MCHIP Country Brief: Indonesia

Selected Health and Demographic Data for Indonesia	
Maternal mortality ratio (deaths/100,000 live births)	220
Neonatal mortality rate (deaths/1,000 live births)	15
Under-5 mortality rate (deaths/1,000 live births)	40
Infant mortality rate (deaths/1,000 live births)	32
Contraceptive prevalence rate	43
Total fertility rate	2.6
Skilled birth attendant coverage	79%
Antenatal care,4+ visits	82%
Sources: World Bank 2012; Indonesia 2012 DHS; WHO.	

Health Areas:

- Family Planning
- Maternal Health
- Newborn Health
- Child Health

Program Dates	January 2010–December 2012					
Total Mission Funding	Redacted					
Geographic Coverage	No. (%) of provinces	9%	No. of districts	3		20 centers/hospitals 185 midwiferies
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INTRODUCTION

The main goal of the Maternal and Child Health Integrated Program (MCHIP) in Indonesia was to facilitate the uptake of evidence-based and integrated maternal, newborn, and child health (MNCH) programs and policies at the district level. The USAID Mission in Indonesia bought into the global MCHIP mechanism in 2010, as a two-year program for US$ 4.8 million that was later extended to three years for a total of US$ 9.8 million.

In Indonesia, Jhpiego—with implementing partners Save the Children (SC) and John Snow, Inc., and a host of local institutions—collaborated with the Ministry of Health (MoH) and district health offices (DHOs) to design and implement a dynamic and innovative approach to providing technical assistance to the MNCH program in three selected program districts. Officially launched in June 2010, MCHIP served as the bridge between the two USAID MNCH bilaterals—Health Services Program (HSP) and Expanding Maternal and Neonatal Survival (EMAS)—as the former ended in 2010 and the latter was initiated in 2011.

Major Activities

- Postpartum hemorrhage (PPH)
- Pre-eclampsia/eclampsia (PE/E)
- Integrated postnatal care
- Handwashing for newborn survival
- Facility quality improvement
- Emergency obstetric and newborn care
- Essential newborn care (ENC)
- Newborn asphyxia
- Kangaroo Mother Care (KMC)
- Community case management (neonatal sepsis)
- Early initiation of and exclusive breastfeeding
- Maternal and perinatal audits
- Evidence-based maternal, newborn, and child health (MNCH) planning at all levels of health system

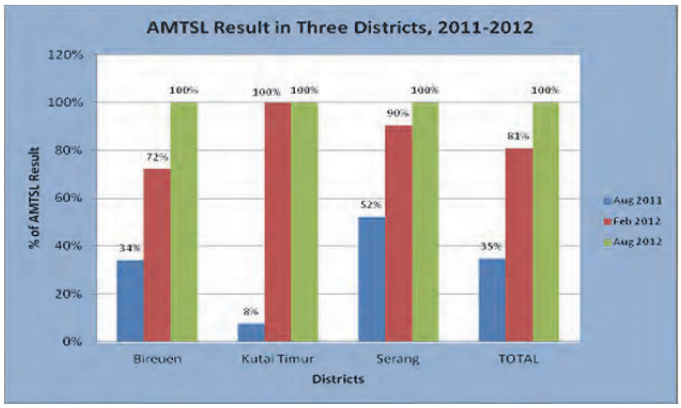
When MCHIP started working in Indonesia, it still had one of the highest maternal and newborn mortality rates in Southeast Asia, despite significant development success. One of the explanations was that, at the central level, Indonesia has several evidence-based policies, materials, tools, and high-impact approaches developed, introduced, and endorsed by the MoH, yet few remote districts succeeded in implementing these policies. To address this gap, MCHIP was tasked with demonstrating how integrated, high-impact MNCH approaches can be scaled up throughout the remote districts. The MoH and MCHIP selected three districts that ranked low in the MoH composite index for development and community health—classified as "Health Problem Areas."

Program Target Population

DISTRICT	TOTAL POPULATION	TOTAL NUMBER OF NEWBORNS	TOTAL NUMBER OF DELIVERIES	TOTAL NUMBER OF PREGNANT WOMEN	HIGH-RISK PREGNANT WOMEN	HIGH-RISK NEWBORNS
Bireuen	389,288	7,708	8,093	8,479	1,696	1,156
Serang	1,402,818	28,758	30,196	31,634	6,327	4,314
Kutal Timur	255,637	4,678	4,912	5,146	1,029	702
TOTAL	**2,047,743**	**41,144**	**43,201**	**45,258**	**9,052**	**6,172**

MCHIP facilitated the implementation of MoH-approved, community-based programs—such as health information classes for pregnant women and mothers, the Traditional Birth Attendant (TBA)-Midwife Partnership, and Handwashing with Soap (HWS)—in 17 sub-districts across the three districts. In addition to these MoH-approved programs, MCHIP also modeled new

programs such as Community Case Management (CCM) and Integrated Postnatal Care (IPNC). These community-based programs were designed to increase the demand for and awareness of key MNCH messages and services. Lessons learned from these community health programs were funneled up to the national level to enhance the national guidelines, policies, and job aids.



To meet the demand for MNCH services, MCHIP facilitated the strengthening of three district hospitals, 17 community health centers, and 185 midwifery practices using a quality improvement approach called Standards-Based Management and Recognition (SBM-R®). All facilities and midwifery practices complied with 80% or more of the evidence-based MNCH standards. For the midwives who are frontline health care providers, lifesaving skills such as active management of the third stage of labor (AMTSL), management of pre- eclampsia/eclampsia, and essential newborn care were reinforced through on-the-job training and supportive supervision. As a result, 100% (400) of the midwives observed showed compliance with standards in all three steps of AMTSL; the majority of women with severe pre-eclampsia and eclampsia cases at the community health centers received magnesium sulfate before referral; and at the three district hospitals, approximately 46% (302) of low birth weight (LBW) babies received Kangaroo Mother Care (KMC)—with 66% (199) of the LBW babies who received KMC showing an increase in weight.

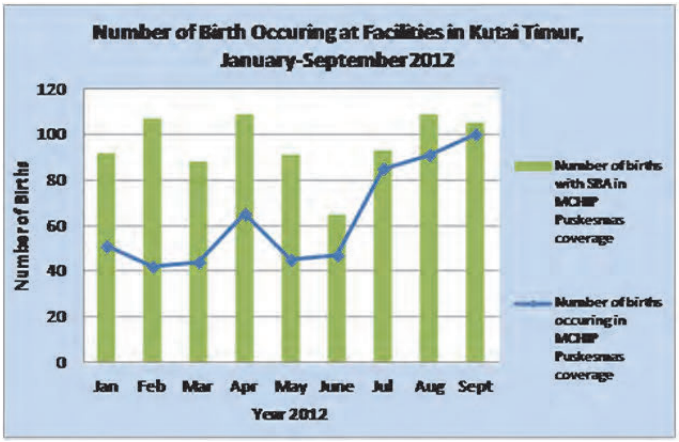
MCHIP also facilitated strengthening of the district health management system. After political decentralization in 2001, the districts were provided the autonomy to lead and manage their health programs. However, districts lack the technical resources and management capacity to do so. MCHIP facilitated the rollout of the District Team Problem-Solving (DTPS) process to ensure evidence-based planning and budgeting for district-level programs. As a result, the districts saw an increase in the percentage of allocation in the total district budget toward MNCH. Maternal and perinatal audits to conduct verbal autopsies of 100% of the maternal and newborn deaths and review of selected cases, ranging from the community to the district level, were facilitated by MCHIP in all three districts. And finally, to ensure that the MNCH programs are sustained over time, MCHIP facilitated the development and adoption of 148 MNCH local laws and regulations.

To disseminate accomplishments of and lessons learned from the MCHIP districts in adopting the national MNCH programs, as well as to generate the interest of other districts and provinces, MCHIP facilitated a Mini-University in each of the three districts. Over 650 participants representing 42 districts were in attendance. The district teams included the head of the district, head of the district hospital, *Bappeda* staff, head of the DHO, and head of the Family Welfare Department of the DHO. Representatives from the MoH, USAID, and MCHIP target districts also attended. The district-level ownership was outstanding and clearly visible in all three MCHIP districts. The Mini-University was truly a showcase of the district's achievements and efforts, with districts tirelessly advocating for adoption of the programs. There was also strong participation from non-MCHIP districts. The districts were excited to hear about and learn from the MCHIP model district. They asked questions, expressed enthusiasm and commitment, and in some cases held strong discussions—sharing their own experiences related to why or why not the MCHIP model could be replicated in their area.

One of the goals of the Mini-University was to help establish commitment from the participating districts to implement similar MNCH programs in their districts. The

participating districts selected the MNCH programs they intend to implement using the following criteria: 1) district need; 2) availability of budget; and 3) availability of human resources. The districts also felt that if the program was deemed necessary, funds could be requested for implementation in the district's planning and budget cycle. MCHIP developed a package of tools and guidelines in support of program replication for non-MCHIP districts and set criteria for districts interested in MCHIP replication. All 42 participating districts selected programs for replication after the Mini-University, and 34 of these districts participated in training-of-facilitator events for at least one program intervention.

KEY ACHIEVEMENTS



Increased the actual number of deliveries assisted by skilled birth attendants by 28% and facility-based deliveries by 20% in MCHIP-assisted sites.

Increased the proportion of newborns who receive postnatal visits during the first week of life by 6% and mothers who receive postnatal visits during the first week postpartum by 10 %.

Decreased the proportion of births attended by TBA by 5% and increased the number of births attended by TBA-midwife partnerships by 14% in two of the three MCHIP-assisted sites.

Contributed to reaching an estimated 12,025 mothers and pregnant women with maternal and newborn health messages through the mother support group classes.

Provided on-the-job mentoring and/or training to a total of 5,335 providers and community health workers on various clinical and non-clinical skills related to maternal, newborn, and child health.

A total of 46% (302) of the low birth weight babies born received Kangaroo Mother Care, and 66% (199) of those who received KMC gained weight in the MCHIP-assisted sites.

Assisted all three MCHIP districts in submitting an allocation request for MNCH funding based on real need. In two of the three districts, allocation for MNCH, as a part of the MoH budget, increased by 12%.

Tested a new community case management (CCM) model for children 2 to 59 months of age (pneumonia and diarrhea) and infants less than 2 months of age (newborn sepsis) delivered by community midwives. In Bireuen and Kutai Timur, with training and support, the midwives were able to provide CCM services (identify, refer, and treat cases) in their communities. Lessons learned from these community health programs were funneled up to the national level to enhance the national guidelines, policies, and job aids.

Assisted the passage of laws and regulations in three MCHIP districts and 85% of the MCHIP villages. These laws represent the commitment of the local government to MNCH and may lead to sustained allocation of resources over time.

Conducted dissemination of the program findings and experiences in the form of Mini-Universities in three provinces and Jakarta. As a result of the dissemination, all 42 participating districts (100% of the districts in the three MCHIP provinces) showed interest in replication.

WAY FORWARD

Community members in general preferred that midwives, rather than community health workers, facilitate community classes, as midwives were trusted more. MCHIP developed a model for the village level classes in which the midwife *acted* as the supervisor and the community health worker *acted* as a facilitator, which was also accepted by the community. This model allowed the midwives more flexibility and an opportunity for the community health workers to be engaged.
Selection of community health workers should be well thought out. Midwives with strong supervision skills can support weak community health workers.

Monitoring and supervision of midwives and community health workers is essential. Monthly visits to the health facility and quarterly visits to the program site are recommended.

In areas with very small populations, midwives do not see enough deliveries to keep up their skills, and other methods must be used to ensure this.

Internship experience at the hospital for the community health center's Basic Emergency Obstetric and Newborn Care team is necessary to strengthen their skills.

A clear linkage between the Maternal and Perinatal Audit process is essential. Quality improvement and supportive supervision teams can be revised to address identified gaps.

Once the planning is complete, advocacy and development of local laws and regulations should be prioritized. This is often a challenge because of limited funds to finance these activities. Advocacy to ensure proper allocation is intensive and essential at every step in the planning process; the time needed to develop a law that remains consistent, despite changes in government, is longer than the one- to two-year program cycle. A "public figure" with access to executive and legislative teams should be nurtured as a MNCH advocate.

The process and time required to initiate, develop, and pass regulations were different in all three MCHIP districts, but equally complicated. MCHIP recommends a District Team Problem-Solving workshop as an orientation to MNCH for all parties before initiating the regulation development process. Commitment and involvement from other sectors are stronger when they are tasked with a specific deliverable.