Health Centers.

Regarding postpartum mothers who can access services at the Puskesmas, too experiencing quite a lot of problems or blockages, due to its size Puskesmas working area, the location of the puskesmas is on the border between cities Semarang and Demak Regency. So that the traffic of residents leaving and Entering these areas is often not recorded. There are many cases where postpartum mothers who moved residence before completing postpartum services for 42 days in the Puskesmas area and do so in other areas. Several nutrition programs related to services for postpartum mothers include: following:

1. Giving high doses of vitamin A to postpartum mothers
2. Breastfeeding and nutritional counseling for breastfeeding mothers;
3. Call for the provision of breastfeeding rooms in public service locations;
4. Team coaching at RS/RB/BPM/Puskesmas that loves mothers and babies.

4. Analysis of coverage, quality of service and handling of new baby complicationsborn.

Newborn health services according to standards according to the SPM are services provided to babies aged 0-28 days and refer to Services Essential Neonatal as stated in Minister of Health Regulation Number 25 of 2014 concerning Child Health Efforts, carried out by midwives and/ornurses and/or doctors and/or pediatricians who have a certificate Register (STR). Services can also be provided at health service facilities (Hospital, Community Health Center, Clinic), Posyandu and home visits. PWS KIA Semarang City data shows that the coverage of visits neonates (KN 1) level in Semarang City in 2016 was 26,556 (100.8%) of 26,337 babies were born alive. Complete KN coverage achievement in 2016 was 100.8%This may be due to weakness in determining targets. neonates are babies aged 0 – 28 days, where this age is included in the category vulnerable age, so it is necessary to carry out intensive monitoring, Coverage Neonatal visits are monitored from the coverage of Neonatal Visit 1 (KN1: 6-48hours), Neonatal Visit 2 (KN2: 3-7 days) and Neonatal Visit 3 (KN3: 8-28 days). PWS KIA data also shows that in 2016 the number of neonates risti are handled according to standards by trained health personnel throughout health service facilities amounted to 3,304 cases or 83.6% of the total estimate 3,951 neonatal risk. This number has decreased from 2015, namely the number Neonatal risk treated was 3,332 cases or 81.3% of the estimated total 4.100 neonatal crosses. Apart from that, in order to reduce the Infant Mortality Rate (IMR). Intensive monitoring by health workers is required 4 times, namely: 1 time at the age of 29 days - 2 months, 1 time at the age of 3 - 5 months, 1 time at the age of 6-8 months, and once at the age of 9 – 11 months. Coverage of Baby Visits in the CitySemarang in 2016 was 26,602 visits, 98.1% of 27,107 babies There is. Compared to 2015, with 26,281 visits or 95.2% of 27,601existing babies, meaning this number has increased. The quality of newborn care also includes an exclusive breastfeeding program. From the results of the study, it was found that there was a fairly high blockage in the supply of non-human resources in Exclusive breastfeeding program from several health centers studied

This is caused by the availability of teaching aids or IEC tools for The exclusive breastfeeding program is not adequate. There is no specific budget provided for the implementation of the Exclusive Breastfeeding Program. Additionally, everyPuskesmas experiences obstacles related to the variable of complete service to mothers to provide exclusive breastfeeding. Monitoring exclusive breastfeeding by health workersonly until postpartum or 3 months after giving birth. After 3 months, no Active monitoring of breastfeeding mothers can be carried out. The mother's excuseMost mothers also do not continue exclusive breastfeeding work in the formal and informal sectors. For mothers who work in the formal sector difficulties in providing exclusive breastfeeding related to the leave period which has endedso the mother has to go to work, and it is a hassle to keep expressing breast milk.

Meanwhile, another reason is the lack of encouragement from the mother's immediate family toprovide exclusive breastfeeding. Complete service coverage is an illustration acceptance of health services provided to the community, after given the first contact, it will continue in accordance with the rules and requirementsfrom patients/community.

This is in line with research on Determinants of Water Giving Behavior Exclusive Mother's Milk for Working Mothers, results of this study Related variableswith exclusive breastfeeding to working mothers is the mother's attitude, availabilityfacilities, and caregiver support. The mother's attitude is the most variable dominant in giving exclusive breastfeeding to working mothers. Semarang City has carried out various program efforts in providing services Baby health includes:

1. Support for PP-ASI
2. Exclusive breastfeeding data collection;
3. IMD data collection;
4. Breastfeeding counseling;
5. Breastfeeding Counselor Training;
6. Formation of a cadre of breastfeeding motivators;
7. Call for the provision of breastfeeding rooms in public service locations;
8. Team coaching at RS/RB/BPM/Puskesmas that loves mothers and babies.

5. Analysis of the coverage and quality of health services for children under five.

Underfive health services according to standards according to the SPM are serviceshealth care provided to children aged 0-59 months and carried out by Midwives and/or Nurses and/or Doctors/DLPs and/or Pediatricians have a Registration Certificate (STR) and it is given at a health facility government and private sector, and UKBM. These services include: Weighingat least 8 times a year, measuring length / height at least 2 times a year, administering vitamin A capsules twice a year and providing complete basic immunization. PWS KIA Semarang City data shows that service results the health of children under five received coverage in 2016 at least 8 times 101,859 toddlers or 93.96% of the total 108,412 toddlers. This figure is experiencedan increase from 2015, namely 76,382 or (90.8%). As for the number of toddlers those weighed this month minus the toddlers weighed this month but did not come in the previous month (D') was 77,759. From these numbers as many as 69,688 (80%) toddlers with increased weight. Meanwhile, those who experience BGMwas 1,026 (1.2%). Meanwhile, Semarang City SPM data is related to services toddler health reached 95.01% when compared to the SPM standardnasiolan (100%) has not reached the target.

Several efforts have been carried out in health services toddlers, namely:

1 Monitoring weighing and measuring body length/height at posyandu/health center 2 times a year;
2 Implementation of simultaneous weighing months;
3 Monitoring Nutritional Status (survey);
4 Data collection on toddlers weighed 8 times/year;
5 Giving vitamin A in February & August;
6 Development of posyandu and posyandu cadres;
7 Procurement of posyandu kits (anthropometric tools);
8 Procurement of Baby & Toddler cohorts;
9 Nutrition education & counseling for toddlers
10 Increasing the abilities and skills of community health center officers
11 Increasing the abilities and skills of health cadres
12 Providing complete basic immunization.

5. Analysis of the coverage and quality of health services for school-aged childrenbase.

Primary education age health services are health screening given to children of primary education age, at least once in grade 1 and class 7 conducted by the Community Health Center. Effort programs carried out in the City The presentation includes: Data collection on elementary age children in class 1 and class 7

1. Pre-screening: a) informed consent, b) distribution of my health report bookand explanation of use
2. Implementation of health screening: assessment of dental and oral health
3. Implementation of health screening follow-up results: a) referral ifrequired b) KIE
4. Recording and reporting

There are still problems with health services for school-age children where the screening form does not yet contain a vital sign assessment. In health services

Productive age is still hampered by unfulfilled/lack of health facilities able to screen all targets.Based on the results of a study of maternal mortality rates in Semarang City in 2017 It is known that the highest presentation of maternal death cases occurs in productive age, namelyat the age of 20-35 years 66.7%. Furthermore, looking at the level of education, The highest percentage of maternal death cases occurred in mothers with higher levels of education middle, namely 51.4%. So that health services at school age too becomes important in the context of health screening and the pre-pregnancy period.

CHAPTER V
MATERNAL MORTALITY REDUCTION PROGRAM POLICY

A. Global Policy in Sustainability Development Goals (SDGs) 2030

Currently there is a post-MDGs global commitment, namely Sustainable Development Goals (SDGs) which have 17 goals, 169 targets and 300 indicators. In general, those related to health and gender equality can be found in goal 3, goal 5 and goal 6. In goal 3: Ensure healthy living and promote a good life for all ages. The 5th SDGs goal, namely achieve gender equality and empower all women and girls. Meanwhile, the goal of SDGs 6 is to ensure availability and sustainability water and sanitation management for all.

In the principles of implementing SDGs, one of them is No One Left Behind means that it must provide benefits for all, especially the vulnerable, and implementation involving all stakeholders. The third goal is: Ensure a healthy and encouraging life prosperity for all people at all ages, namely by 2030 with the target:

1. Reduce MMR to below 70 per 100,000 KH.
2. End preventable infant and toddler deaths, by reducing the Neonatal Mortality Rate to 12 per 1,000 KH and Under-five mortality rate 25 per 1,000 KH;
3. End the epidemics of AIDS, tuberculosis, malaria and other tropical diseases neglected, as well as fighting hepatitis, waterborne diseases and diseases other infectious
4. Reduce by 1/3 premature deaths due to non-communicable diseases through prevention and treatment, and promoting health and mental wellbeing;
5. Strengthen substance abuse prevention and treatment, incl dangerous drug and alcohol abuse;
6. Halve the global number of deaths and injuries due to accidents traffic
7. Ensure universal access to sexual and health services reproduction
8. Achieve universal health coverage, including risk protection finances, access to quality basic health services and access to basic medicines and vaccines that are safe, effective and of good quality for everyone
9. Substantially reduce mortality and morbidity due to compounds dangerous as well as contamination and pollution of air, water and land.

Target number 1, 2 in Semarang City is still an ongoing effort supported by the SANPIISAN program, regional regulations on the safety of mothers and children in the city Semarang Number 5 in 2015. In achievement target number 7, in Semarang City strive to provide family planning services with a motorbike for service Free birth control implant. On target number 8, there have been efforts through the SANPIISAN program The city of Semarang with the Universal Health Coverage program is comprehensive health insurance program for working residents of Semarang City the same as BPJS Health, including providing maternity or health services pregnant mother. Apart from that, JAMPERSAL also provides the budget used for accommodation costs for birth waiting homes, examination services, care and delivery assistance for poor pregnant women, mobility rental costs (already via great ambulance), and transportation of delivery health workers (no utilized).

B. Central Government Policy in Efforts to Reduce Maternal Mortality Rates

Health development in the 2015-2019 period is the Indonesia Program Healthy with the target of improving the health status and nutritional status of the community through supported health and community empowerment efforts with financial protection and equitable health services. Main target The 2015-2019 RPJMN are: (1) improving the health and nutritional status of mothers and children (2) increased disease control; (3) increasing access and quality basic and referral health services, especially in remote, disadvantaged and remote areas borders; (4) increasing universal health service coverage through Cards. Healthy Indonesia and the quality of SJSN Health management, (5) fulfillments the need for health workers, medicines and vaccines; and (6) increase responsiveness health system

Maternal and child health is a priority for improving health status in Indonesia Indonesia. As in the health indicators to be achieved by The Indonesian Ministry of Health, among other things, stated:

1. Reducing the maternal mortality rate from 359 per 100,00 live births (SP 2010), 346 to 306 per 100,000 live births (2012 IDHS).
2. Reducing the infant mortality rate from 32 to 24 per 1,000 births life
3. Reducing the percentage of LBW from 10.2% to 8%.
4. Increased efforts to increase health promotion and empowerment community, as well as financing promotive and preventive activities

Strategies for implementing the 3 main pillars (main strategy) include: 1) pillars The healthy paradigm is carried out with a strategy of mainstreaming health within development, strengthening promotive preventive and community empowerment; 2) pillar. Strengthening health services is carried out with strategies to increase access health services, optimizing the referral system and improving the quality of services health, using a continuum of care and intervention-based approach health risks; 3) Meanwhile, the pillar of national health insurance is carried out with strategies for expanding targets and benefits as well as quality control and cost control. The importance of a family approach is also mandated in the Ministry's Strategic Plan Health 2015 – 2019. In the Strategic Plan it is stated that one of the references The policy direction of the Ministry of Health is the implementation of a service approach integrated and sustainable health (continuum of care). This matter This means that health services must be provided at all stages of the cycle human life (life cycle), from being in the womb, until birth as a baby, grow into toddlers, school age children, teenagers, young adults (age productive), and finally become old adults or old age (see figure 6). For can provide sustainable health services to all stage of the human life cycle, the focus of health services must be on the family. The provision of health services to individuals must be seen and treated as part of this family.

In order to support the strategy that has been determined, in the health sector mothers and children, the Ministry of Health has also formulated a strategic plan The National Maternal Health Action (RAN Maternal) for 2016-2030 includes.

1) Increase universal coverage of maternal health services and address them coverage disparities
2) Improving the quality of maternal health services and referrals in particular emergency handling
3) Strengthen the continuity and integration of maternal health services
4) Build collaboration with related sectors/parties and involve roles and active in the community.

C. Policy Regarding Health Insurance in Presidential Regulation of the Republic of Indonesia Number 82 of 2018

Health Insurance is a guarantee in the form of health protection so that Participants get the benefits of health maintenance and internal protection meet the basic health needs provided to everyone who has pay the Health Insurance Contribution or the Health Insurance Contribution is paid by Central Government or Regional Government. Mandate of Presidential Regulation of the Republic of Indonesia Number 82 of 2018 in article 84 paragraph 1 and 2 mandates that in the context of policy making in the health sector in the Regions, BPJS Health is obliged to provide data and information to the Head Regency/city Health Service and Head of the local provincial Health Service periodically every 3 (three) months. Data and information as intended includes:

a. number of Health Facilities collaborating with BPJS Health;
b. membership;
c. number of visits to Health Facilities
d. type of disease; and
e. amount of payment and/or claim.

In the Guidelines for implementing the Healthy Indonesia Program with Family Approach in the Minister of Health of the Republic of Indonesia Number 39 2016 which consists of three main pillars, one of which is related implementation of national health insurance (JKN) which applies the approach integrated and sustainable health services (continuum of care) with a family approach. This means that health services must carried out on all stages of the human life cycle , since childhood in the womb, until birth as a baby, growing into a toddler, a child school, adolescence, young adulthood (productive age), and finally old adulthood or old age elderly. To be able to provide sustainable health services towards all stages of the human life cycle, the focus of health services must be family. The provision of health services to individuals must be seen and treated as part of his family. In the context of implementing the Program It has been agreed that there are twelve main indicators for Healthy Indonesia the health status of a family through PIS-PK data collection which describes Healthy Family Indicators with 12 indicators. Data and information mandated in Presidential Decree Number 82 of 2018, it can be integrated with data healthy family indicators in PIS-PK to be developed into Integrated and sustainable KIA Data Center for all groups. The targets in the Continuum of Care concept start from pregnant women, mothers giving birth, mothers postpartum, infants, toddlers, elementary school age children, productive age and elderly

D. Semarang City Regional Government Policy in Efforts to Reduce Numbers Mother's Death

The mandate of Law 23 of 2014 in article 11 states that Affairs concurrent government as intended in Article 9 paragraph (3) which becomes Regional authority consists of Mandatory Government Affairs and Affairs Elective Government. Furthermore, in Government Regulation number 38 of the year 2007, Article 7 (1) Obligatory affairs as intended in Article 6 paragraph (2) are government affairs that must be carried out by the provincial regional government and district/city regional government, relating to basic services. There are 26 mandatory affairs that must be carried out by regional governments provincial and district/city regional governments and one of them is health.

In line with this mandate, the City of Semarang has regulations Regional Mayor of Semarang Number 2 of 2015 concerning Maternal Safety and Children is a form of policy that focuses on efforts to reduce numbers maternal, infant and toddler deaths. Mother and Child Safety through an approach Comprehensive and continuous service is the main factor for family and community life, because of the level of welfare and Family health can be measured from maternal mortality rates, infant mortality rates and toddlers and nutritional problems. This regulation also aims to gather joint attention and commitment from all parties in support achieving a reduction in the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). The objectives of providing maternal and child safety services are:

a. Achievement of increased access to maternal and child safety services;
b. Realizing improvements in the quality of maternal and child health services for achieve an increase in the level of public health;
c. There has been a change in the behavior of the community, health workers, local government and the private sector in providing more maternal and child health services optimal;
d. Creation of cooperation between all stakeholders in reducing maternal and child morbidity and/or mortality rates through a service approach comprehensive and continuous;
e. Achieved increased access to information about Maternal Safety services and child; and
f. Availability of the required resources effectively and efficiently for Mother and Child Safety services.

The regional regulation on the safety of mothers and children in Semarang City refers to the concept Healthy Indonesia Program with a Family Approach through approach a comprehensive and continuous continuum of care at all stages human life cycle (life cycle), from in the womb, until birth being a baby, growing into a toddler, school age child, teenager, young adult (productive age), and finally become old adults or old age. This is in line with the policy of the Governor of Central Java through the Program Jateng Gayeng Nginceng Pregnant Woman (5 NG) Save Mother and Child starting from the pre-pregnancy phase, pregnancy phase, labor phase up to postpartum phase.

Apart from that, local government policies through the Semarang City RPJMD with the RPJMD Vision, namely Semarang, a Great City of Trade and Services Towards a More Prosperous Society. The mission of the RPJMD is to make life a reality a cultured and quality society with the aim of increasing the RPJMD Quality and cultured Human Resources. Targets in the RPJMD Increasing educational accessibility and public health status. Following synchronize the Semarang City RPJMD with health services in each target groups in accordance with the SPM and Healthy Indonesia Program Approach Family.

Table 9. Synchronization of the Semarang City RPJMD with the Strategic Plan of the Semarang

City Health Service

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
Maternal Health Services Pregnant Blockage: ANC examination that does not meet standards 10 T, availability of midwives Kit drug availability medication (pre-eclampsia and hypertension), standardized assistance for pregnant women, difficulty reaching the upper middle class, empowerment of less active FKK.	Necessary programs reinforcement, namely: 1. Make an effort You are welcome Natal Care (ANC) integrated. 2. Improve preparation and use of books KIA. (KIA book no given by the doctor specialist)	Improving the quality of recording, reporting, data collection on pregnant women through Gasurkes KIA and empowering FKK, Dawis and PKK.	Quality Improvement Health services Improved health information and resources Fulfillment basis for the poor (increased health insurance)	Strengthening of pillars: Dinas Health at Levels Community (UHC program for pregnancy checks, Assistance for Pregnant Women and Postpartum Mothers by Gasurkes KIA Optimizing mother's assistance Pregnant via PKK, Dawis and naturist). Logging Optimization reporting by Gasurkes KIA via Sigaspol.

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
Maternal Health Services Obstacles: delivery services that do not meet standards, limited facilities and infrastructure to support community health center facilitation PONED, a supporting facility for free family planning services in ensuring the distribution of contraceptives, the use of high-speed ambulances is still low and response time has not yet been achieved Home use Waiting for births is still low, PONED Health Center is not yet *Lean* / found *waste*.	Necessary programs reinforcement, namely: 1. Increase the number Waiting House Birth (RTK). 2. Improve delivery in a facility health. (limited means infrastructure and manpower trained midwife) 3. Organize Initiation counseling Early Breastfeeding and Postpartum birth control.	Mother's assistance with normal delivery in health facilities standard basis. Maternal referral service Pregnancy is risky high is referred to the House Sick and monitored "hit" by the PKK/ Dasa Homestead and Public.	Quality Improvement Health services Improved health information and resources Fulfillment basis for the poor (increased health insurance)	1. Health Service in Community Level (utilization of the program UHC, utilization jampersal, Ambulance Great Ambulance on Standby) 2. Health Service with Professional Organization (in collaboration with IBI through midwife meetings Independent Practice and give punishment to the BPM that carry out services not up to standard competence as well collaboration with POGI in giving

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
				coaching for doctors Obsgyn specialist.) 3. Health Service with Community Health Center (Dinas Health does facilitative supervision, development of community health centers PONED by RS PONEK which is done every 3 month and construction to the coordinating midwife) **4.** Health Service with Hospital (MOU / Mutual agreement with 18 RSU Directors and RSB in 2012 in decreasing numbers maternal death, MOU RS

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
				PONEK, clinical assessment PONEK Hospital by EMAS and house construction disease).
Maternal Health Services Postpartum Blockages in: non-HR supply in drug procurement (eclampsia and hypertension), human resource supply (limited number of midwives)access to services (coverage of health facilities services is very wide), busy working mothers, participation of mothers who want to be accompanied is still low, service There are still postpartum services that are not up to standard		Improved postnatal nursing care by doctors/ midwives/nurses. Maternal health monitoring postpartum by PKK/Dasa Guesthouse and Community. Cross-sector collaboration with universities with One Student One Client (OSOC) in monitoring and accompanying postpartum mothers	Quality Improvement Health services	Strengthening pillars: **1.** Health Service at Level Community (Assistance Postpartum Mothers by Gasurkes KIA) **2.** Health Service with Professional Organization (in collaboration with IBI through midwife meetings Independent Practice and give punishment to the BPM that carry out services not up to standard

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
				competence
Baby Health Services newborns and treatment Neonatal complications Blockages in: exclusive breast milk services, namely non-supply Human resources have limited tools demonstrated during counseling, in the variable of complete service to mothers, namely limited monitoring only until the postpartum period (babies aged 3 months), difficulties in continuous monitoring due to the mother's busy work schedule	(1) Providing guarantees for quality of visits complete newborn. (2) Organizing Breast Milk counseling (Exclusive breastfeeding. (3) Organizing post family planning services labor. (4) Organizing giving activities Complementary Foods breastfeeding (MP ASI).	Postpartum Phase: Recording and monitor and baby up to the first 1000 days Birth. System reporting melalui SIKIB (System case mapping information maternal and infant mortality).	Quality Improvement Health services Improved health information and resources Fulfillment basis for the poor (increased health insurance)	Strengthening the 4 pillars of friends at the community level to support postpartum mothers, including babies.
Health services news Problems were found in the rate of malnutrition and	(1) Doing revitalization of Posyandu. (2) Strengthen		Quality Improvement Health services	Health Department with Professional Organizations (in collaboration with IBI through Midwife meetings

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
less and the coverage of posyandu arrivals	Pokjanal institutional Integrated Healthcare Center. (3) Improve KMS transformation to in the KIA Book. (4) Strengthening cadres Integrated Healthcare Center. (5) Organizing Feeding Additional (PMT) news			Independent Practice and provide punishment to BPM who carry out services that do not meet competency standards
Primary school age Health Services Blockage on: non-HR supplies, namely the screening form without vital sign assessment,	1. Do Business revitalization School Health (DOOR). 2. Strengthen Team institutional UKS Supervisor.	Pre-pregnancy phase: encourage the minimum age of compulsory education to be 12 years	Increasing educational accessibility and public health status	

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
Not yet inadequate/lack of health facilities capable of screening all targets.	3. Organize Child Nutrition Program Sekolah (OCCASION). 4. Develop use of report cards health. 5. Strengthen human resources Public health center.			
Productive Age Health Services Blockage in : program Pre-Wedding KIE for candidates bride and groom in the City Semarang discovered	1. Organize giving tablets Add Blood (TTD). 2. Organize education reproduction health at school	Pre-pregnancy phase: Increasing the role of the education service in implementing reproductive health Role enhancement Ministry of Religion, Department Health in postponing the age of marriage in the regulations		

SPM indicator	Indonesian Program Healthy Approach Family (priority program)	Program 5NG	RPJMD Semarang City GIAT Program	
	7. Organize providing immunization and TTD. 8. Organize family planning counseling pre-wedding. 9. Organize nutritional counseling balanced			
Health services Elderly Blockages in: access, reaching targets due to sugar checks, cholest, ECG for screening not being covered BPJS, elderly people's accessibility to health facilities is not yet good			Quality Improvement Health services	

A. Policy Direction and Road Map Strategy for Efforts to Reduce Maternal Mortality Rates 2019 to 2023

The RPJMD's vision is that Semarang will be a great city for trade and services Increasingly Prosperous Society. The mission of the RPJMD is to make life a reality a cultured and quality society with the aim of increasing the RPJMD Quality and cultured Human Resources. Targets in the RPJMD Increasing educational accessibility and public health status

Table 10. Road Map Strategy for Efforts to Reduce Maternal Mortality Rates

Service based *Approach Continuum of Care* (long-term)	2019	2020	Year 2021	Year 2022	Year 2023
Enhancer n health services for pregnant women standardized one	1. 100% Puskesmas & its network able to provide *Ante Natal Care* (ANC) for early detection all risk factors especially in triple elimination. • 100% of pregnant women are tested for HIV • 80% Pregnant women Syphilis test • 90% of pregnant women tested for Hepatitis • 90% of pregnant women who are (+) adhere to drinking NUMBER	1. 100% Community Health Centers & their networks are able to provide *Ante Natal Care* (ANC) for early detection of all risk factors especially in triple elimination. • 100% of pregnant women are tested for HIV • 100% Pregnant women Syphilis test • 100% pregnant women hepatitis test • 100% pregnant women who are (+) compliant with drinking NUMBER	1. 100% Puskesmas & its network able to provide *Ante Natal Care* (ANC) for early detection all risk factors especially in triple elimination. • 100% of pregnant women are tested for HIV • 100% Pregnant Women Test for Syphilis • 100% pregnant women tested for Hepatitis • 100% of pregnant women who are (+) adhere to taking ARVs	1. 100% Puskesmas & its network able to provide *Ante Natal Care* (ANC) for early detection all risk factors especially in triple elimination. • 100% of pregnant women are tested for HIV • 100% Pregnant women Syphilis test • 100% pregnant women tested for Hepatitis • 100% pregnant women who are (+) compliant with drinking NUMBER	Defend and achieving targets for pregnant women's health services for early detection of risk factors, especially in triple elimination efforts through ANC quality integrated
	2. Coverage of health services for pregnant women (Q4 Visit) 100%	2. Coverage of health services for pregnant women (Q4 Visit) 100%	2. Coverage of health services for pregnant women (K4 Visit) 100 %	2. Coverage of health services for pregnant women (K4 Visit) 100 %	
	3. Strengthening cross-sector cooperation within monitoring and construction Midwife HR Which	3. Quality improvement recording, reporting, data collection on pregnant women through Gasurkes KIA and	3. Improving the quality of facilities and standardized supporting infrastructure. (procurement of medicines, provision of KIA books)	3. Guarantee the quality of standardized ANC services, guarantee the quality of structured recording and reporting and guarantee the quality of facilities and equipment	

Service based ***Approach Continuum*** **of Care (long-term)**	**2019**	**2020**	**Year 2021**	**Year 2022**	**Year 2023**
	quality and standardized	increased empowerment n society FKK, Dawis and PKK 4. Developer a data center for services for pregnant women integrated and sustainable ungan based on information data from BPJS Health and PIS-PK		infrastructure standard support	
Enhancer n quality of standardized maternity services and services quality birth control	1. 50% PONED Community Health Centers and PONEK Hospitals able to provide service online _ *site* and implementing *lean health care management*	1. 75% of PONED Community Health Centers and PONEK Hospitals able to provide service on *site* and implementing *lean health care management*	1. 100% PONED Community Health Center and PONEK Hospital able to provide service on *site* and implementing *lean health care management*	1. 100% PONED Community Health Center and PONEK Hospital able to provide service on *site* and implementing *lean health care management*	Defend and achieving coverage & quality of maternal health services according to standards in all Public health center PONED and PONEK HOSPITAL

management	management	management	management
	2. Quality improvement means patient referral transportation and increased utilization and provision of Great Ambulances and Standby Ambulances.	2. Quality improvement companion n and utilization of home facilities Wait Birth	2. Guarantee stop maternity services, means supporting infrastructure, Trained human resources, assistance n continuous childbirth young
2. Coverage of maternal health services 100%	3. Coverage of maternal health services 100%	3. Coverage of maternal health services 100%	3. Coverage of maternal health services 100%
3. Strengthening cross-sector collaboration in monitoring and developing human resources for midwives	4. Increase in family planning acceptors and supplies means supporting the distribution of contraceptives		

Service based *Approach Continuum of Care* (long-term)	2019	2020	Year 2021	Year 2022	Year 2023
	quality and standard				
	4. Improvement of facilities and facilities infrastructure support in health service facilities PONED and PONEK the standardized one.	5. Development of a maternal birth data center integrated and sustainable bro, based on information data from BPJS Health and PIS-PK			
Enhancer n quality of service for postpartum mothers is standardized and sustainable an	1. 50% Community Health Center able to provide nursing care and emergency postpartum response/m Postpartum hope meets standards and is sustainable n.	1. 75% Community Health Centers able to provide nursing care and emergency postpartum/mas response a postpartum /according to standards and sustainable	100% Public health center able to provide Nursing care and emergency response after delivery/ postpartum period are according to standards and are sustainable	100% Public health center able to provide Nursing care and emergency response after delivery/ postpartum period are according to standards and are sustainable	Achieve appropriate postpartum maternal health services SPM target is 100%

	2. Improved quality of monitoring and companion and postpartum maternal health at the community level through PKK/Dawis and Public	2. Development of the KIA data center integrated and sustainable bro, based on information data from BPJS Health and PIS-PK	Repair quality provision of facilities and standardized postpartum mother service infrastructure (procurement of medicines emergency, midwife kit)	Quality assurance of human resources, facilities and supporting infrastructure, medical supplies, and sustainable care for postpartum mothers	
Enhancer n the quality of newborn health services meets standards	100% Public health center able to give tests HIV in 70% of babies who have mothers with HIV (+) 100% Public health center able to provide	1. 100% Community Health Center able to give tests HIV in 90% of babies who have mothers with HIV (+) 100% Community Health Center able to provide visit	100% Public health center able to give tests HIV in 100% of babies who have mothers with HIV (+) 100% Public health center able to provide	100% Public health center able to give tests HIV in 100% of babies who have mothers with HIV (+) 100% Public health center able to provide	memeprtahank and achieving newborn health services according to targets SPM is 100%

Service based *Approach Continuum of Care* (long-term)	2019	2020	Year 2021	Year 2022	Year 2023
	complete neonatal visit according to quantity target 100% Public health center able to support the achievement of breast milk Exclusive and IMD compliant target.	complete newborn according to quantity target 100% Community Health Center capable supports the achievement of exclusive breastfeeding and IMD according to targets.	complete neonatal visit according to quantity target 100% Public health center able to support the achievement of breast milk Exclusive and IMD compliant target.	complete neonatal visit according to quantity target 100% Public health center able to support the achievement of breast milk Exclusive and IMD compliant target.	
		2. Quality improvement promotion and provision means program supporting infrastructure exclusive breastfeeding 3. Development of an integrated and sustainable KIA data center bro, based on information data from BPJS Health and PIS-PK	2. Strengthening cross-collaboration inner sector improving the quality of human resources Health trained in appropriate management of newborn complications with standards.	2. HR Quality Assurance, supporting infrastructure and cross-sector collaboration.	

Enhancer n standardized quality of toddler health services	50% of Community Health Centers have attempted to implement it MTBS according to standards	75% of Community Health Centers have attempted to implement IMCI according to standards	100% The Community Health Center has made efforts to implement it MTBS according to standards	100% The Community Health Center has made efforts to implement it MTBS according to standards	Defend and achieving health services for children under five according to the SPM target of 100%
	Coverage of toddler health services reaches 100%	Coverage of toddler health services reaches 100%	Coverage of toddler health services reaches 100%	Coverage of toddler health services reaches 100%	
	Increased revitalization Posyandu and guarantee quality Giving Food Additional (PMT) News.	2. Strengthening the Posyandu Pokjanal institution 3. Developer an integrated and sustainable toddler health data center thinking based on information data	2. Increasing the transformation of KMS into KIA Books and strengthening Posyandu cadres.	2, Guaranteeing the quality of standardized posyandur services, PMT quality Toddlers, cadre empowerment and institutional posyandu pokjanal.	

Service based *Approach Continuum of Care* (long-term)	2019	2020	Year 2021	Year 2022	Year 2023
		from BPJS Health and PIS-PK			
Enhancer n quality Service Health in the elementary school age group	1. 100% of elementary schools can provide health screening or screening for students quality and according to standards	1. 100% of elementary schools can provide health screening or screening for students quality and according to standards	1. 100% of elementary schools can provide health screening or screening for students quality and according to standards	1. 100% of elementary schools can provide health screening or screening for students quality and according to standards	Defend and achieving quality Service Health in the elementary school age group 100%
	2. Repair procurement of human resources and facilities infrastructure supporting health screening	2. Development of a health data center for primary school age integrated and sustainable bro, based on information data from BPJS Health and PIS-PK	2. Revitalization of the School Health Business (UKS) and institutional strengthening of the UKS Advisory Team	2. The maintainer n Program Secret School children (PROGAS) and development use of health reports	

Enhancer n quality Service Health in the productive age group	1. 100% Community Health Center and the network is able to organize and youth care health services (PKPR) regularly quality	1. 100% Community Health Center able to maintain It's a youth health service (PKPR) quality and nutritional counseling for young women	1. 100% Community Health Center able to organize and youth care health services (PKPR) quality and nutritional counseling for young women and pre-marital counseling	Striving to postpone the age of marriage and counseling on balanced nutrition.	Achieving quality Service Health in the productive age group 100%
	2. Increasing the availability of the number of Community Health Centers that provide it and youth care health services (PKPR)	2. Development of a health data center integrated and sustainable youth & productive age bro, based on information data from BPJS Health and PIS-PK	2. Improve procurement of human resources and facilities supporting infrastructure nutritional counseling and premarital counseling programs		
Enhancer n quality of health services on	1. 100% of Community Health Centers and their networks are capable of screening	1,100% of Community Health Centers and their networks are capable of screening	1,100% of Community Health Centers and their networks are capable of screening	1,100% of Community Health Centers and their networks are capable of screening	Defend and achieving quality Service Health on

Service based *Approach Continuum of Care* (long-term)	2019	2020	Year 2021	Year 2022	Year 2023
elderly age group	health for elderly mother	quality health for elderly mothers	quality health and interventions for elderly mothers	health and interventions for quality elderly mothers	mothers in the elderly age group 100%
	2. The percentage of health services for the elderly	2. The percentage of health services for the elderly reaches 100%	2. The percentage of health services for the elderly reaches 100%	2. The percentage of health services for the elderly reaches 100%	
	reaches 100% 3. Improve the quality of posyandu services for the elderly infrastructure supporting and empowering posyandu cadres	3. Development of an integrated and sustainable health data center for elderly mothers bro, based on information data from BPJS Health and PIS-PK	3. HR quality assurance standardized and sustainable elderly health support infrastructure	3. Strengthening cross-sector collaboration in increasing the use of elderly posyandu and health screening	

A. Estimated Funding Needs for Policy Strategy Road Map for Efforts to Reduce Maternal Mortality Rates from 2019 to 2023

To achieve the objectives of each Strategy and Program, each Strategy and Program is formulated into a number of activities. Then a number of activities are determined on the amount of costs and required and then a draft of funding and financing needs is prepared, as a step in using resources as input to produce an output that is in line with the objectives of the Strategy and Program. Based on the calculation of the amount needed for funding the Strategy for Reducing Maternal Mortality Rates from 2019 to 2023; So the indicative funding plan for the Strategy is as follows:

Strategy	2019	2020	Year 2021	Year 2022	Year 2023
Enhancement Service Maternal Health Standardized pregnancy Enhancement Quality Mother's Service Standardized maternity and Quality family planning services Enhancement Quality Mother's Service Standardized and sustainable postpartum	Rp8.863.155.500	Rp9.632.029.500	Rp9.912.544.500	Rp10.199.351.750	Rp10.473.577.500
Enhancement Service Health New Baby Standard birth Enhancement Quality Service Health Standardized toddler	Rp1.319.481.250	Rp1.368.786.750	Rp1.424.421.875	Rp1.502.765.000	Rp1.585.417.000
Enhancement Quality Service Health Mothers/ Women in the group School Age Base	Rp1.258.648.750	Rp1.303.606.500	Rp1.356.592.250	Rp1.431.204.750	Rp1.509.921.000
Enhancement Quality Service Health Mothers/ Women in the group Productive age	Rp1.597.947.000	Rp1.603.970.750	Rp1.710.903.000	Rp1.811.543.250	Rp1.924.764.750

Strategy	2019	2020	Year 2021	Year 2022	Year 2023
Enhancement Quality Service Health Mothers/ Women in the group Elderly	Rp1.358.255.000	Rp1.363.375.000	Rp1.454.267.500	Rp1.539.811.750	Rp1.636.050.000
Total Estimation Plan Indicative Need Days	**Rp14.395.487.500**	**Rp15.271.768.500**	**Rp15.858.729.125**	**Rp16.484.676.500**	**Rp17.129.730.250**

Source: Semarang City Health Service Strategic Plan 2016-2021 and Semarang City RPJMD 2016-2021 (Processed data)