Saving Newborn Lives (SNL)

Progress in newborn health in Indonesia

EnCompass LLC

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Progress in newborn health in Indonesia

This report is part of a special study that consists of two country case studies conducted in Indonesia and Mali, and a synthesis study that draws lessons across the two. All were completed with support from Save the Children's Saving Newborn Lives (SNL) Program.

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Context

Section 01

- Global context for newborn health
- History of newborn health in Indonesia
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Global context for newborn health

Before 2000, newborn health was not a top priority on global or national agendas.

In their efforts to reduce infant and child mortality, many health policymakers were either unaware of the magnitude or severity of neonatal mortality and its contribution to infant mortality rates and under-5 mortality rates, or did not believe that it could be effectively addressed in low-resource settings. Even after the infant mortality rate declined and the neonatal mortality increasing came into focus, many were unaware of effective interventions that could be implemented through lower-level health services and in communities.

The increased attention to infant and child mortality from the Millennium Development Goals (MDGs) highlighted the need to reduce neonatal mortality in order to attain MDG 4. Evidence and guidance for lifesaving interventions for newborns was strengthened and disseminated. Countries began to incorporate specific plans and programs specifically targeting newborns.

From 1990 to 2010, progress in reducing newborn deaths was 40% slower than for post-neonatal deaths, improving only 1.7% per year from 1990 to 2000, and 2.1% per year from 2000 to 2010.

--Lawn 2012

History of newborn health in Indonesia

Indonesia had a big commitment with the MDGs, so there was concern about the stagnant under-5 mortality rate, not only at the Ministry of Health (MOH) but also the Bureau of Planning, which gave money at all levels for training, evaluation, socialization, and equipment. ***-- MOH official***

Newborn health was not a program focus in Indonesia until the late 1990s, when the infant mortality rate declined steeply and the neonatal mortality rate showed only a small decrease.

With the launch of the MDGs, there was interest in decreasing neonatal mortality to achieve MDG 4. Indonesia set its target to decrease the neonatal mortality rate from the 1991 rate of 32 deaths per 1,000 live births to 15 per 1,000 by 2015.

Although an AusAID-funded project included activities related to the first neonatal visit in the late 1990s, the first project that included a significant focus on newborn health was the United State Agency for International Development's (USAID) Healthy Start for Healthy Life in 2000. Active in in four districts, it strengthened the first-week neonatal visit at the community level. Other programs also began to include newborn elements.

In 2005, a national program was begun to teach village midwives to manage birth asphyxia, then the most common cause of newborn mortality.

The Essential Newborn Care (ENC) policy and guidelines following global standards were implemented in 2011.

Activities of SNL in Indonesia (2000–2012)

SNL has supported Indonesia's efforts to improve newborn health by presenting evidence of the extent and causes of the problem, demonstrating feasible solutions, and supporting the MOH to develop policies and strategies. Although Indonesia was not a focus country, it benefitted significantly from SNL's raising awareness about the needs of the newborn and providing inputs during a crucial period.

SNL's activities at the global level have continued to influence Indonesia since the program ended. In response to the global Every Newborn Action Plan, the country developed the Indonesia Newborn Action Plan (INAP), which drew directly from SNL's five key newborn interventions. Stakeholders continue to refer to and have confidence in SNL's technical resources and leadership. The current USAID bilateral program, Expanding Maternal & Neonatal Survival (EMAS), has a newborn component led by Save the Children. Having developed credibility with the MOH through SNL, Save the Children was well-positioned to be the subcontractor for a significant newborn component under EMAS, and could bring in trusted SNL experts as technical advisors.

SNL 1

Managing birth asphyxia in home deliveries, Cirebon, 2000–2005

This project demonstrated that most birth asphyxia cases can be managed by trained village midwives. The neonatal mortality rate was decreased from 13/1,000 live births to 9/1,000 live births. As a result of the study, the MOH declared managing birth asphyxia by village midwives as a national program in 2005. Supportive supervision for newborn care was also developed in this project.

SNL 2

Operations research in Garut district, 2007–2011

This project developed and tested a model of comprehensive ENC, with Kangaroo Mother Care (KMC) implemented in primary health care centers. By the end of the project, the MOH had adapted the ENC module for national implementation.

Birth outcome following newborn resuscitation by village midwife in Cirebon, 2007–2010 (PATH)

This cohort study showed that there were no significant problems in later development among children who had been resuscitated at birth. (Though this project was not directly funded through SNL, it was closely related.)

Purpose of the study

To learn from the experience of Indonesia's efforts to integrate neonatal care into the national health system and study its progress along the Pathway to Effective Coverage

Indonesia was not an SNL focus country, so the program's inputs were limited. However, they helped to catalyze both interest in and solutions to the problem of neonatal mortality. The provision in SNL 3 for a special study to assess the lasting effects of the program's earlier phases presents a rare opportunity to trace their influence and capture the current status of newborn health in Indonesia.

Specific Objectives of the Study:

1. **Identify progress**
2. **Discuss challenges faced in integrating newborn health in Indonesia**
3. **Make recommendations for further improvements**
4. **Identify the contributions of SNL and other actors to ensure continued progress in Indonesia**

Methodology

Section 02

- Study questions
- Methodology

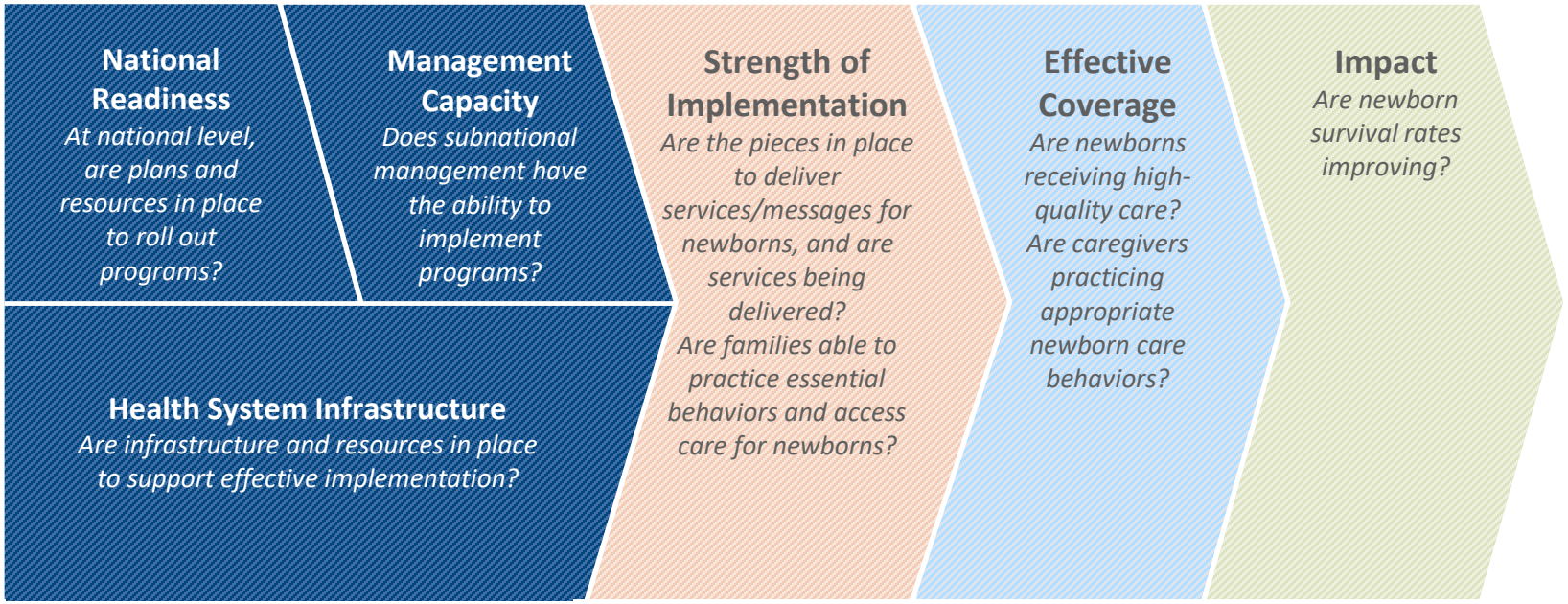
Key study questions

1. **In what ways have countries supported by SNL maintained, increased, or decreased progress for newborn health?**
   a. **Which aspects of progress do stakeholders perceive and value the most?**
2. **What factors have contributed to or inhibited progress in these countries?**
3. **How have SNL's activities at the country or global levels contributed to momentum in the case study countries?**
4. **Where do newborn stakeholders in these countries envision the need for greater progress, and what is required (at country and global levels) to make that progress happen?**

Methodology

Pathway to Effective Coverage at Scale

The Pathway to Effective Coverage at Scale, developed by SNL, was used as a framework for this study. The Pathway allows identification of the key ingredients of success and assessment of the capacity for and degree of implementation of newborn programs. It contains six categories and 42 elements, all of which will be detailed in this report.



Jeremy Shiffman framework

Shiffman's framework provides the means for understanding factors that facilitate or hinder elevation of newborn health issues in a specific context. It complements the Pathway by clarifying why progress in national and subnational readiness and implementation was or was not attained.

Transnational Influence: International agencies' efforts to establish a global norm for the unacceptability of newborn death and the offer of financial and technical resources to address newborn mortality

Domestic Advocacy: Political community cohesion among key stakeholders, presence of champions, credible evidence to demonstrate the problem, focusing events, and clear policy alternatives to reduce newborn mortality

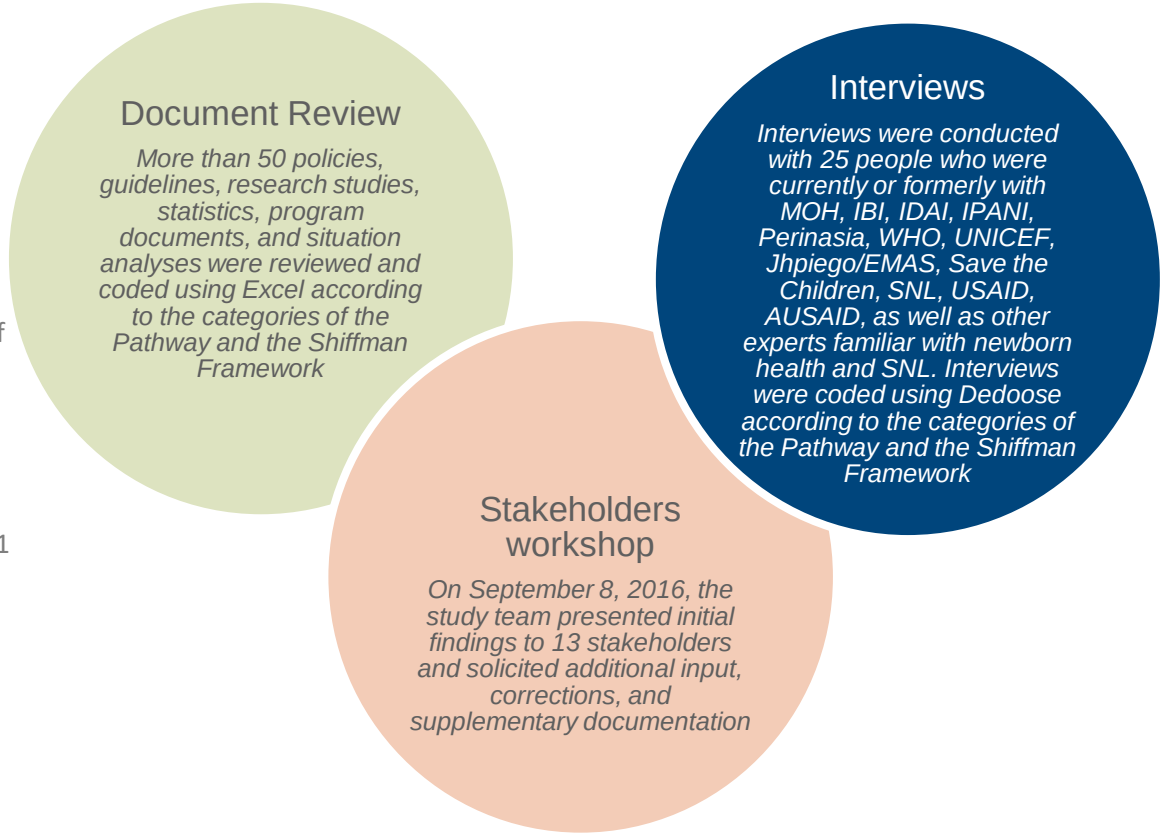
National Political Environment: Political transitions and changes, and competing health priorities

Shiffman, Jeremy et al., Generation of political priority for global health initiatives: a framework and case study of maternal mortality. Lancet . 2007; 370: 1370 - 1379

Data collection and analysis

This study is based on extensive document review, in-depth interviews, and a workshop with key stakeholders.

To assess progress on the Pathway to Effective Coverage, the primary method of data collection was a review of the literature on newborn health in Indonesia. This was supplemented by interviews with people active in newborn health today and/or during the implementation of SNL 1 and 2. The third method of data collection was a group discussion with key stakeholders. The literature review and interviews were iterative, and the group discussion provided validation and correction, further information, and additional documents (see Annex E).



A list of interviewees is in Annex B

Principle data sources

A Situational Analysis on Newborn Health in Indonesia (MOH, 2014)	• Profile of national situation and identified challenges in newborn health • Information gathered from national surveys (i.e., Demographic Health Survey, Basic Health Survey or Riskesdas, Village Potential Survey, Health Facility Surveys) and reviews of government documents (e.g., budget allocations and policy documents)
" …and then she died" Indonesia Maternal Health Assessment (World Bank, 2010)	• National profile and identified challenges in maternal health as the delivery platform into which newborn health care is integrated • Describes additional details on translation of relevant national policies into overall program management and implementation at the subnational level • Presents information on significant challenges in the community on program acceptance and use as identified in several project sites
Indonesia Health Profiles (MOH,2014)	• Provides great detail on newborn health problems, program inputs (materials, workforce, money), logistics, and distribution, design of community structures, program use, and coverage
SNL1 Final Report 2000–2005 (Save the Children, 2006) SNL End of Country Program Report (Save the Children, 2011)	• Implemented in all sub-districts at Cirebon district for SNL 1 and in 10 sub-districts at Garut District for SNL 2 • Provides historical perspectives on newborn health efforts in Indonesia prior to and after SNLs' implementation
EMAS Year 4 Annual Report (Jhpiego, 2015)	• Implemented in 62 districts/cities in six provinces (Banten, Central Java, East Java, North Sumatera, South Sulawesi, and West Java) • Provides the latest information on newborn health efforts as a "continuation" of SNL

Study limitations

Despite some significant limitations, the consistency of the findings among secondary quantitative data sources, review of more recent documents, and interviews and the group discussion, is reassuring regarding the overall accuracy of the main findings.

Data limitations - Many of the quantitative data were quite old (e.g., the World Bank clinical data were from 2010, and the Indonesia Demographic and Health Survey (DHS) were from 2012) and from the national level. Subnational data were generally available only from intervention projects in particular provinces or districts.

For some elements of the Pathway, no data were available. Neither Riskesdas nor the DHS differentiate between public and private sector providers of newborn health services; therefore, although many people obtain services from the private sector, it was not possible to fully assess the status of the those services.

Although we interviewed several representatives from the MOH, we were able to speak to only one person responsible for oversight of service delivery facilities.

Informant (and Interviewer) Bias - Given the lack of objective data and that few people know about newborn health in Indonesia, both the interview subjects and the interviewers were affiliated with current or past newborn projects and had vested interests or views that may have influenced their responses.

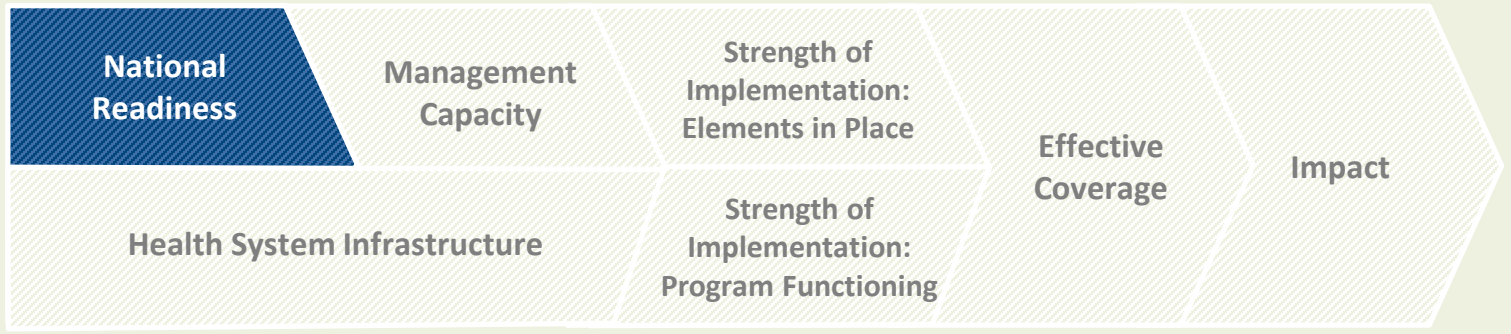
Personnel turnover in government organizations and NGOs - Although we interviewed several people who had been closely involved with SNL and newborn health in previous positions, many informants had been in their positions for a short time and did not have a historical perspective about the trajectory of newborn health in Indonesia or the potential influence of SNL.

Summary of Findings

Section 03

- National readiness
- Management capacity
- System structures
- Program elements in place
- Program functioning
- Effective coverage/impact

1. National Readiness



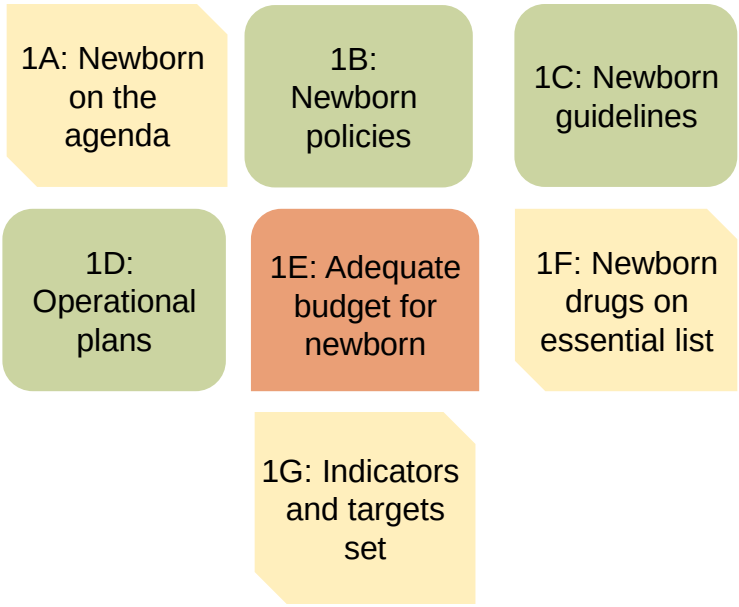
Summary of Findings

National readiness

At the national level, have interventions been integrated into national systems and reflected in policies, plans, and resources?

National readiness assesses the degree to which health systems are prepared to deliver interventions for newborn survival. National readiness includes measures of agenda setting, policy formation, and policy implementation.

Status of National Readiness



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Summary of Findings

1A: Newborn on national agenda with a convening mechanism and a focal person at MOH in place

Newborn health is on the agenda, but some key elements are missing

- SNL 1 and 2 raised awareness in Indonesia's maternal and child health (MCH) community of the needs of newborns as distinct from infants. Even more important was SNL's and others' global-level advocacy during the last decade. Following ENAP, Indonesia developed its own action plan in 2014, which has increased awareness of the needs of newborns beyond those working in MCH.
- There is a focal person for newborn health in the Sub-Directorate for Family Health in the Directorate General of Primary Care, but not one for clinical care of newborns. This is because the Directorate for Clinical Services is divided by type of services (e.g., primary, private, referral), not by the recipient of services.
- There is no effective convening mechanism or advocacy group for newborn health, although the Gerakan Kesehatan Ibu dan Anak is an NGO/INGO group for maternal, newborn, and child health. In addition, the Indonesian Society of Perinatology (Perinasia) is a multi-sector group focused on maternal and newborn health. There is recognition that newborn health would benefit from a working group or subgroup focused on this vulnerable period.

One of greatest contributions of SNL is awareness that newborns exist. Before, the *Bupati* would ask, "What is the difference between a newborn and a baby?" Everyone just ignored newborns; they were very easy to bury, not registered, no permit, etc. But no mother wants to lose her baby after 9 months.

-- Development partner

INAP, Interviews

Summary of Findings

1B: Policies are revised or formulated based on the latest evidence

Policies pertaining to key newborn interventions have generally been based on the latest international evidence. However, comprehensive data on the status and characteristics of maternal and newborn health in Indonesia are lacking and, therefore, the appropriateness of some policies is still uncertain.

Indonesia has implemented numerous policies on newborn health

- All essential newborn interventions are included in INAP, although chlorhexidine is currently only for research purposes.
- Healthy Indonesia is a Presidential priority that includes an infant mortality rate reduction target.
- The national health insurance, Jaminan Kesehatan Nasional, has been revised to cover newborns.
- All hospitals must have comprehensive emergency obstetric care capability to be accredited. UNICEF's Mother Child Friendly Hospital certification includes newborns.
- Now that MOH has reintegrated MCH, the INAP and the Maternal Health Action Plan will be integrated into a single plan.
- A law regarding midwife competence has been drafted but not passed.
- The Indonesia Ministry of National Development Planning requires that there be one comprehensive emergency obstetric care facility and four basic emergency obstetric and newborn care facilities for every 500,000 members of the population.
- The National plan for Maternal and Perinatal Death Review is being developed.
- The Alert Village Program was created to foster collaboration among sectors to empower communities to ensure accessibility of health services.

INAP, MOH documents, Interviews

Summary of Findings

1C: Implementation guidelines, training materials, and standards of care developed

Numerous guidelines, training materials, and standards have been produced at the national level, but operational guidance for actual implementation at the district and lower levels is lacking.

- Guidelines for ENC
- Operational Guideline for Mentoring Management of Clinical Newborn Health
- Standards of care and clinical guidelines for midwives (does not include KMC)
- Inclusion of newborn in Integrated Management of Childhood Illness (IMCI) Guidelines

Care package

- Three pocket books developed and distributed to maternal, newborn, and child health providers on maternal, neonatal, and child health
- Management and operational guidelines for conducting classes for pregnant women
- General guidelines for development of Alert Village Program

- Early initiation of breastfeeding included in the Normal Delivery

1D: National operation plans include services related to newborns

Though operational plans include specific newborn health services, they are incomplete

- Indonesia is rolling out a new national health insurance plan, Jaminan Kesehatan Nasional (JKN), that covers the newborn. However, the role and responsibility of the provincial level is unclear, and MOH does not have the authority to specify implementation at the district level, which is where the planning and budgeting for health occurs.
- INAP omits operational guidance in several areas, including program management (i.e., supportive supervision, governance, and accountability), behavioral change communication (BCC) for community mobilization, and referral.

INAP, MOH Documents, Interviews

Summary of Findings

1E: National budgets updated with sufficient allocation for newborn-related services

The total budget for newborn health cannot be estimated, as there is no reporting up from the district level, where most health services are budgeted and provided.

- Certain elements for newborns, including training, equipment, and monitoring, are included in national MCH budgets, but there is no specific earmark or expenditure tracking for newborns. The amount for newborns continues to increase, although the proportion has decreased.
- Most health expenditures are decided at the district level. These amounts are not reported to the national level. Some national-level "special funds" are available to support newborn-related activities at the *puskesmas* level (health centers with special responsibility for providing basic emergency obstetric and neonatal care) but the decision is made by the districts. Anecdotal reports, however, are consistent that, outside of districts with specific projects, there is no allocated budget for newborn health.

1F: Drugs on essential list and production plans in place

Indonesia's essential medicine list includes three of four lifesaving commodities for newborns: antenatal cortocisteroids, resuscitation equipment for birth asphyxia, and antibiotic injection for sepsis.

- The Indonesia Food and Drug Administration specifies developing domestic production for all essential commodities. However, production facilities authorized to sell to the public sector are extremely limited, leading to insufficient production and poor distribution. Stock-outs may also be the result of lack of demand from the facility.
- Chlorhexidine has not been approved for use in Indonesia.

INAP, Countdown tracking 2015; Indonesia Food and Drug Administration Strategic Plan, interviews

Summary of Findings

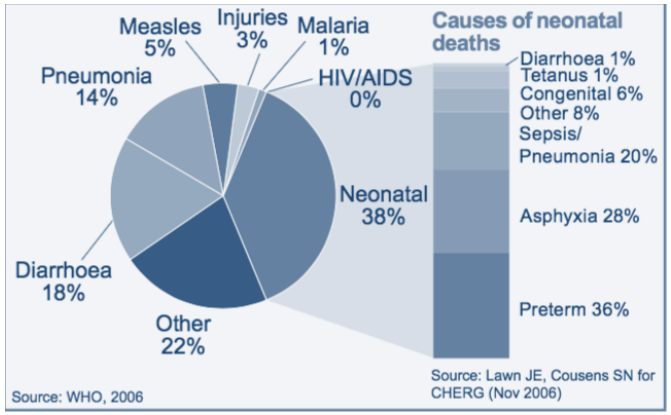
1G: Appropriate targets and indicators set for newborn-related interventions

Indonesia has set overall newborn mortality reduction targets and collects data on newborn deaths and stillbirths.

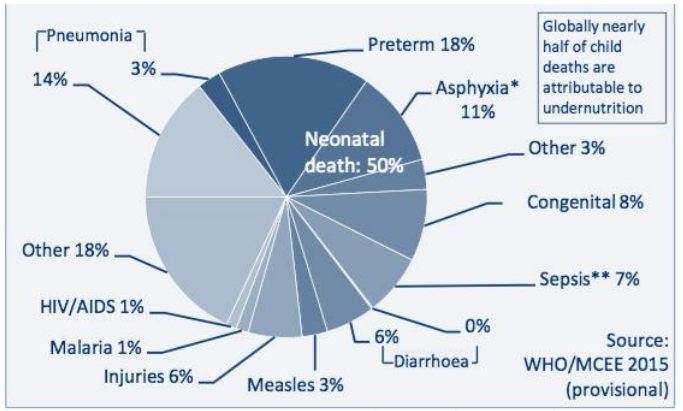
- INAP contains impact, outcome, and equity indicators pertaining to newborn deaths and stillbirths, and proposes newborn service delivery indicators.
- Effective coverage targets at the national level are limited to post-natal visits and exclusive breastfeeding, although some projects have included indicators for other interventions.
- A perinatal death review system is in place, but not occurring consistently.
- There are no national indicators to measure the quality of services, such as the percentage of health providers who provide ENC according to standards.
- There is no adjustment of targets to reflect the vastly different conditions across the country.

When newborn activities began, birth asphyxia was the primary cause of newborn death in Indonesia. Now, complications due to prematurity have become the leading cause, and the MOH has reprioritized.

Causes of Under-5 Deaths in Indonesia, 2006 and 2015



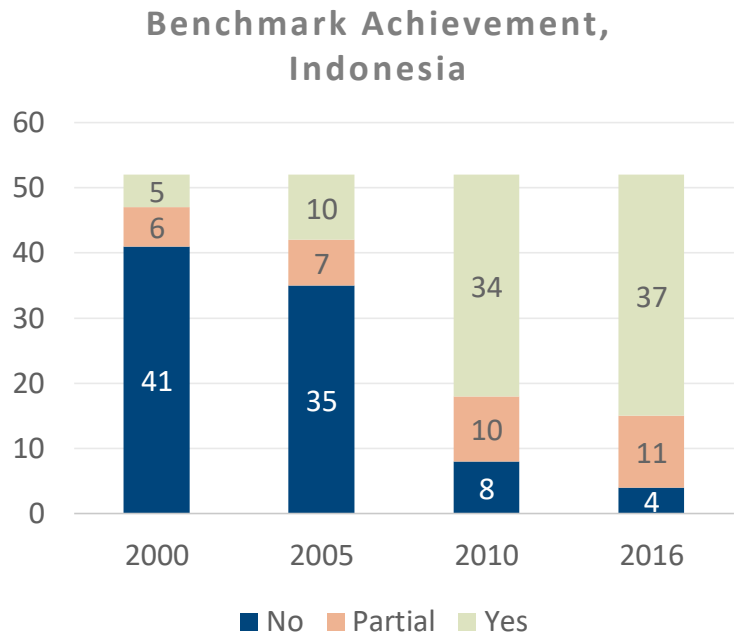
Countdown to 2015 Indonesia tracking reports 2010, 2015



Scale-up readiness benchmarks in Indonesia

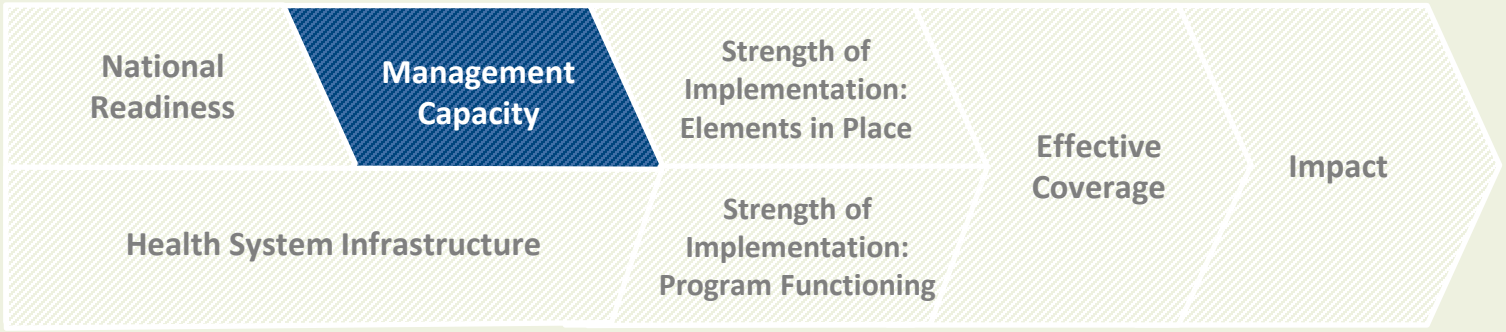
Indonesia has made progress toward achieving benchmarks for scaling up newborn health interventions.

These benchmarks, developed by SNL between 2007 and 2011, provide a detailed examination of more than 50 elements in the Pathway to Effective Coverage at Scale's national readiness category. SNL had evaluated these benchmarks for 2000, 2005, and 2010; this special study assessed the status in 2016.



Source: Moran A, Kerber K et al. 2012. Benchmarks to measure readiness to integrate and scale up newborn survival interventions. *Health Policy and Planning* 27:iii29-iii39, doi:10.1093/heapol/czs046 pour les données de 2000- à 2010,. Les données pour 2016 viennent de la revue documentaire et les interviews.

2. Management Capacity

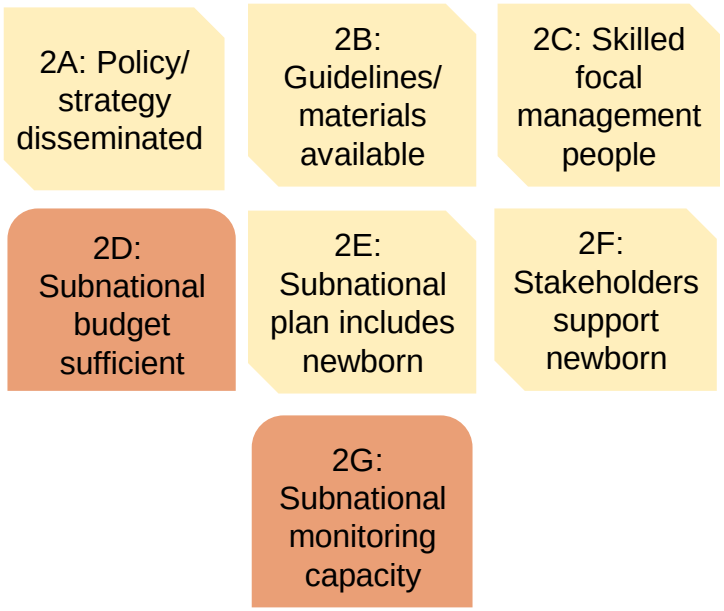


Management capacity at the subnational level

At the subnational level of the health system, is there sufficient management capacity to implement the newborn health program?

Decentralized management capacity assesses whether personnel are able to manage implementation of interventions for the newborn, and implement and follow the policies, strategies, and guidelines developed at the national level.

Status of Decentralized Management Capacity



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Summary of Findings

2A: Policy or strategy disseminated to intermediate management

Policies are widely distributed to the provincial level, but not always to the district level, where services are decided and supervised.

- INAP was developed in 2014 and will be combined with the Maternal Health Action Plan in 2016 to create a comprehensive Maternal and Newborn Health Action Plan. Nevertheless, the distribution of this action plan, especially at the district level, is not adequate.
- Other policies and strategies (e.g., ENC, early initiation of breastfeeding, newborn resuscitation, KMC, IMCI for newborns) have been developed, but the dissemination to district level is still insufficient.

2B: Guidelines and materials available at the subnational level

References or guidelines on standards of care are abundant at the national level and distributed to the province, but distribution and availability at the district level can be improved.

- A 2014 World Bank study of all facilities in the country found that between two-thirds and three-quarters, depending on the type, had basic emergency obstetric and newborn care (PONED) guidelines at the facility (see box at right).

Type of facility	Availability of PONED guidelines at facility
Rural *puskesmas*	71%
Urban *puskesmas*	66%
Non-PONED *puskesmas*	68%
PONED *puskesmas*	77%
All *puskesmas*	70%
All public hospitals	74%

INAP 2014, World Bank Readiness 2014, interviews

Summary of Findings

2C: Skilled focal management people in place at the subnational level

Focal management people with newborn-related knowledge and skills are available in some districts, but not in most. Management skills in general are lacking at the district level.

- The decentralization policy gives authority to the District Health Office for placing appropriately skilled personnel, but actual allocations depend greatly on local managers' understanding of newborn health.
- A 2015 study of Midwife Coordinators (*Bikor*) and midwives indicated that not only did many midwives score poorly on knowledge, but their supervisors scored worse on nearly every measure (see box at right).

"Currently, most *Bikor* have low levels of knowledge and skills in key areas of clinical midwifery practice. This is likely to be a significant constraint to their ability to provide clinical supervision to the midwives in their areas of responsibility."

-- Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH) Knowledge and Skills of Midwife Supervisors and Midwives Nusa Tenggara Timur Province 2015

INAP, AIP Bikor and Midwives 2015. interviews

Summary of Findings

2D: Subnational budget has sufficient allocation for newborn services

Most districts and provinces are not budgeting for overall health according to Indonesia's minimum standards, and budgets for newborn health are not tracked.

- According to National Health Act No. 36, 2009, provinces and districts should allocate at least 10 percent of their local budget for health. However, in 2014, only 40 percent of provinces and 28 percent of districts met or exceeded this amount. There is no earmark or line item to allow measurement of allocation specifically for newborn services.
- EMAS, a maternal and newborn health project in 62 districts/cities in six provinces, is gathering information to develop costing information for maternal and newborn health that can be used at the district level.
- Private out-of-pocket expenditures are a large proportion of health costs. Although specific data for the amount of private newborn health expenditures are not available, almost 40 percent of the poor who seek health care treatment do so from private providers. In most areas of Indonesia, the private sector now accounts for more than two-thirds of ambulatory care, more than half of hospital contacts, and 30-50 percent of all deliveries.

2E: Subnational work plans include newborn services

Subnational workplans for newborn health exist in only a few provinces

- INAP states that each province and district should develop a local action plan that is based on local conditions and targets, but only a few provinces and districts have done so—primarily those supported by externally funded health projects.

National Health Act 36, Indonesia Health Profile 2014, EMAS Year 4 Annual Report, INAP, Interviews

Summary of Findings

2F: Stakeholders ready to support newborn services

Newborn health indicators are included in district performance indicators, primary health care statistics, and hospital accreditation criteria, but local leaders and civil society groups, including women's groups, are not generally knowledgeable about newborn health.

2G: Capacity for monitoring and accountability exists at the subnational level

A monitoring mechanism and monitoring capacity are lacking, although some projects are working to improve national, provincial, and district capacity.

- EMAS has finished developing and testing a new approach to monitoring in its project districts, and the MOH is assessing it to be used nationwide.

Interview, Hospital accreditation form, PHC accreditation form, joint declarations

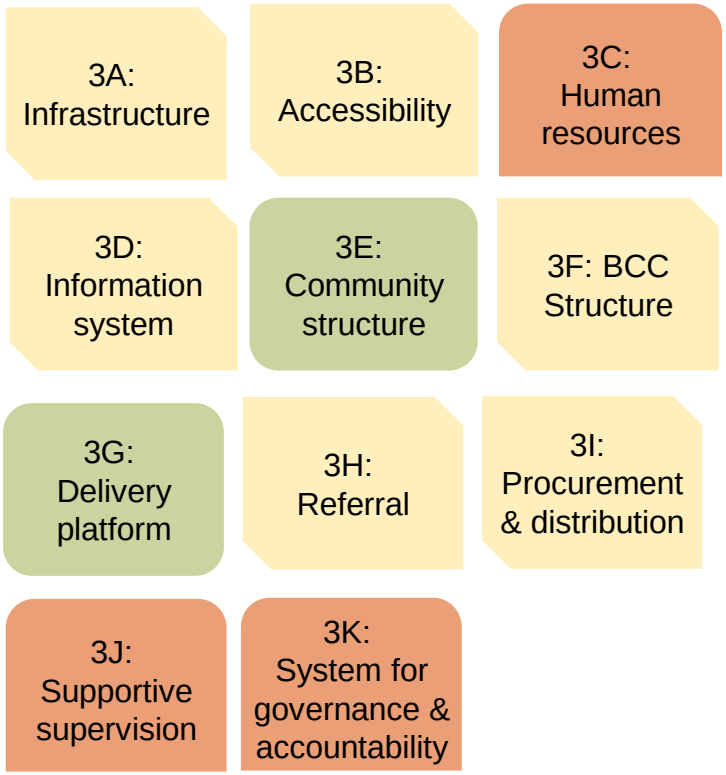
3. System Structures

System Structures

The platforms through which the intervention (service provision or demand generation) will be delivered are in place and sufficiently capacitated to deliver the intervention.

Structures of the health system or implementing partners include important contextual elements that can have a direct effect on the strength of implementation. Many many are not under the control of the program (e.g., geographic reach), while others may be more easily modified (e.g., linkages between health facilities and communities).

Status of Decentralized Management Systems



Good | Partial | Inadequate | Insufficient data available

Summary of Findings

3A (SS): Physical infrastructure for delivery exists

Physical infrastructure for basic and emergency care is mostly in place, but highly variable in terms of completeness, appropriateness, quality, and maintenance.

- Disparities exist between private and public facilities, across public facilities, and among districts and provinces.
- The Health Facility Research 2011 showed 15 percent of 102 public hospitals had a neonatal intensive care unit. The proportion is varied by class of hospital and provinces. Seventy-five percent of Class A hospitals have a care unit, but in one province, no Class A hospitals do. Thirty-six percent of Class B hospitals have a care unit, with 0-67 percent among provinces. Only 6 percent of Class C hospitals have a neonatal intensive care unit, with 0-33 percent among provinces.
- A 2014 World Bank study found very few *puskesmas* lack electricity, but only 72 percent had water and sanitation. Data are not available for private sector facilities, but they are unlikely to be better equipped in general.
- Whether or not the standard criteria for infrastructure are met can be attributed to direct factors (e.g., local government budget allocation, land, agreement, person in charge) and indirect factors (e.g., political issues, local leaders knowing their roles, and local government regulation).

A national profile on hospitals issued by Binkesmas shows there is great variability. Only four of 27 provinces had the appropriate ratios of comprehensive and basic emergency obstetric and newborn care facilities to population.

-- World Bank 2010

World Bank Readiness 2014, World Bank "…and then she died" 2010, INAP Annex 1, Indonesia Health Profile 2014, Indonesia Health Facility Survey 2011, Wibowo, Interviews

Summary of Findings

3B: Health system is accessible

Access to high-impact, high-quality services is variable between and within districts or provinces.

- Indonesia's target was to have at least four basic emergency obstetric and newborn care facilities for each district, but in 2014, only 68 percent of districts met this criterion. Few data are available on private sector provision of newborn care specifically, but most women deliver in private sector facilities, and this proportion is increasing as facility-based births increase. In the 2012 DHS, 46 percent of the most recent deliveries were in private facilities; 17 percent were in public facilities.
- The new national insurance scheme has reduced economic barriers, but inequity in service use remains between socioeconomic classes due to lack of standardized service charges, which deter the poor from seeking services. In addition, because a pregnant woman can register their fetus only at 7 months, early premature births do not benefit from insurance.
- Government and external projects do not necessarily select priority provinces based on greatest need.

IDAI news, EMAS Year 4 Annual report, World Bank "and then she died" 2010, INAP Annex 1, Indonesia Health Profile, DHS 2012, MOH documents, Wibowo, Shankar, Makoweicka, Interviews

Summary of Findings

3C: Human resources/cadre exist(s) for delivery of services

At the highest level of service delivery, Indonesia has a highly qualified health workforce, but the equitable distribution of competent health providers remains a challenge.

- A 2010 World Bank study reported that there were 2,100 obstetricians and 2,700 pediatricians in Indonesia; respectively, 1,393 and 1,487 were in Java. The 2014 MOH Situation Analysis identified 5,267 ObGyn specialists, of whom 1,829 were in private hospitals. Estimates of the numbers of midwives working in the private sector vary widely: The World Bank in 2010 reported 44,616, while the Indonesian Midwives Association (IBI) reported 37,289 in 2014. Keep in mind that many providers at all levels work in both the public and private sectors.
- Many facilities do not have neonatologists or neonatal nurses, and many pediatricians are unfamiliar with neonatal care. Some villages still do not have a midwife; among those that do, the midwives often do not live in the village or are not reliably present for other reasons.
- In poor and remote locations, attracting and retaining even general health professionals is very difficult.
- Volunteer health workers for mobilizing the community are abundant, but they do not have sufficient knowledge of newborn health issues.

IDAI news, EMAS Year 4 Annual report, World Bank "and then she died" 2010, INAP Annex 1, Indonesia Health Profile, DHS 2012, MOH documents, Wibowo, Shankar, Makoweicka, Interviews

Summary of Findings

3D: Information systems exist

The information system has been designed to actively involve stakeholders at all levels, including community members, but to date has operated as a routine recording-reporting activity.

- Specific newborn care indicators have been included in the routine information system since 2006.
- MOH is currently revising and expanding Perinatal Death Audits.
- Duplicate collection creates a reporting burden.
- Methods of data collection, definitions, timeline, and formats are not standardized.
- No real-time data is available.
- Monitoring is not applied to ensure the information system is functioning.
- Although private midwives are supposed to report to their local *puskesmas*, the quality of reporting varies. There is no system for private doctors to report, and referrals are also lost.
- No data is collected on key metrics, such as quality of services and stillbirths.
- Data is not fed back to service providers to improve understanding and quality.
- In 2016, the merged directorate for MCH is planning to adapt the global ENAP tracking tool to assess progress.

3E: Community structures exist

Civil society organizations and the local governance structures are available everywhere at the subnational level.

- Since decentralization, community structures have significant power to mobilize resources, but they are underused. They often provide political support, issue statements, or perform health promotion activities without being well-informed about newborn health.
- Alert Village is the government program aimed at improving access to health services through community mobilization. It is designed to promote collaborative work among stakeholders across sectors and administrative levels by describing the links and roles of each.

INAP Annex 1, MOH documents, Local Level Advocacy, Indonesia Health Profile, Wibowo, Interviews

Summary of Findings

3F: BCC structures exist

BCC structures have been designed to ensure newborn caretakers are enabled to deliver high-quality care

- Structures include classes for pregnant women, family welfare clubs, and distribution of the MCH handbook for families.
- Relevant data for assessing the extent to which such interventions have been implemented are not available.

3G: Delivery platforms into which newborn services can be integrated are present

Delivery platforms are present, and newborn services have been integrated into platforms and relevant national guidelines

- Nationally, newborn care has been integrated into pre-pregnancy, pregnancy, delivery, and post-partum care delivery systems.
- Newborn illness management has also been included in IMCI.
- Integration of newborn services to post-partum care, however, has created confusion about the purpose, content, and timing of newborn health visits (especially the first day visit) versus the early post-partum visit.

Countdown, INAP, MOH documents, Interview

Summary of Findings

3H: Links exist between the levels of the health system and the community

Significant gaps remain in the referral system for newborns.

- Gaps include late referrals, failure to provide pre-referral treatment, lack of communication between the sending and receiving facility, absence of integration of private providers, and no mechanism for back referrals.
- National guidelines, including INAP, lack detailed information describing the links and processes for referral between levels of the health system.
- When close and informed medical supervision is still needed, but not necessarily at the emergency level, there is no mechanism or process for referring patients to a lower-level facility.
- Some NGOs have developed strategies to improve the referral system, but these remain operational only in their project areas. EMAS has piloted approaches to referral in 62 districts/cities in six provinces that have recently been incorporated into the draft National Collaboration Guidelines.

3I: A system for procuring and distributing commodities exists

A wide-reaching commodity logistics system is in place, but it remains centralized even though it is functioning in a highly decentralized health system

- An e-catalog for health commodities allows facilities to order needed supplies, but delays occur because the production capacity and distribution have not been decentralized.
- There is a limited number of government-approved suppliers of essential commodities, so many supplies are not produced or procured at the subnational level, leading to delays across the country.
- Some medicines and medical supplies are frequently out of stock due to poor coordination between the health service administration and the District Health Office logistics personnel.

INAP, INAP Annex 1, MOH documents, World Bank "…and then she died," EMAS reports, National Collaboration Guidelines (draft), interviews

Summary of Findings

3J: Supportive supervision systems exist

Provincial and District Health Offices are responsible for supervising lower-level facilities, but the content may not qualify as "supportive supervision."

- The MOH has launched a policy on the Supplementary Health Operational Fund to support implementation quality management, supervision, and coordination through a weekly meeting (the "mini *lokakarya*," or "minilok") at all primary health care facilities. Village midwives should be invited to this meeting. Occasionally, community members such as *Posyandu* cadres can be invited.
- There is now an emphasis on mentoring at the MOH. Some NGOs have piloted mentoring programs, especially for health professionals (e.g., pediatricians, doctors, and nurses) and/or electromedical staff at the referral hospitals. However, this activity is still limited within their project areas.
- National accreditation for referral hospitals exists, but is not necessarily accompanied by supportive supervision.

INAP Annex1, MOH documents, EMAS Reports, Wibowo, interviews

Summary of Findings

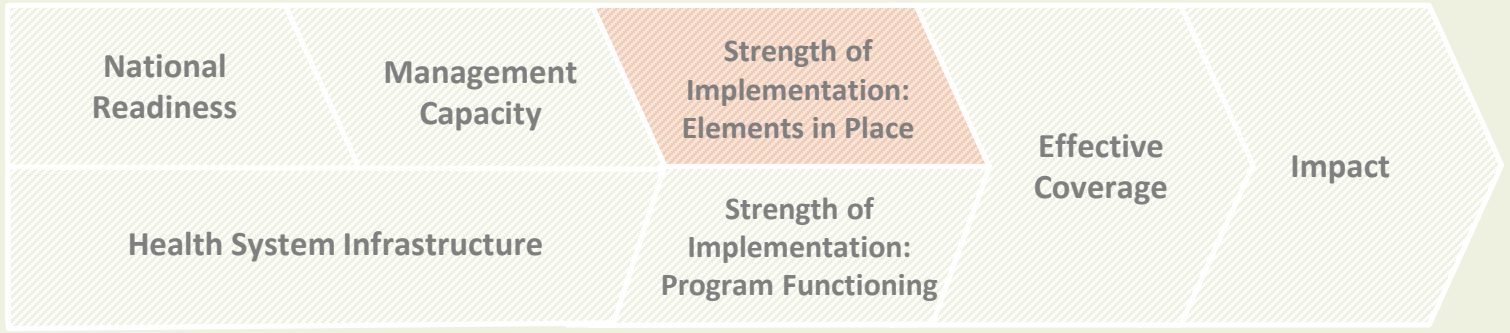
3K: Systems for governance and accountability exist

With decentralization, the chain of command and coordination across administrative levels and sectors has become unclear.

- The chain of authority between levels and across sectors could not be identified in the document reviews or interviews. Consequently, collaboration and coordination between levels and across sectors were largely driven by personal initiative rather than designed into the system.
- There are two relevant directorates in the MOH, Public Health and Health Services. The latter has had a hospital accreditation system since 1995, but the former has only just implemented a system. Newborn care has been included in hospital accreditation, but not in primary health care accreditation. It is the responsibility of the Family Health sub-directorate of the Public Health directorate to develop the accreditation criteria for the newborn care services in the Health Services accreditation system. Follow-up on overall service delivery shortcomings is delegated to the District Health Office, which may or may not take action. There is currently no system of follow-up from the higher level.
- In order to improve pre-service education and training and accreditation, close coordination is needed between the MOH and Ministry of Education.

INAP Annex1, MOH documents, EMAS Reports, Wibowo, interviews

4. Program Elements in Place

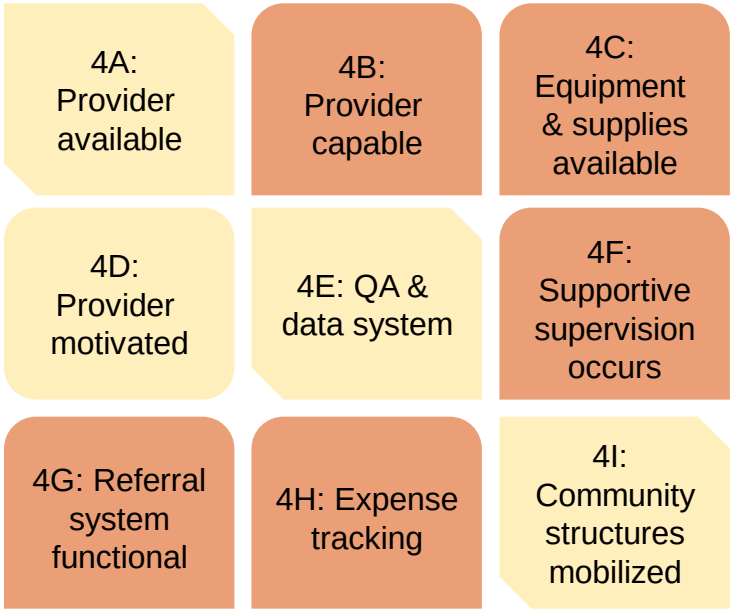


Program elements in place

Are the elements in place to deliver newborn services?

At the point of service delivery, resources are in place and adequate in terms of quality and quantity, and systems are functional.

Status of Program Elements in Place



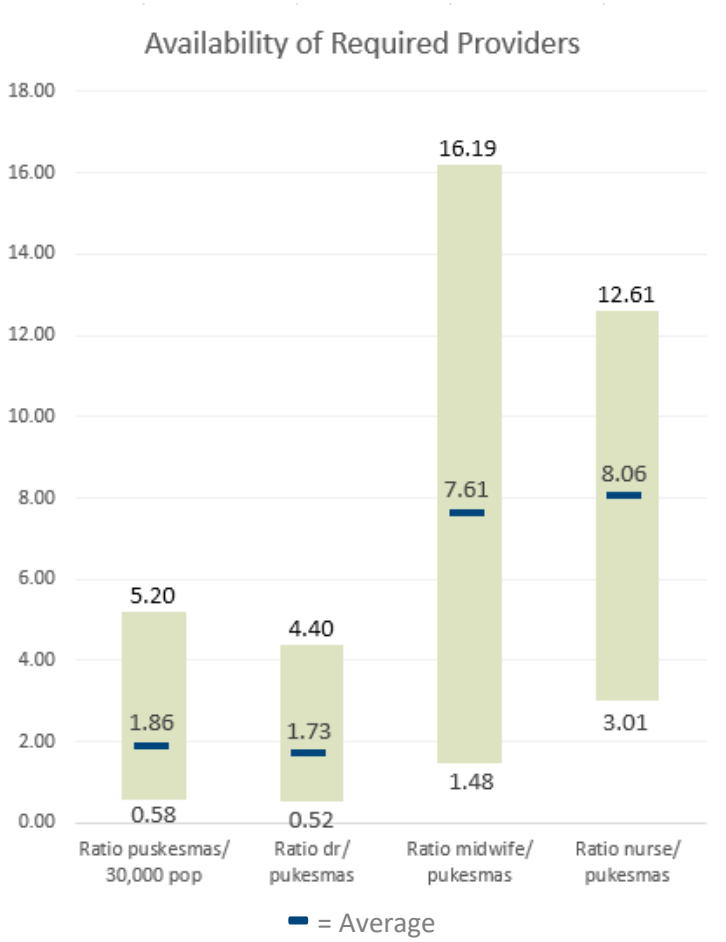
Good | Partial | Inadequate | Insufficient data available

Summary of Findings

4A: Service provider is routinely available at service delivery point

Availability of required providers varies across Indonesia's 500 districts.

- The national goal to have a midwife in every village has not yet been reached, and not all midwives live in their village, which works against community acceptance and trust. The MOH has not officially revisited this goal to decide whether it should remain a priority.
- At the village level, there frequently is not a 24-hour coverage of by a midwife, neonatal nurse, anesthesiologist, or others needed for emergency newborn care.
- Many hospitals do not have perinatal/neonatal specialists.
- In 2015, an average of 1.15 *puskesmas* were available for every 30,000 people, with a range of 0.58 to 5.20. The higher numbers are often in remote, less populated provinces.
- In 2013, the number of clinical personnel per *puskesmas* ranged from 4.4 to 0.52 for doctors, 16.19 to 1.48 for midwives, and 13.31 to 3.01 for nurses, generally with lower concentrations in remote areas.



World Bank 2010; Wibowo

Summary of Findings

4B: Service provider is capable (skills/knowledge)

The level of skills and knowledge among providers varies greatly across the country, a critical shortcoming that is widely recognized and being addressed.

- There are few neonatologists and neonatal nurses, and not all pediatricians understand problems that concern newborns.
- The quality of in-service training is inconsistent and has often been ineffective. MOH is shifting to a mentoring approach and emphasizing skills-based training, but skills sessions are the first to be cut when budgets are tight. A 2015 post-training follow-up study in the less-developed province of Nusa Tenggara Timur found that only 58 percent of trainees retained satisfactory knowledge of newborn care.
- A 2007 baseline study in the district of Garut found that 51 percent of providers had adequate knowledge on the management of birth asphyxia, and 69 percent on ENC. When it came to demonstrating skills on a mannequin, however, only 51 percent performed correctly on birth asphyxia, and 47 percent on ENC.
- The quality of pre-service training varies, especially for nurses and midwives. Renewal of certification is not skills-based. IBI is currently leading an effort to strengthen standards for training, certifying, and monitoring midwives.
- MOH has instituted residencies for obstetricians/pediatricians to upgrade skills.

Many service providers are not prepared to provide up-to-date care for routine or complicated deliveries, or essential or sick newborn care.

Profil Kesehatan. 2014.World Bank 2010, AIPMNH Skills Retention 2015, Baseline Survey Report for SNL-2 Garut 2007 interviews

Summary of Findings

4C: Service provider has equipment and supplies

The INAP specifies that newborn supplies and equipment should be provided, but newborn-specific and general equipment and supplies are not consistently available.

- Lack of supplies and equipment may be due to shortcomings in the supply system or failure at the facility level to request supplies.
- Even where equipment is available, staff may not know how to use and maintain it.
- Private midwives—from whom many families seek care for sick newborns—are prohibited from stocking or providing antibiotics.
- The 2014 World Bank study Assessing the Readiness of Public Health Facilities to Provide MHC found that most PONED *puskesmas* generally do not have the inputs required to manage and treat obstetric emergencies, such as postpartum hemorrhage and neonatal care. Only 11 percent had all of the inputs for needed neonatal care. Non-PONED *puskesmas* were even more poorly equipped.

4D: Service provider is motivated

Information on provider motivation is limited to small-scale studies and project reports, and the findings present some contradictions.

- Perinasia and IBI report that both doctors and midwives willingly pay for training to improve their skills, although these participants may not be representative of the entire country.
- Documents and interviews cite challenges in placing and retaining providers in remote areas, particularly village midwives, which can be interpreted as problems in motivation, at least in those remote areas.
- A 2010 World Bank study cited conflicting evidence, with community ties, marital status, well-established private practice, amount of income, and availability of supportive supervision all reported as affecting retention and motivation. The degree to which community altruism is a motivating factor for midwives varied across studies.

World Bank Readiness, 2014, INAP, 2014 INAP Situation Analysis 2014. Wibowo 2016 , World Bank "…and the she died" 2010, interviews

Summary of Findings

4E: Functional quality improvement/quality assurance systems with regular review and use of data

There are no specific quality improvement/quality assurance guidelines or systems for maternal and newborn health, but there is a regular weekly meeting at the primary care level

- The "mini *lokakarya*," or "minilok," is a regular weekly meeting at the primary health center during which health staff, sometimes with community representatives, discuss health-related issues, including access and quality of services. There is no specific information on the content or quality of these meetings.
- The system for accreditation of hospitals includes newborn care indicators; the system for primary health care does not. Furthermore, even for hospitals, there is no direct clinical skills observation in the accreditation process, which focuses on checking documents and facilities. The follow-up system for hospital or primary health care facilities that fall short on accreditation criteria is still weak.

In 2011, 70% of primary health care centers were been supervised by district health office, and 50% received clinical monitoring.

-- Health Facility Survey 2011

4F: Supportive supervision occurring regularly

Supervision may occur, but supportive supervision is rare.

- Many districts, which are responsible for supervising the *puskesmas* and community health centers, have neither the skills nor the personnel to conduct supportive supervision on a consistent basis.
- Although minilok can be utilized as a form of supportive supervision at the primary health care facilities, the implementation may be varied and depends on the leadership and managerial capacity of the head of the center.
- Although the importance of supervision and mentoring is widely recognized and projects have piloted models, these approaches have not been maintained or expanded after project closeout. The most extensive effort is ongoing in EMAS, in 62 districts/cities in six provinces, and discussions with the MOH are ongoing about how to sustain these approaches.

EMAS Year 4 Annual Report, RUU KEBIDANAN 2016 (DRAFT), Health Facility Survey 2011, INAP, interviews

Summary of Findings

4G: Referral system functional

Although the system and process for referral of newborns is specified in the "Maternal Health Services at Primary and Referral Health Facilities – Guideline for Health Providers" (2013) pockett book, it is often not followed and there is wide recognition of multiple difficulties in the referral system.

- Families and midwives may not recognize danger signs and referral is delayed.
- The receiving facility may not be staffed or equipped to deal with the emergency. Among Level A public hospitals, 69 percent have functional comprehensive emergency obstetric care; the proportion at Level B and C public hospitals is 77 percent and 44 percent, respectively.
- Unnecessary or dangerous referrals may also occur because the facility does not want to accept a potentially fatal emergency and risk being audited.
- EMAS has piloted approaches to referral in 62 districts/cities in six provinces that have recently been incorporated into the National Collaboration Guidelines. Although the project has seen improvements for referral for maternal complications, the same has not been true for newborns, because care-seeking for newborns is predominantly from private providers who are outside of the reach of the project.

4H: Expense tracking used

Information on newborn expenditures is not available outside of the local area

- At the district level, where budgeting occurs, newborn expenditures are not necessarily segregated from MCH. Even where newborn health is a line item, there is no requirement to report up through the system.

I_BUKU_SAKU_PELAYANAN_KESEHATAN_IBU_2013, EMAS Year 4 Annual Report, Indonesia Health Facility Survey 2011, interviews.

Summary of Findings

4I: Community structures mobilized to increase demand for high-quality services

The growing awareness of the role of the community in demanding high-quality services is evidenced by its role in the INAP. However, efforts are still sporadic and depend on the interest and commitment of local leaders.

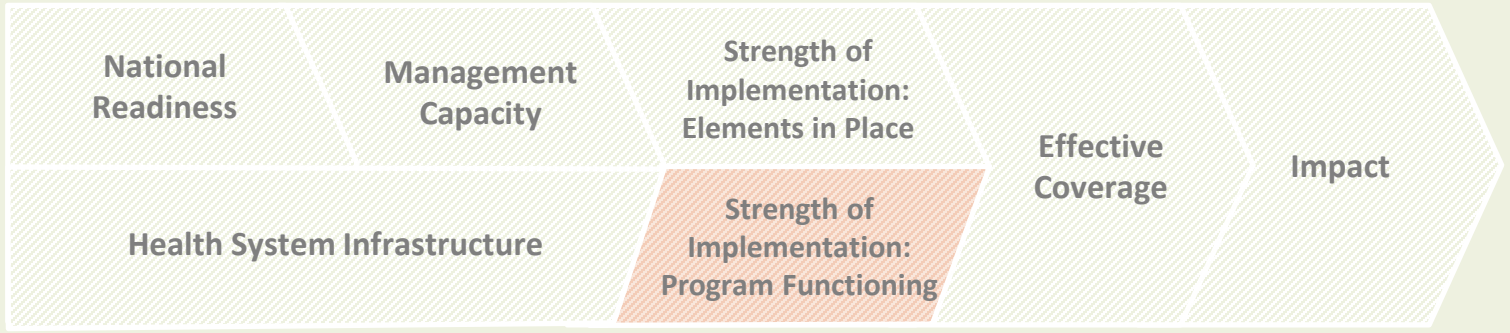
- Mother, Pregnant Woman, and Father classes are conducted at the village level, but depend on funding from the village headman.
- In its 62 districts, EMAS has invested in informing and strengthening the two existing structures, *Pokjas* and civic forums, to encourage and enable them to engage on maternal and newborn health. Other projects such as Selaras have also engaged community groups.
- The women's community welfare organization Pembinaan Kesejahteraan Keluarga is present throughout Indonesia and organizes a forum that focuses on health and health planning. It could be mobilized to prioritize newborns.
- There is a lack of knowledge among local/village government about its role in newborn health.
- Although the Alert Village Program began in 2006, implementation has been slow to result in community mobilization.

One recent study interviewed cadres and heads of villages who were found to have limited understanding on their role in making the village midwife program function. As a result, ensuring housing and the safety of the village depended on the individual generosity of leaders rather than awareness of their responsibility.

-- Wibowo 2015

Wibowo, INAP, EMAS Year 4 Annual Report, interviews

5. Program Functioning



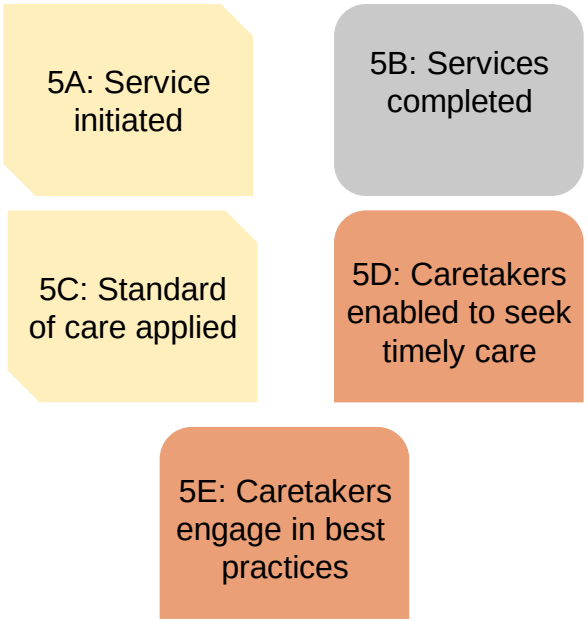
Summary of Findings

Program functioning

Are services or messages being provided with adequate quality and do they reach those who need them, resulting in a decline in mortality in the target population?

Demand and community mobilization efforts are particularly relevant to newborn programs, which require decision-making around care-seeking and use of newborn care practices by families.

Status of program functioning



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Summary of Findings

5A: Service initiated

There are very limited data on the number of newborns and pregnant women/mothers initiating care or treatment for complications or receiving services or newborn care practices that prevent complications and promote newborn health.

- The SNL2 study in Garut district (2011) revealed that two-thirds of newborns with danger signs were brought to a health facility, but only one-third of mothers could cite danger signs.

5B: Service completed

Data at the national level are limited for service completed for mothers initiating care/treatment.

- In the 2012 DHS, 73 percent of women received four antenatal visits.

- **In 2011 in Garut district, only one-third of mothers knew the danger signs for newborns**
- **A 2010 World Bank study showed delays in seeking care for pregnant women**

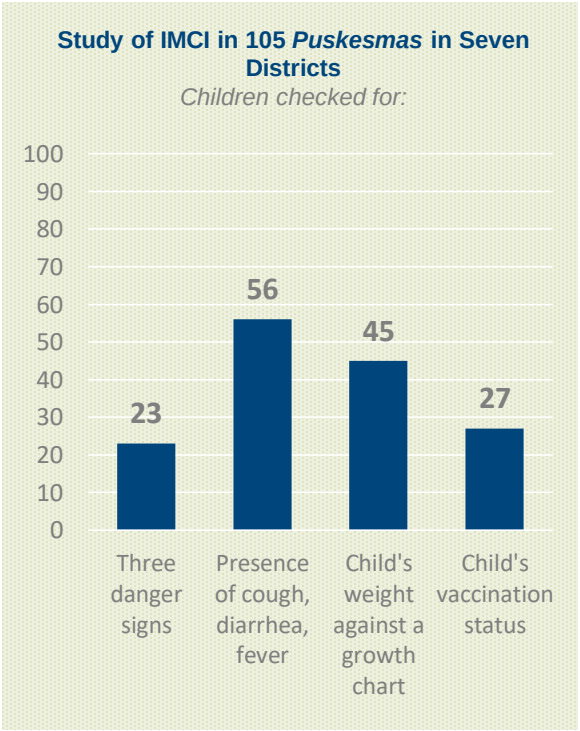
Interview, SNL-2 End of Project report, World Bank "…and then she died" 2010

Summary of Findings

5C: Standards of care applied

Standards of care are applied in many project areas, but not nationwide. There is lack of both indicators and systematic monitoring.

- The 2012 DHS showed coverage of postnatal visit for mothers in first 2 days after births was 80 percent, while coverage for the neonatal visit was only 48 percent.
- In a 2009 study of provider contacts with 635 sick children (not specifically newborn) across 105 *puskesmas* in seven representative districts, actual provider performance against integrated management of childhood illness (IMCO) standards was poor, with required practices being performed only 23 to 56 percent of the time (see chart).
- MOH's Indonesia Health Profile 2015 states that only 60 percent of newborns with complications received standard care.
- IBI implements competency testing for all graduated midwives before they can do their midwifery practices.
- Newborn care practices are included in primary health care and hospital accreditation.
- EMAS is working to improve and monitor standard of care for newborn health.
- The World Health Organization and MOH recently completed a study on quality of care, but have not released the results.



INAP 2014, IMCI Evaluation Survey 2009, MOH Indonesia Health Profile 2015, DHS interviews

Summary of Findings

5D: Caretakers enabled to seek timely care

There are no national-level data on the degree to which caregivers are aware of services available for newborns and pregnant women and how to access them. Projects have focused on the supply side, not the demand side.

- Sociocultural barriers include lacking a sense of urgency for seeking health care and a lack of social skills in the health cadres. To address the latter, some project areas (e.g., EMAS) have created partnerships between midwives and the more socially accepted traditional birth attendant to minimize cultural gaps. This is still in limited areas, however.

Summary of Findings

5E: Caretakers enabled to engage in best practices for newborns

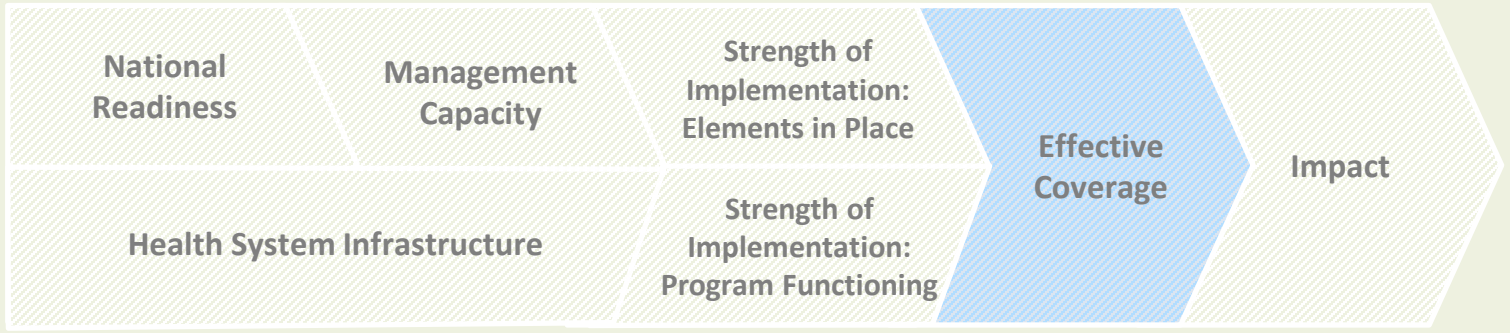
Although data are limited, it is believed that the use of best practices for newborn care at home by caretakers is still low.

- Only 35 percent of mothers practice immediate breastfeeding, and only 24 percent refrain from applying anything to the cord stump.
- Although in only one district, this general finding of significant gaps is supported by the 2001 SNL-2 survey in Garut, in which 65 percent practiced immediate breastfeeding, 45 percent skin to skin contact, 47 percent refrained from applying anything to cord stump, and 20 percent delayed first bath to 24 hours.

Family Handbook for MCH

INAP 2014, interview, Indonesia Basic Health Research 2013, Baseline Survey Report for SNL-2 Garut 2007

6. Effective Coverage and Impact



Summary of Findings

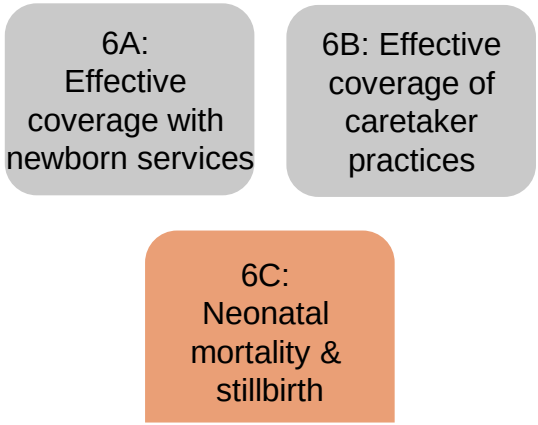
Effective coverage and impact

Are newborns receiving high-quality services and care from health providers and caretakers, and are newborn survival rates improving as a result?

The services or messages are being provided with adequate quality and are reaching those who need them.

As a result of the delivery of intervention(s) and/or changes in behaviors and care-seeking, mortality in the target population is decreasing.

Status of Effective Coverage and Impact



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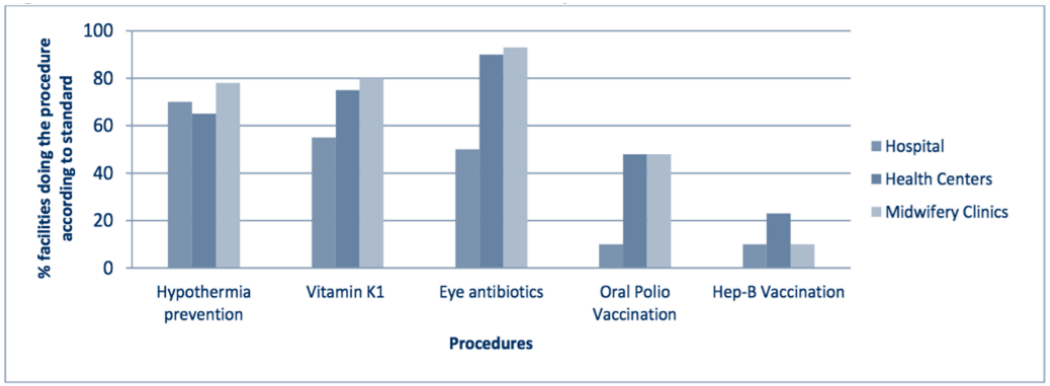
Summary of Findings

6A: High-impact, high-quality services received

Current data on the actual receipt of high-quality services are lacking

- The INAP Situational Analysis presents information the proportion of newborns who received the full complement of services in their neonatal visit. It should be noted that the source of this information is not provided—it may be from service delivery statistics reported by providers—and we do not know the actual quality of services performed. There is considerable variation by province, ranging from more than 100 percent of women receiving complete visits (due to more than one visit) to less than 10 percent.
- Indonesia Basic Health Research 2010 showed coverage of first neonatal visit was 73 percent, but coverage of first neonatal visit meeting quality standards was only 13 percent.
- Special projects often do not choose to work in areas that are difficult and expensive to access. As a result, more remote areas with greater need may receive less attention and not have their circumstances addressed.
- The figure to the right shows the findings of a survey of 100 facilities in 10 provinces comparing the performance of hospitals, health centers, and midwifery clinics regarding the provision of selected newborn care procedures. Again, we do not have information about the quality, although each of these interventions is quite simple to perform.

Performance on selected ENC procedures



Source: MoH. *Laporan hasil pengumpulan data kualitas pelayanan kesehatan ibu di 100 fasilitas kesehatan dari 10 provinsi di Indonesia*. 2012.

Summary of Findings

6B: High-impact, high-quality services provided by family caretakers

There are very few quantitative data regarding the quality of care provided by mothers, families, and other caretakers. Expert consensus, however, is that caretaking is less than optimal.

Immediate initiation of breastfeeding was 44% at the time of the 2007 DHS. This had increased slightly, to 49%, in the 2012 DHS.

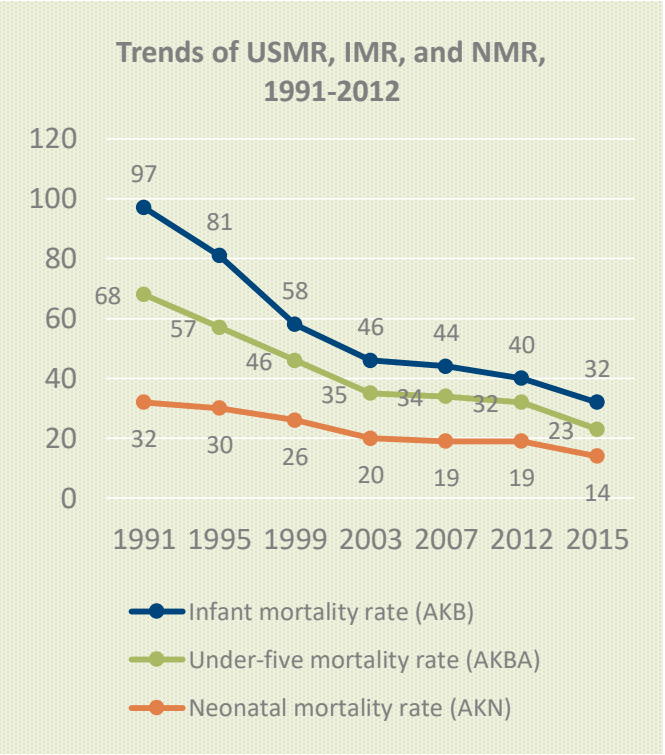
Summary of Findings

6C: Improved survival of newborns, and incidence of stillbirths

Newborn mortality: Following more than a decade of decline, neonatal mortality has been stagnant at 19 per 1,000 live births for more than a decade.

- The most recent national statistics suggest a decline to 15 per 1,000 live births, but the figures are still being confirmed. Several experts believe that neonatal mortality is underreported by up to one-third.

- As in many countries, accurate data on the incidence of stillbirth is lacking. It is widely believed to be high, however, possibly related to the high rates of maternal anemia, at 30 percent. Indonesia is also believed to have a high prevalence of thalassemia carriers, at 3-8 percent.



MOH INAP 2014, interviews, WHO. Global anemia prevalence and trends 1995-2011. Geneva: World Health Organization; forthcoming. 2. Stevens GA, Finucane MM, De-Regil LM, et al. Global, regional, and national trends in hemoglobin concentration and prevalence of total and severe anemia in children and pregnant and non-pregnant women for 1995-2011: a systematic analysis of population-representative data. The Lancet Global Health 2013; 1(1): e16-e25). Deputy Health Minister Ali Ghufron Mukti quoted in the Jakarta Globe, June 5,2012.

Status of specific interventions

Some health professional organizations (e.g., POGI, IDAI, Perdatin, HOGSI, PPNI, IBI) and the provincial health offices in three provinces (Jabar, Sulsel, and Sumut) made joint statements to support the adoption of KMC, PSBI, and ACS as part of standard practices for newborn care.

Kangaroo Mother Care (KMC): KMC was introduced 1997 by Perinasia. A National KMC Task Force was founded in 2009, followed by training in KMC for 100 hospitals. In 2011, KMC was included in certification for comprehensive emergency obstetric care facilities, and was included in INAP in 2014. Nevertheless, the adoption of KMC in health facilities and communities is slow.

Chlorhexadine (CHX): At the national level, the neonatal mortality rate in Indonesia falls on the cusp of the World Health Organization's recommendations regarding the use of CHX, but more remote areas fall well within them. While not proposing it as a national strategy, the INAP plans trials of CHX in such locations. Some independent projects (World Vision International) have already piloted this practice in provinces such as Papua.

Possible Serious Bacterial Infection (PSBI): Management of PSBI has been included in the standard of care, but only medical doctors are authorized to give antibiotic injection before referral.

Helping Babies Breathe: The inclusion of newborn resuscitation into the standard of care for birth asphyxia has been completed with national guidelines. Soon, the ambu bag will be provided by MOH as part of the midwifery kit for all village midwives.

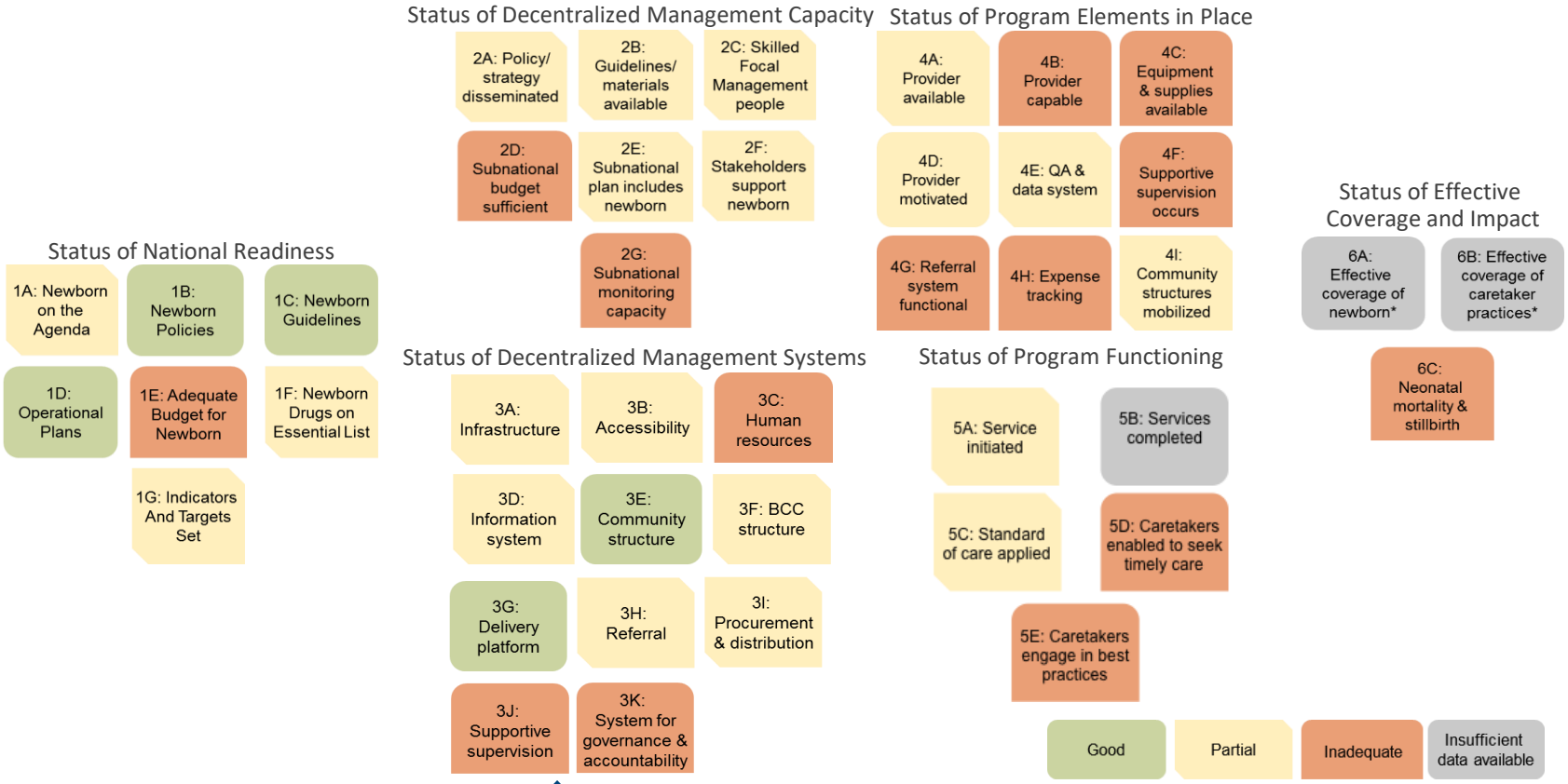
(Antenatal corticosteroids (ACS): ACS is widely adopted as the standard of care for preterm management.

Essential Newborn Care (ENC): ENC is included in the normal delivery care package following the World Health Organization's guidelines.

Summary of Findings

Pathway to effective coverage

Although some elements are largely in place, others need strengthening if Indonesia is to attain effective coverage of newborn health interventions



Progress most appreciated by key stakeholders

MOH attention to newborns and INAP

Many stakeholders mentioned that the current and previous ministers and director generals responsible for MCH had given significant profile to newborn health issues, most notably in the development of INAP. This senior-level attention made it easier for stakeholders to get other actors, including local health and political leaders, other ministries, and funders, to take newborn health seriously.

Economic barriers largely removed due to insurance

The ambitious national health insurance plan, Jaminan Kesehatan Nasional, while not without growing pains, has already significantly reduced cost barriers for many Indonesians. Stakeholders expect that, as design glitches are corrected and more people are reached, the positive effect will grow and mothers and newborns will benefit. In addition, the plan is expected to eventually force a closer look at service quality and outcomes as returns on investment, rather than relying only on measuring inputs and process indicators.

Clear global guidance on ENC and key newborn interventions

As noted elsewhere, Indonesia takes a cautious approach to the introduction of new interventions. Having evidence of efficacy and clear, World Health Organization-supported guidance built on global consensus greatly facilitated the adoption of these interventions in pilots, policies, and programs.

Factors Explaining Progress

Section 04

Factors facilitating and impeding progress

Transnational Influence: International agencies' efforts to establish a global norm for the unacceptability of newborn death and the offer of financial and technical resources to address newborn mortality

Domestic Advocacy: Political community cohesion among key stakeholders, presence of champions, credible evidence to demonstrate the problem, focusing events, and clear policy alternatives to reduce newborn mortality

National Political Environment: Political transitions and changes, and competing health priorities

Factors Explaining Progress

Transnational influence

Global actions influence Indonesia's priorities

Indonesia tends to follow global initiatives and priorities, as was the case with newborn health. However, Indonesia lacks the data and evidence needed to evaluate whether global priorities are appropriate to its context.

> *ENAP got Indonesia started on its own process.* – *Development partner*

> *Commitment came because the national government representatives were involved in global events such as World Health Assembly.* – *Technical expert*

Evidence of effective, feasible interventions

The MOH prefers to introduce new interventions after international consensus is reached and global standards have been set.

> *The core of the action plan was taken from the global priorities from SNL and the five Key Interventions.* – *Technical expert*

Financial support for testing interventions

- External funding has supported national-level pilots that introduced key interventions and convinced policymakers that they are feasible and effective in the Indonesia context.
- As with global agendas, donor priorities may be the deciding factor in setting national strategies for health in the absence of comprehensive and up-to-date health data needed for optimal planning.

In recent years, SNL's activities at the global level have continued to influence Indonesia. The INAP drew directly from SNL's five key newborn interventions, and stakeholders continue to refer to and have confidence in SNL's technical resources and leadership. EMAS, the current USAID bilateral program, has a newborn component led by Save the Children, which can be traced directly to the foundation built under SNL.

Domestic advocacy

Renewed efforts to reach MDG 4

One thing that was important was the understanding at [the] national level and among NGO partners of the increasing proportion of newborn mortality in infant and [under-5] mortality rates, and the necessity of reducing it in order to progress in [under-5 mortality rates]. – *Multilateral partner*

Senior leaders focused attention on the issue

Compared to other ministries, the MOH is way in advance in translating global discussion to national context.
– *Development partner*

We need to identify leaders or pioneers to inspire many people to implement newborn care according to the standard of care. For example, the decision-maker to implement KMC at hospital is the pediatrician, thus his/her leadership and motivation to ensure correct conduct is really essential. – *Professional association*

Efficacy of priority interventions confirmed

As in most countries, Indonesian health officials and providers wanted to see Indonesia-based evidence. Combined with global consensus, even small local trials or pilot studies proved to be persuasive.

When people know that some [newborn] complications can actually be treated with simple interventions and existing equipment, this made for a change. -- *Development partner*

Indonesia adapted [the] WHO OneHealth costing tool to the data available in order to show costs and benefits of investment in newborn care. This was a powerful argument for other ministries. – *Multilateral partner*

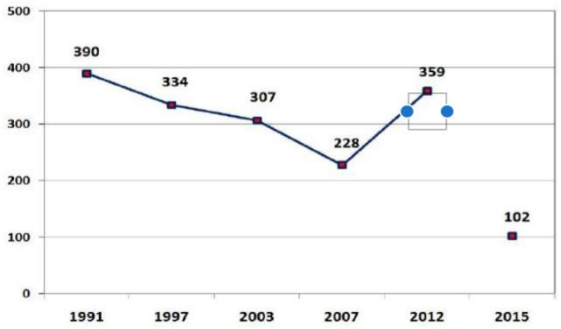
National political environment

> *The focus is on very high maternal mortality ratio*
>
> It is hard to trace the leadership of newborn issues. While newborn mortality needs attention, the maternal mortality ratio is high [so] that it rightfully gets more attention. – *Development partner*

> *Changing political leadership at all levels is challenging*
>
> For example, when the new mayor [is] elected, the director of hospital could also be replaced. The shifting on political will of the new governance could just wipe out the support and continuation of the intervention as well as its expected outcome. – *Professional association*

There are competing priorities at all levels, and with frequent changes in political and MOH leaders, there is a need to continually educate and persuade regarding the importance of newborn health.

Trends of MMR, 1991-2007



Source: DHS data 1991-2012 and target for 2015.

Summary of factors that facilitate or impede progress

Impeding

- Shortage of charismatic and visible champions and leaders
- Changes in MOH personnel and political leaders
- Projects ending without sufficient attention to sustainability
- Legitimate competing priorities
- Other donor priorities

Facilitating

- Significant government capability to provide domestic financial resources
- Global attention to newborns, such as ENAP and Lancet series
- WHO guidelines for key newborn interventions
- Demonstration of effective interventions in Indonesia
- Strong support at MOH and strong leadership at local government “once they are convinced”
- Supportive national policies
- Increased engagement of professional associations
- Donors who emphasize newborns

Looking Forward

Section 05

What does Indonesia need to do for greater progress on newborn health?

Respondents had different ideas about what is missing and what is needed to further progress. Elements and suggestions that came up repeatedly are summarized here.

Strengthen advocacy on newborn issues

- Create a working group on newborn health at the national level to advocate and advise. It should include charismatic champions for the newborn, as well as technical experts.
- The existing community structures could have a significant role and power in the context of decentralization. Communities can be educated about the importance and feasibility of improving newborn health, and effectively engaged to demand and participate in creating and monitoring better services.

Concrete guidance and action to implement INAP at all levels of the health system

- Demonstrate full implementation of the INAP across all levels of the health system, solving bottlenecks encountered along the way.
- Need to develop mechanisms to engage lower-level political and health leaders to participate in identifying and defining local problems and priorities, and designing context-adaptable solutions.
- Ensure system-wide accountability. With decentralization, there are significant structural gaps in oversight, certification, and accountability, with no one fully responsible for clinical supervision that ensures the quality of service delivery.

Focus on quality

- Improve pre- and in-service training.
- Include indicators for the quality of services and health outcomes.
- Strengthen linkages across all levels of the health system to facilitate supportive supervision and mentoring and an effective referrals system.
- Build stronger data and information systems that allow for accurate identification of problems and monitoring for improvement.

What is needed at the global level for greater progress?

Stakeholders did not identify many actions that they felt would be useful at the global level. The continuing value of up-to-date information and guidelines was mentioned, but not emphasized. The most meaningful contribution was identified as specialized technical assistance where it is not available domestically, or ideas and solutions to thorny challenges that have proven successful elsewhere.

Timely, highly specialized technical expertise

- Indonesia is largely able to provide its own experts, but for work requiring highly specialized technical expertise, the global community should be prepared to respond in a timely manner. For example, while developing the INAP, there was an opportunity to perform a Lives Saved Tool analysis, thereby strengthening the appropriateness of the plan to the context. However, it was not possible to secure the technical assistance needed and the opportunity was missed.
- There is uncertainty on how to proceed with implementation of the INAP, particularly in the context of decentralization and wide variation in the newborn context throughout the country. There is eagerness for expert assistance in this area.

Progress and challenges in Indonesia

Progress Made

Fifteen years ago, SNL planted the seeds for the interest in newborn health that has accelerated in recent years. Indonesia has made some important investments in policy change, research on interventions, and integrating newborn health into existing health and community structures. And yet, the newborn mortality rate remains largely unchanged, suggesting that significant additional, different efforts will be needed to attain the targeted reduction.

Meeting the Challenges Ahead

The barriers that Indonesia faces in improving newborn health are not simple to overcome. They are the problems faced by the health system overall: inadequate quality in an environment of weak supervision and accountability. These changes require whole-system solutions that take time to develop and implement, and require sustained political leadership and specialized expertise. Furthermore, the diversity of conditions across Indonesia's 550 districts demands flexible and modifiable models of implementation appropriate to different contexts. However, the solutions that are devised have the potential to benefit the entire health system.

Annexes

Section 06

- Timelines
- References
- Interview Guides

Annex A

Acronyms

ACS	Antenatal Corticosteroids
AIPMNH	Australia Indonesia Partnership for Maternal and Neonatal Health
BCC	behavioral change communication
CHX	Chlorohexidine
DHS	Indonesia Demographic and Health Survey
EMAS	Expanding Maternal and Neonatal Survival
EMAS	Expanding Maternal & Neonatal Survival
ENC	Essential newborn care
HOGSI	Himpunan Obstetri dan Ginekologi Sosial Indonesia (Indonesian Social Obstetrics and Gynecology Society)
IBI	Ikatan Bidan Indonesia (Indonesian Midwives Association)
IDAI	Ikatan Dokter Anak Indonesia (Indonesian Medical Doctors Association)
IMCI	Integrated Management of Child Illness
INAP	Indonesia Newborn Action Plan
IPANI	Ikatan Perawat Anak Indonesia (Indonesian Pediatric Nurses Association)
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KMC	Kangaroo Mother Care
MCH	maternal and child health
MDG	Millennium Development Goal
Moh	Ministry of Health
NB	Newborn
PATH	Program in Appropriate Technology in Health
Perinasia	Perkumpulan Perinatilogy Indonesia (Indonesian Society of Perinatology)
POGI	Perkumpulan Obstetri dan Ginekologi Indonesia (Indonesian Society of Obstetrics and Gynecology)
PONED	basic obstetric emergency and neonatal care
PPNI	Persatuan Perawat Nasional Indonesia (Indonesian National Nurses Union)
PSBI	Possible Serious Bacterial Infection
SNL	Saving Newborn Life
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Annex B

People interviewed and/or participating in group discussion

Name	Current Role	Past Role (where relevant)
Dr. Agus Sasmito		Former Project Leader of SNL2
Dr. Ina Herawati	Freelance consultant	Former head of MNCH sub-directorate Former Head of Community Nutrition
Massee Bateman	Senior Health Advisor, USAID	
Dr. Ardi Kaptiningsih	Freelance consultant	MNCH technical advisor WHO-SEARO
Nancy Caiola	Country Director of Jhpiego	
Kristina Geary	Deputy COP EMAS	
Dr. Erna Mulati	Directorate of Pharmaceutical, MoH	Head of Newborn Sub-Directorate, MOH
Dr. Eni Gustina, MPH	Director of Family Health, MOH	
Dr Lukas C. Hermawan, M.Kes	Head of Maternal and Neonatal Sub-Directorate, MoH	
Dr. Nida Rohmawati, MPH	Head of Neonatal Health Section, MoH	

Annex B

People interviewed and/or participating in group discussion

Name	Current Role	Past Role (where relevant)
Dr. Lovely Daisy	Head, Section of Standardization Sub-directorate of Child Survival, Family Health Directorate, MoH	
Dr. Irwan	Sub-directorate staff for Newborn, Family Health Directorate, MoH	
dr Rina Rohsiswanto	Neonatology Department -Faculty of Medicine, Indonesia University	Chair of Neonatology Working Group of IDAI
Dr. Emi Nurjasmi, MKes	President of The Indonesian Midwives Association	
Dr. Wahdini Hakim	Senior Program Manager – Health at Sayangi Tunas Cilik Foundation	
Patricia Norimarna	Save the Children, Jakarta	
Trisnawati Gandawidjaja	Save the Children, Jakarta	
Dr. Pancho Kaslam	Newborn Advisor – EMAS Project, Jhpiego	
Dr. SetyaWandita (Iding)	Chair of Neonatology Working Group of IDAI since 8/14; Faculty of Medicine, Gadjah Mada University	
Dr. Karina Widowati	NB Health Program Officer, UNICEF Country Office, Indonesia	

Annex B

People interviewed and/or participating in group discussion

Name	Current Role	Past Role
Dr. Kirana Pritasari, MQIH	Secretary of Human Resource Development and Empowerment Body, MoH	Director of Child Health Care under the Nutrition and MCH Directorate (2010); Head of Sub-Directorate of Infant Health Care under the Child Health Care Directorate (2007)
DR. dr. Setyadewi Lusyati Sp.A (K) PhD	Secretary of Perinasia; Neonatologist at Harapan Kita Hospital	
Paula Tibuludji	Monitoring and Evaluation Specialist, AIPMNH Project	
Prof Hadi Pratomo	Faculty of Public Health School, University of Indonesia; member of Perinasia	
Dr. Mohamad Taufiq	Head Sub-directorate of Quality Assurance & Accreditation of Primary Health Care, MoH	
Dr. Tini Setiawant	WHO Jakarta	
Dr. Rustini Floranita	WHO Jakarta	
Dr. Theingi Myint	WHO	

Annex C

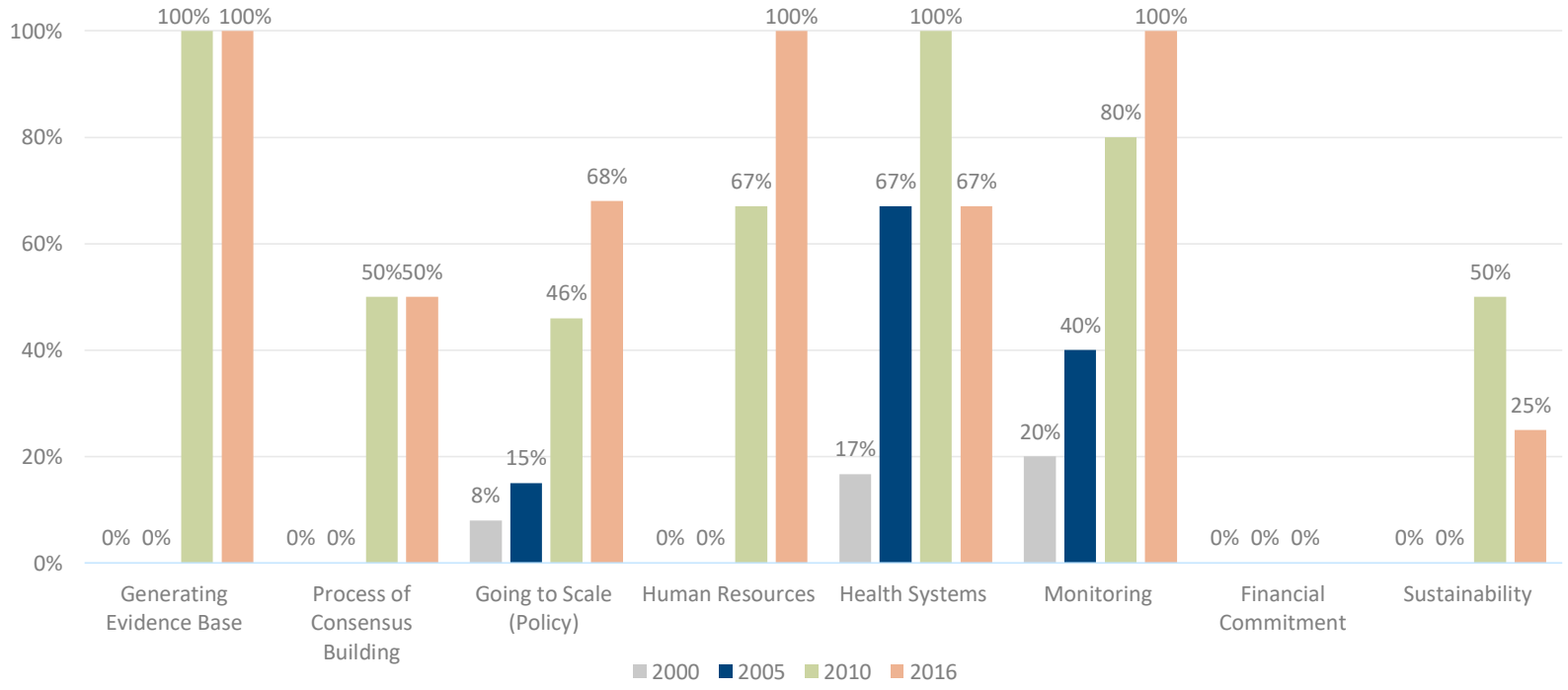
Scale-up readiness benchmarks

Generating Evidence Base	
1	National level NB health needs assessment/Situational Analysis conducted
2	NB health services/packages tested and documented in local settings
Process of Consensus Building	
3	Evidence of NB health interventions/packages disseminated at provincial/district and national levels
4	Technical working/advocacy group established and advocating for NB health OR existing working/advocacy groups integrated newborn health into terms of reference
Going to Scale	
Policy	
5	National NB policy/strategy strengthened and adopted by MOH
5a	a. National NB policy/strategy includes early postnatal checkups at home
5b	b. National NB policy/strategy includes essential newborn care
5c	c. National NB policy/strategy includes facility-based KMC
5d	d. National NB policy/strategy includes management of newborn sepsis at the primary health center level
5e	e. National NB policy/strategy includes resuscitation of newborns who have trouble breathing at birth in basic essential obstetric care (EOC) package
6	National NB policy/strategy integrated into existing programs
6a	a. National NB policy/strategy integrated in maternal health program and endorsed by MOH
6b	b. National NB policy/strategy integrated in reproductive health program and endorsed by MOH
6c	c. National NB policy/strategy integrated in child health program and endorsed by MOH
6d	d. National NB policy/strategy integrated in other health program(s) and endorsed by MOH
7	IMCI adapted to cover newborns 0-1 week of age
8	National policy/strategy includes community-based treatment guidelines for newborns with pneumonia/infection (with oral antibiotics) and endorsed by MOH
9	National essential drugs and supply list for newborn care developed and endorsed by MOH
9a	a. National essential drugs and supply list for newborn care includes gentimycin for treatment of NB sepsis at first level facilities
9b	b. National essential drugs and supply list for newborn care includes weighing scale (e.g. pan-style)
9c	c. National essential drugs and supply list for newborn care includes NB resuscitation equipment
9d	d. National essential drugs and supply list for newborn care includes thermometers for newborns (e.g. low grade or digital)
10	Implementation plan for maternal newborn and child health costed
11	National behavior change communication strategy for NB health established and endorsed by MOH
12	Maternal death audit/verbal autopsy policy established and endorsed by MOH
13	Neonatal death audit/verbal autopsy policy established and endorsed by MOH
14	National policy established to authorize midwives* to conduct newborn resuscitation and endorsed by MOH
15	Midwives authorized to administer core set of life-saving interventions
16a	Community-based cadre(s) authorized to provide injections for newborns
16b	Primary health center cadre(s) authorized to provide injectible antibiotics for newborns
17a	Community-based cadre(s) authorized to provide newborn resuscitation
17b	Primary health center cadre(s) authorized to provide newborn resuscitation
Human Resources	
18	Cadre(s) to deliver home-based NB care services identified and core competencies established
19a	In-service NB training curricula and materials developed for community-based cadres and integrated into existing curricula
19b	In-service NB training curricula and materials developed for facility-based cadres and integrated into existing curricula
20a	Pre-service NB education curricula and materials developed for community-based cadres and integrated into existing curricula
20b	Pre-service NB education curricula and materials developed for facility-based cadres and integrated into existing curricula
Health system	
21a	NB integrated into job descriptions for community-based cadres
21b	NB integrated into job descriptions for facility-based cadres
22	Supervision system for maternal/NB/child health established for relevant health cadres
23	Guidelines for referral of NB with complications established
24	Referral sites NB care strengthened
25	Perinatal death audits established and endorsed by MOH
Monitoring	
26	Key maternal and NB indicators included in national HMIS
27	Key maternal and NB indicators included in national surveys
28	National targets to track newborn health established
29	Specific notification of maternal deaths established and implemented
30	Specific notification of newborn deaths established and implemented
Financial Commitment	
31	Government expenditure on health as % of total government expenditure
32	Per capita Official Development Assistance (ODA) to maternal and neonatal health per live birth (US$)
Sustainability	
33	Technical working/advocacy group meeting on regular basis
34	Functional national guiding institution for maternal/NB/child health established
35	Focal person for NB health established in MOH on NB health
36	Statements of public support (public and private) for NB health officially released
37	Resources leveraged for NB health

Annex C

Scale-up readiness benchmarks for Indonesia 2000–2016

This chart shows the degree to which the benchmarks indicating that a country is ready for scaling up its newborn health interventions have been accomplished. SNL performed the review of these benchmarks in 2000, 2005, and 2010. The study team reviewed the benchmarks in 2016 as part of this study.



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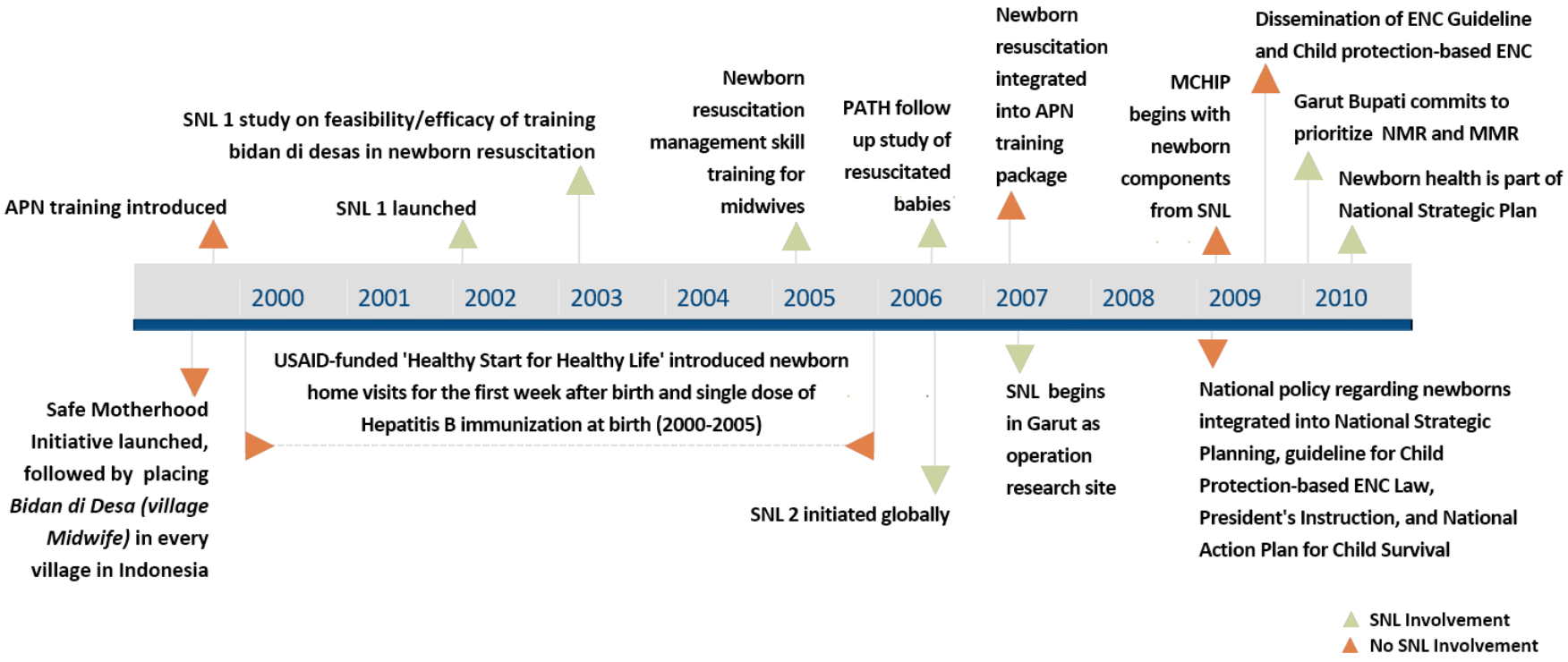
Annex D

Timeline showing key projects and policies related to newborn health 2000–2016



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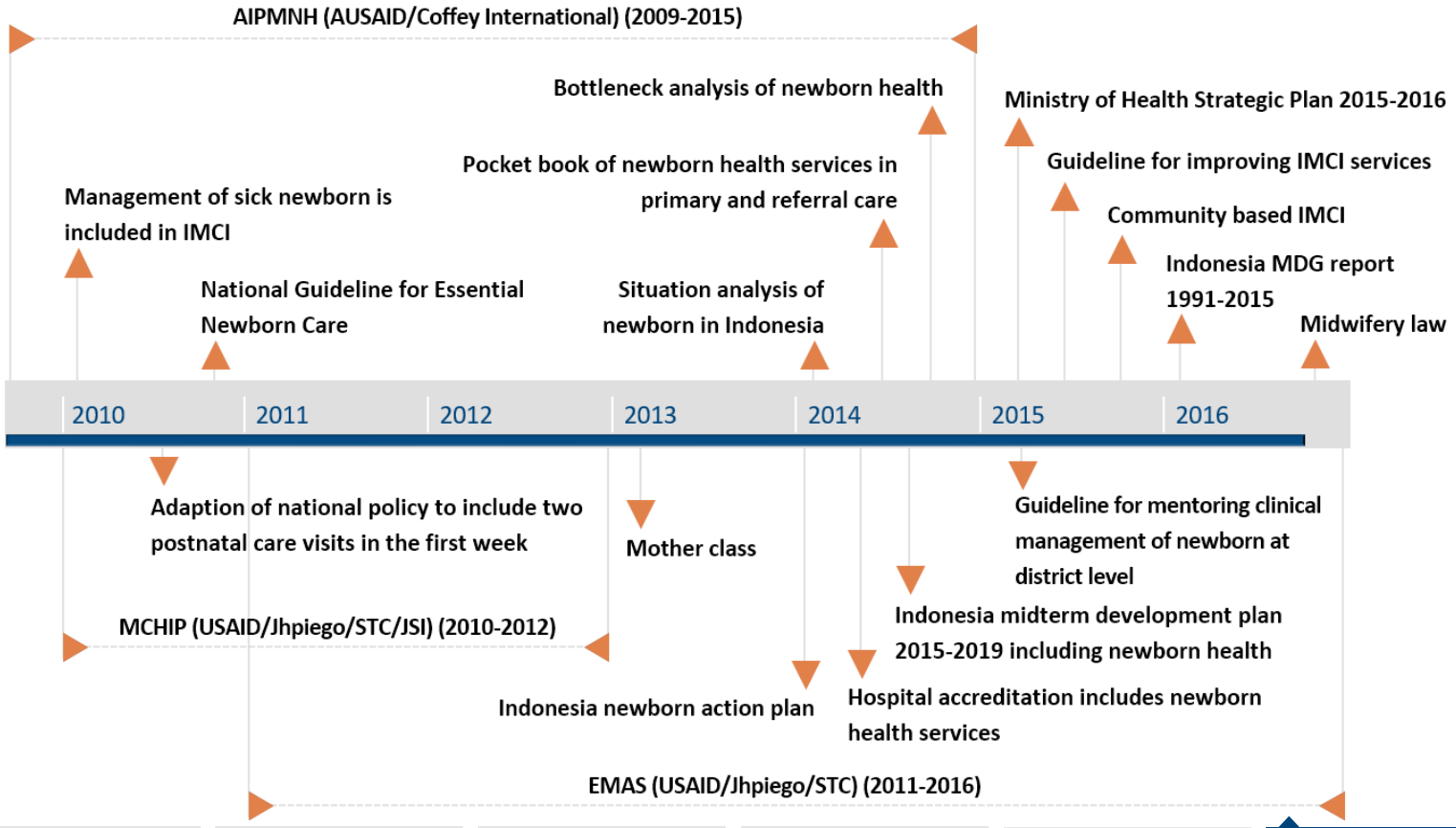
Timeline showing key projects and policies related to newborn health 2000–2016



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Annex F

Interview Guide

Introduction

1. Please tell me/us briefly how you have been engaged with newborn health in [COUNTRY].

2. How long have you been working with [ORGANIZATION] in this area and in what capacity?

Progress in Newborn Health

3. In your opinion, what progress has been made in newborn health over the past 4 years? Which interventions have seen the greatest progress?).

   a) Among these newer interventions, which ones have made the most progress?

4. In your opinion, what are the factors that have facilitated the integration of newborn interventions into the package of essential health services in Indonesia?

5. What would you say are the key factors that have enabled this progress?

6. What factors do you think have inhibited making further progress for newborn health and newborn interventions in Indonesia?

7. Thinking back over the last 5-10 years, which key people or organizations contributed to this progress?

SNL's Contributions to Newborn Health

8. SNL worked in Indonesia from 2005-2014 to create attention and momentum around newborn health. Were you working in Indonesia during this period? (If No, skip to Q9)

   a) In your opinion, did SNL contribute to the integration of newborn care into the minimum package of interventions?

   b) What contributions did SNL make in newborn health?

   c) How or in what ways did SNL make these contributions?

9. What other major contributions did other stakeholders make to help achieve progress towards newborn health?

Looking Forward

10. If we want to strongly increase coverage with high impact newborn interventions in order to decrease neonatal deaths, what does Indonesia need to do in the next few years to achieve that result?

11. What kinds of global level actions over the next few years, if anything, would support achievement of these results?

12. If you had three wishes which would help sustain the gains achieved and achieve even more progress for newborns in (Country), what would they be?

Conclusion

13. Is there anything else that you would like to share or discuss related to newborn heath?

14. What questions do you have for me/us?

Contact

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