



Editorial



Maternal Mortality in Indonesia, Ask for Help

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INTRODUCTION

Maternal mortality rate (MMR) consistently becomes a hot topic from day to day because there isn't a bright hope or the best exit door. Definition of maternal death according to World Health Organization (WHO) is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes [1]. The amount of maternal death related to pregnancy has constantly been escalating from day to day since many decades ago. In the event of discussion at the Health Department of East Java Province in November ago, the data was alarming about a great problem related to maternal death in Indonesia, as shown in Fig. 1 [2].

From this maternal death absolute number, it appears that the provinces of East Java, Central Java, West Java, and Banten are the top four, with very high maternal death numbers and significantly different from those of the other provinces. The location of this province is the island of Java, known for its dense population, strong economic activity, competitive currency market, better facilities for education and transportation, and superior hard and soft infrastructure. Districts of Serang, Bogor, Garut, Surabaya, Karawang, Jember, Lebak, Malang, Bandung and Tasikmalaya are

modern districts with better life facilities but the number of maternal death in the top 10. This is the first paradox.

The second paradox is in terms of the number of doctors, where west Java has the most doctors (21.454), followed by east Java (15.728), Central Java (14.064), Banten (6.847), and north Sumatra (8.491). In contrast, there are 570 specialists in obstetrics and gynaecology in East Java, 642 specialists in Obstetrics and Gynaecology in west Java, 460 specialists in central Java, 219 specialists in Banten, and 288 specialists in North Sumatra [3,4]. Additionally, there is the highest number of midwives and nurses in Java. Given the abundance of local general practitioners and specialists in obstetrics and gynaecology, maternal mortality is still prominent in the area.

The third paradox is the hospital aspect. The total number of hospitals in Indonesia are 3112, most of them located in those provinces. The table below identifies the location of the hospital and shows that maternal death occurs in areas with a large number of hospitals. There were 533 hospitals in East Java, with 2 types A hospitals as top referral hospitals with complete facilities and human resources, 416 hospitals in West Java, 330 hospitals in Central Java, 234 hospitals in North Sumatra, and 115 hospitals in Banten [4,5]. A higher number of hospitals having no relationship with maternal death, a high number of hospitals a high number of maternal death, where ideally, a high number of hospitals will slow the rate of maternal death.

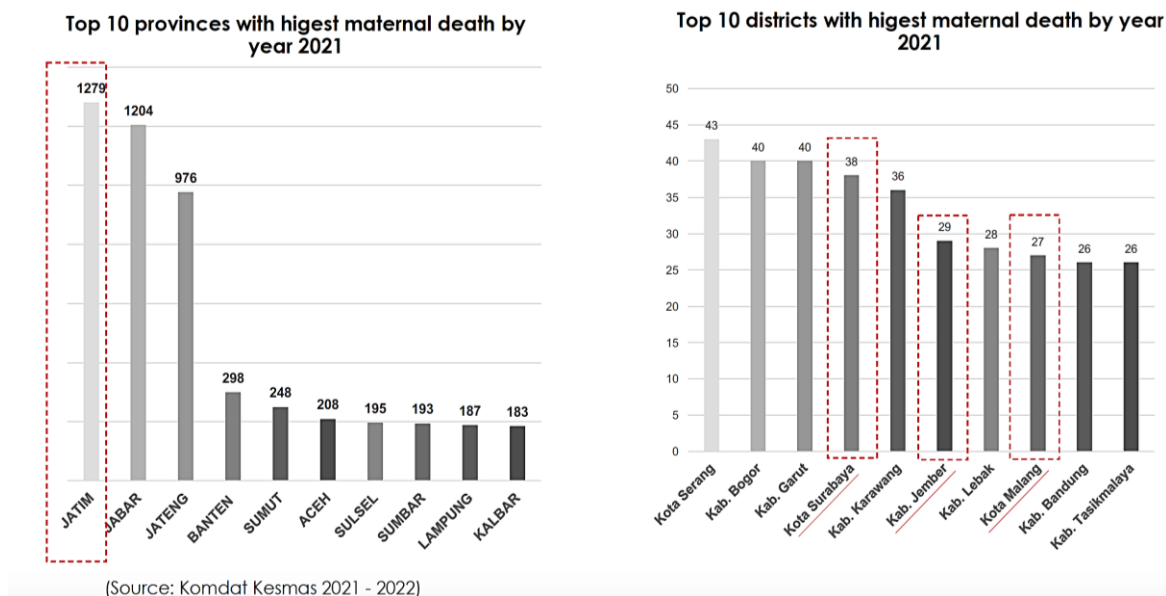


Fig. 1. Maternal Death in Indonesia by Year 2021 Based on Provinces and Districts

The fourth paradox is related to the primary health centre. Most primary health centres are located in west Java, East Java, central Java, Banten, North Sumatra and the rest in other provinces. The gap in the total number is relatively high. West Java had 1053 units of primary health centres, the highest number of other provinces. East Java Province had 968 units, Central Java had 878 units, North Sumatra had 608 units, South Sulawesi had 461 units, then Papua provinces had 428 units. The primary clinic, the first place when patients come and ask for treatment, is also denser in Java and north Sumatra, but the data speak that maternal death has a prominent number in those provinces [4].

Maternal deaths are difficult to record, even in nations with sophisticated statistical systems. Some of these challenges stem from the very nature of maternal mortality, which is prone to underreporting due to incorrect cause classification, sensitivity in the case of specific conditions such as induced abortion, and the absence of a diagnosis or pregnancy declaration. The inadequacies of routine reporting methods and the size of the sample sizes required to get current estimates are also sources of further measurement challenges. Unsurprisingly, the poorest nations suffer the most from a severe lack of accurate maternal mortality data, with some having to rely exclusively on model-based estimates [6].

Strong health systems, particularly in the poorest nations in sub-Saharan Africa and south Asia, will be necessary to ensure high coverage of midwifery services and timely and professional hospital care, which will eventually be necessary for progress. The ongoing focus

on regional, geographic, economic, and social variations in maternal mortality within populations have frequently resulted in a neglect of global variations and maternal health policies. In order to evaluate governments' accountability for lowering this most fundamental of inequities—maternal mortality—targeting measures for the most disadvantaged groups also involves focusing on advances in tracking their burden of mortality [6].

The term vision is crucial. In committing to the MDG-5, countries have expressed their goals. However, it is useless unless it is transformed into a precise plan of action. An estimated 10 million women are thought to have perished from maternal causes in the 20 years that international and national campaigning for safe motherhood has existed. Other public health specialists have not been as hesitant to follow up on the rhetoric of advocacy with specific advice on what to do while occasionally skipping over crucial details like how to carry out effective treatments. The extremely safe motherhood community that is so dedicated to advancement has been overly cautious with these concerns in terms of maternal death. But it's enough already. What are we doing if maternal mortality is the prioritized issue? [7]

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