Innovative approaches to enhancing maternal and newborn survival: Indonesia’s experience in an era of global commitments to reducing mortality

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Abstract
Globally, countries have made impressive strides toward achieving targets set by the Millennium Development Goals (MDGs) to reduce maternal mortality. The subsequent Sustainable Development Goals (SDGs) have further challenged countries to accelerate these reductions. While Indonesia invested in several initiatives to improve care for mothers and newborns and made large gains in improving skilled care at birth, the country fell short of its MDG target. This paper outlines some of the remaining challenges and highlights the role of the US Agency for International Development-funded Expanding Maternal and Neonatal Survival (EMAS) program in eliminating the barriers to improved care. Achieving the SDGs by 2030 will require strong cross-sectoral collaboration and innovative approaches, such as the recent launch of Indonesia’s national health insurance program, which can accelerate reductions in mortality by reaching women most in need of services.

KEYWORDS
Expanding Maternal and Neonatal Survival (EMAS); Indonesia; Maternal and neonatal mortality; Millennium Development Goals (MDGs); Skilled birth attendants

1 | INTRODUCTION: OVERVIEW OF GLOBAL CHALLENGES WITH MATERNAL AND NEWBORN HEALTH

With the launch of the Millennium Development Goals (MDGs) in 2000, 193 countries committed to reducing maternal mortality by 75% (MDG 5) and child mortality by two-thirds (MDG 4) by 2015, compared to base levels from 1990. These were lofty goals, designed to drive attention to and investment in the delivery of high-impact, life-saving interventions to prevent maternal and child mortality. Achievement against those goals was noteworthy; by 2016, maternal mortality was reduced by 44% and child mortality by 49%, compared to 1990. However, overall progress has been slow and uneven.1,2 Despite increased use of maternity services among the 75 Countdown to 2015 countries that account for 95% of global maternal, newborn, and child deaths, only four—Cambodia, Eritrea, Nepal, and Rwanda—achieved both MDGs related to maternal and newborn mortality.3

To further the promise of economic and social development, improvements in the quality of reproductive, maternal, and newborn care and reductions in disparities in access to care are urgently needed. To face this challenge head on, countries set even more ambitious targets in the 2030 Sustainable Development Goals (SDGs); the Global Strategy for Women’s, Children’s, and Adolescents’ Health; the Newborn Action Plan; and country commitments to achieve universal health coverage. It is in this context of bold goals and clear commitments that Indonesia’s unique health situation must be viewed.
Maternal and newborn health in Indonesia has changed drastically since 1990. In 1990, 79% of births took place at home; 65% of these took place without a skilled birth attendant. Only 23% of pregnant women attended the four prenatal care visits recommended by the Ministry of Health. The maternal mortality ratio was tragically high at 446 deaths per 100,000 live births, and nearly 10% of all children died before the age of five.

Determined to address those statistics, the Indonesian government invested heavily in improving care for mothers and newborns, creating a stronger reproductive health service delivery system spanning the country’s many islands. The government designed several initiatives, including placement of bidan di desa (midwives) at the village level, community education and mobilization efforts such as Desa SIAGA (Alert Villages), and social safety net programs such as Jamkesmas, which expanded access to services and created positive social norms that promoted skilled attendance at birth, increased male involvement, and improved prenatal care. Births assisted by a skilled birth attendant increased to 83% by 2012, and 74% of pregnant women attended at least four prenatal care visits. As a result of the government’s commitment and focus, commendable reductions in maternal and neonatal mortality were achieved. Compared to 1990, maternal mortality declined by 31% to 305 deaths per 100,000 live births in 2015. Neonatal mortality dropped by half, from 30.3 deaths per 1000 live births in 1990 to 14.1 in 2015. Despite coming up short of its MDG for reducing maternal mortality (102 maternal deaths per 100,000 live births), these are, nevertheless, tremendous accomplishments for a country with such a vast and diverse population.

Yet, with all this progress, why were women and newborns still dying? Maternal and neonatal mortality in Indonesia remained among the highest in Southeast Asia in the 2000s, despite social and financial progress that created the largest economy in the region. It was clear that several stubborn gaps persisted within Indonesia’s maternal and neonatal service delivery system. To accelerate mortality reductions and achieve greater equity in access to health services, technical expertise was needed to address these gaps, especially the five most critical ones.

First, although facility-based deliveries were increasing, avoidable maternal and neonatal deaths continued to occur in hospitals. According to the Ministry of Health, nearly 60% of maternal deaths occurred in hospitals, largely a result of substandard quality of emergency obstetric care. Second, emergency referrals were typically ad hoc and not systematic. Clear communication, established systems for effective and efficient referrals, and continuity of care during referral were almost nonexistent. Multiple transfers from one facility to another were common, and in rural locations with geographic and transportation barriers, delays in receiving care due to transfers could mean the difference between life and death. End-to-end continuity of clinical care during the referral process was not standard, and there was no culture of review and audit to identify and resolve bottlenecks within the referral process.

Third, confusion and inefficiency within the health financing system contributed to delays in decisions to seek care and in the referral process. While national- and district-level financing and reimbursement schemes existed for poor and vulnerable women and children under five, the processes for accessing them were confusing and cumbersome for consumers.

Fourth, great inequities remained in quality of services between geographic locales and socioeconomic classes. Both maternal and neonatal mortality were higher in rural areas and among women living in lower socioeconomic conditions.

Finally, providers, hospitals, and facilities lacked transparency in the quality of their services. Citizens were unaware of their right to high-quality health services. Nor were there routine mechanisms for community members to provide input or file complaints regarding quality of health services. The national hospital accreditation system was assessed infrequently and was not combined with other quality-of-care efforts or hospital governance. The gulf between the people and their providers seemed unbridgeable.

To address these gaps, the US Agency for International Development launched the Expanding Maternal and Neonatal Survival (EMAS) program in 2011, which was led by Jhpiego and partners. EMAS was designed as a conduit to eliminate these barriers to access and quality of obstetric and neonatal care. In Indonesia, and globally, Jhpiego’s motto is that where a woman lives should not determine if she lives. The papers presented in this Supplement provide insight into the strategies used during project design, data on the results EMAS achieved in improving maternal and neonatal health services, and reflections on challenges that remain.

In the midst of substantial economic progress and midway through implementation of EMAS activities, a monumental change occurred within Indonesia’s health system—the launch of Indonesia’s national health insurance program, Jaminan Kesehatan Nasional (JKN). The Government of Indonesia is now in the middle of an ambitious rollout of JKN, so that by 2019, all 261 million Indonesians will have financial protection and access to quality clinical care. If ever there was a time to reinvigorate focus on maternal and newborn survival, the time is now. As the insurance scheme becomes operationalized throughout the country—and as Indonesia charts a path to universal health coverage—we anticipate seeing greater demand for high-quality health services, improved financial access to and equity of care, and further reductions in mortality. If a country as populous as Indonesia can achieve universal access to health services, it would certainly be a model for other middle-income countries in the early stages of rolling out national health insurance.
CONCLUSION

For Indonesia and for the world, energy and commitment for achievement of the SDGs is building. Countries that fell short of achieving their MDGs will use this opportunity to analyze approaches that have not worked and innovate to include new approaches that will accelerate mortality reductions over the next decade. From September 2011 through March 2017, EMAS worked within the local context to understand and devise innovative and sustainable solutions to health challenges in high-priority districts. Many of these solutions are appropriate for wider iteration, application, and scale-up across Indonesia, especially as JKN matures and demand for high-quality, facility-based care increases. The lessons learned in Indonesia regarding quality improvement and health system strengthening approaches should also be considered by other countries challenged with high maternal and neonatal mortality.

While Indonesia and many other low- and middle-income countries achieved commendable progress in reducing maternal and neonatal mortality, there is more work to be done. Achieving the SDGs by 2030 will require strong cross-sectoral collaboration and innovative approaches. In Indonesia, we must continue to build on progress made while supporting the government’s vision of universal access to improved health services. As deaths due to postpartum hemorrhage and pre-eclampsia/eclampsia decrease, we must address puerperal infection, stem the tide of rising cesarean delivery rates, and hone approaches to address noncommunicable comorbidities. We should continue to emphasize the importance of data use to improve quality of care and prioritize interventions where they are needed most. As members of the global health community, we look forward to seeing continued progress as Indonesia and other countries work toward their SDGs. Dramatic improvements in health systems do not happen overnight, nor do they happen without thoughtful planning. Thus, with an eye toward 2030, let us today renew our commitment to health, well-being, and improved quality of life for families in Indonesia and around the world.

AUTHOR CONTRIBUTIONS

All authors contributed to content generation and production of this article.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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