Saving Newborn Lives is a health program to save life of the newborn in Garut District, West Java.

Save the Children

BAKTI HUSADA

“I bought this shoes for our first child but it’s never happened, she died one day after birth.”

Photo cover: Andrew Caballero Reynolds

Photo: Agus Sasmito

CONTENT

Part I: ESSENTIAL NEONATAL CARE **6**

Why is immediate and postnatal care important? **6**

A. Increased availability and accessibility of essential neonatal care **9**

B. Improving village midwives' capacity to deliver immediate and early postnatal care through on job training and mentoring **11**

C. Improving knowledge, changing behavior and neonatal care practices in the community **12**

D. Enabling environment and policies to support essential neonatal care **12**

Part 2: ESSENTIAL NEONATAL CARE: A SUCCESS STORY FROM GARUT **14**

A successful model of delivering postnatal care in Garut District. **14**

1. Political support from district to national level **16**

   A. National Level: Immediate and early postnatal care becomes national policy of the Ministry of Health Republic Indonesia **16**

   B. The District Level: Government leadership committed to decrease neonatal mortality to achieve MDG 4 **16**

2. Cross-sectoral Cooperation **20**

3. Improved coverage and quality of immediate and early postnatal care **21**

Conclusion **23**

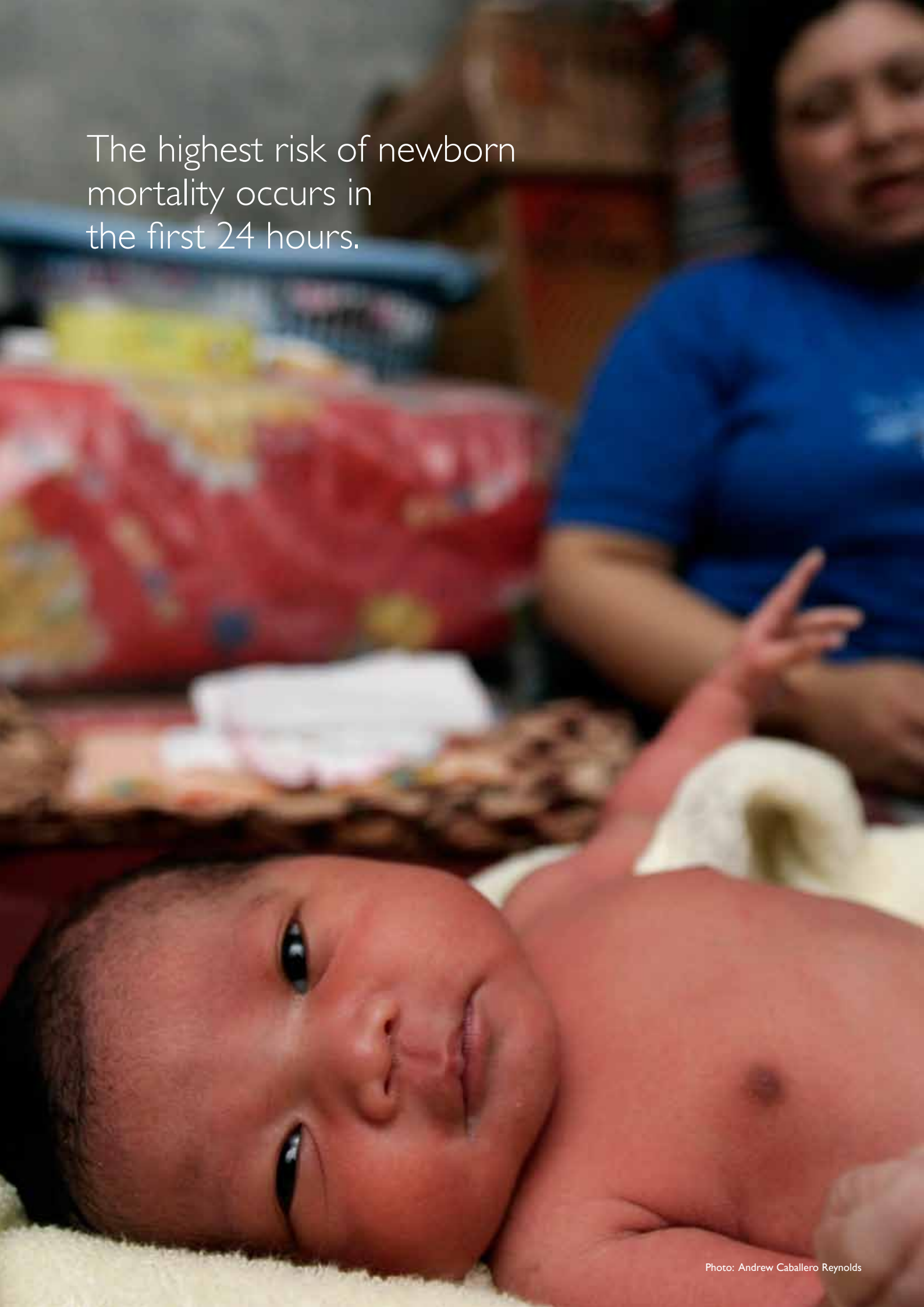


Photo: Andrew Caballero Reynolds

Due to cultural practices and beliefs that newborn can not be brought outside the house before 40 days old so that newborns never meet essential health services.

Part I:

ESSENTIAL NEONATAL CARE

Why is immediate and postnatal care important?

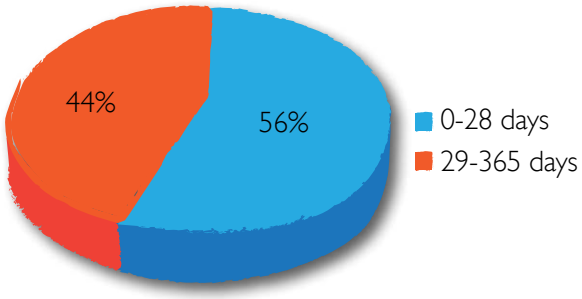
Childbirth is supposed to be a moment of joy. However, it is also a time of vulnerability for both mother and newborn. Lack of appropriate postnatal care during this period leads to significant increase in risk to the lives of mothers and newborns.

Despite significant reductions in the past decades the Indonesian infant mortality rate remains high. According to the 2007/2008 Indonesian Demographic and Health Survey (SDKI), the infant mortality rate in Indonesia was 34 per 1,000 live births, with 56% contributed by neonatal mortality (19 per 1,000 live births). Nearly 80% of the neonatal deaths occurred within the first week of life, with 50% occurring within the first 48 hours after birth (See Figure 1 and 2). In addition, one of Indonesia's Millennium Development Goals' (MDGs) targets is to reduce infant mortality rate (including neonatal), from 35 to 23 deaths per 1,000 live births in 2015. This target cannot be achieved without a significant reduction of neonatal mortality.

To achieve MDG 4, mothers and newborns must have access to immediate and early postnatal care, especially within the first hour, first days and first week of life.

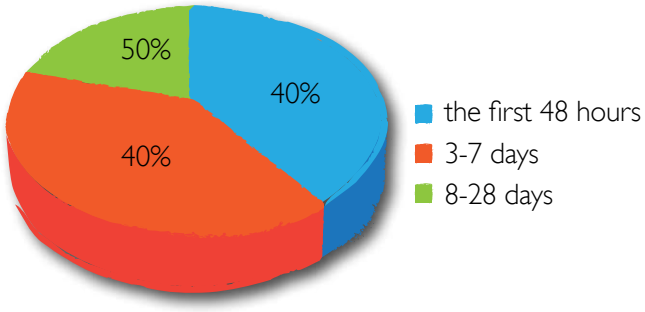
The major cause of neonatal mortality in Indonesia reveals the existing lack of postnatal care. Causes of neonatal mortality include; low birth weight babies

Figure 1. Infant Death Period



Source: SDKI 2007

Figure 2. Neonatal Death Period



(29%), asphyxia (27%), tetanus, infections (15%). Many of the deaths are preventable with basic and essential newborn care.

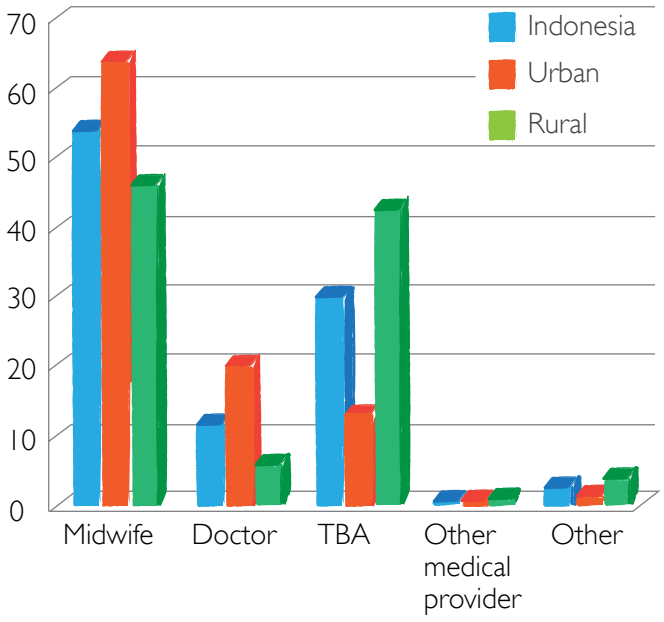
In Indonesia access to essential neonatal care at the time of birth and in the first days of life remains limited. According to the national social and economic survey (SUSENAS 2007), 33% of births are not attended by trained health workers. In rural areas, 43% of deliveries are attended by traditional birth attendants (See Figure 3). When deliveries are not attended by skilled health providers newborns and mothers do not have access to immediate and early postnatal care. This care is crucial to promote healthy newborn practices, support mothers to successfully breastfeed, and identify, treat and refer sick newborns.

The introduction of a model to deliver essential newborn care based on skilled attendance at birth, immediate and early postnatal care in the first week of life, has the potential to significantly reduce neonatal mortality in Indonesia. Such care must be provided within the decentralized Indonesia health care system, recognizing limitations of available resources.

Immediate and early newborn care includes skilled attendance at birth, followed by three home visits in the first month of life. These visits, known as KN1, KN2 and KN3 are provided by trained midwives (See Box 1). Previous national policy included two newborn visits, KN1 in the first 7 days and KN2 from day 8 – 28. However, neonatal mortality is highest within first 48 hours after-birth, thus requiring much earlier care from a skilled provider. Studies in Bangladesh, India and Pakistan demonstrated that immediate and early neonatal home-visits resulted in a reduction of the neonatal mortality rate as much as 30-60%.

A model to deliver immediate and early postnatal care through the decentralized Indonesia health care system has been tested in Garut district, demonstrating that resources can be allocated to provided quality care to mothers and newborns.

Figure 3. Birth Attendant



Source: Susenas 2007.

Photo: Agus Sasmito

Newborn's first contact with health provider (midwife) happened when they were going to Posyandu/Health Center and it was when they were 1 month old or more.

Coverage of village based midwives in the pilot area of Garut district is high, however, indicators of prenatal care and skilled care at birth indicates that demand for their services was low prior to the intervention. This is the result of both supply and demand side barriers.

Social and cultural factors such as the reliance on traditional birth attendants (known as Paraji [2] in Garut) and low level of knowledge of importance of prenatal care and skilled attendance at birth prevent families from seeking care. This is further complicated by economic and geographic barriers.

On the supply side, many midwives have limited training and skills to deliver postnatal care in the first day, week and month of life. The model tested in Garut used a multi program approach to address both demand and supply side barriers.

Why immediate and early postnatal care is tested in Garut?

Garut was selected for testing of a district level model for the delivery of immediate and early postnatal care given high mortality and neonatal indicators in comparison to other West Java Districts. In 2005 Maternal Mortality Rate of Garut District was 297 per 100,000 people; and neonatal mortality rate was 30 per 1,000 live births.[1] The causes of neonatal deaths in this area are low birth weight, infection and asphyxia.

Interventions to improve immediate and early postnatal care:

- Increased availability and accessibility of essential neonatal care at facility and home.
- Improved capacity of midwives to deliver postnatal care
- Improved community and household level knowledge on basic newborn care and recognition of danger signs
- Improved policy environment to support provision of immediate and early postnatal care

Box 1.
Neonatal Visit (KN)

Immediate and early postnatal care includes three visits within the first month of life KN1: the first 6-48 hours after-birth, KN2: on the 3rd-7th days after-birth and KN3: on the 8th-28th days after-birth.

Home visits include the following:

- Support for mothers for early initiation of breastfeeding (within 1 hour after-birth) and exclusive breastfeeding for six months,
- Keeping babies warm with promotion of skin to skin care,
- Keeping the umbilical cord clean and dry
- Identification of danger signs and appropriate referral for sick newborns,
- Identification of newborns with special needs including low birth weight and feeding problems,
- Counseling for mothers and care givers on healthy newborn care practices and immunization.

[1] Maternal mortality rate in 2005 was 262 per 100,000 population and infant mortality rate was 29.4 per 1,000 live births (SDKI 2005)
[2] Paraji is the local term referring to traditional birth attendant

Newborn received immunization and monitoring of childhood development.

A. Increased availability and accessibility of essential neonatal care

Strengthening of immediate and early home and facility based postnatal care by trained village based midwives within the first 6 – 48 hours of life, days 3 – 7 and days 8 -28 was promoted as means of increasing access to essential newborn and maternal care. This addresses the cultural barrier of families not seeking care outside of the home for the first 40 days of life.

Postnatal visits are conducted by village midwives and are guided using algorithm and reporting format from integrated management of childhood illness (MTBS) as described below (See Box 2).

Integrated Management of Young Infant (MTBM)

The Child Health Directorate at the Indonesia Ministry of Health has agreed to bring MTBM services to the home integrated with neonatal visits (KN1, KN2 and KN3). Integrated management of childhood illness is a globally accepted approach for identification, and treatment of sick newborns in use in Indonesia since 1996 at the. facility level. For newborns experiencing symptoms of illness such as fever, difficulty breathing or feeding problems, they may not be brought to health facilities, due to cultural practices and beliefs. For this reason, village based midwives in Garut have used the MTBM algorithm and referral guidance to guide postnatal home visits to identify, and properly refer sick newborns.

Recording and reporting of KN1, KN2 and KN3 also uses the existing MTBM card to keep accurate records and track progress of sick newborns. The increased emphasis on reporting and recording has provided additional motivation for midwives to conduct visits. The MTBM form for recording has been important component of increasing the coverage of postnatal care in Garut District.

Box 2.
What is MTBM?

MTBM (*Manajemen Terpadu Bayi Muda*) or in English Young Infant Integrated Management. MTBM is a method to make sure that health care for young baby aged 1 days – two months old is provided, both for healthy and sick babies. The content of MTBM is how to assess and classify young infant health, deciding on the treatment and medicine, counseling for mothers and follow up care. The MTBM care done by health workers is recorded in MTBM card.

SNL brings Essential Newborn Care to the newborn at home through home visits (KN1, KN2, KN3).

Partnership of midwives and traditional birth attendants (Paraji)

The establishment of a partnership between village based midwives and traditional birth attendants is a strategy to increase the percentage of deliveries attended by midwives and thus the percentage of mothers and newborns receiving immediate and early postnatal by midwives.

Traditional birth attendants (Paraji) are well respected and influential members of the community. Pregnant women and families regularly seek their services for prenatal care, delivery and postnatal care. Many women and families prefer their services, due to traditional beliefs and lower cost. In addition TBAs provide important cultural practices not provided by midwives.

To ensure an effective partnership roles and responsibilities of midwives and TBAs are clearly defined.

The midwife is responsible for provision of skilled prenatal care, delivery care and postnatal care for both mothers and newborns. TBAs are responsible for encouraging women and families to seek midwife services, notification of midwives of pregnant women and women in labor, provision of mother and family support and counseling, and provision of support to women during labor, delivery and the postnatal period.

To formalize this partnership a local village regulation (PERDES) has been passed regulating the sharing of fees between midwives and TBAs without increasing

Box 3.
Why is 'on job training' ?

'On job training' is designed to complement existing in service training. Clinical trainers are able to respond to immediate needs of midwives and use real cases to refresh skills. In addition the on-job methodology is:

- Cost effective,
- Engages doctors and midwife coordinators in the learning process,
- Allows midwives to continue working while learning,
- Real challenges and issues can be used as learning opportunities,
- Issues on daily practices can be continually discussed in the learning forum,
- Realization of knowledge sharing among the training participants and trainers,
- Training participants get supervision from the trainer,
- Refresher activities run regularly and routinely using the monthly meeting of midwives at the health center.

out of pocket expenses for families, or loss of income for TBAs.

Partnership monitoring data indicates a significant increase in skilled birth attendance by midwives leading to improved immediate and early postnatal care.

B. Improving village midwives' capacity to deliver immediate and early postnatal care through on job training and mentoring

A 2007 assessment of midwives in Garut indicated a significant gap in knowledge and practice for the delivery of essential newborn care. Thus an ' on- job-training ' (See Box 3) capacity building program was designed to improve critical newborn care skills among midwives and nurses at the village and facility level. The ' on – job- training ' package includes management of birth asphyxia, care for low birth weight newborns, kangaroo mother care, young infant integrated management (MTBM) and counseling skills.

To establish an 'on-job-training' and mentoring system the following cascade training method was used.

- First a core group of district level trainers were established. This core group included existing trainers from P2KS (Secondary Clinical Training Center) of West Java Province and training consultant from SNL2 program.
- Second, core district trainers built the capacity of clinical trainers (CT) at the district level . Clinical trainers include, doctors, staff of Garut District Health Office, and trainers from Primary/District Clinical Training Center (P2KP).
- Third, clinical trainers provide capacity building for clinical instructors (CI). Clinical Instructors include, doctors, midwife coordinators/village midwives from SNL intervention areas (Health Centers).
- Fourth, clinical instructors provide 'on job training' and mentoring for village midwives and facility based midwives in their working area.

To ensure quality the competency of all clinical instructors are tested by district level trainers. In addition, clinical instructors are responsible for conducting supervision of village midwives participating in on job training program.

The methodology of 'on job training' centers on regular interactions with clinical instructors, to address gaps in knowledge and review existing cases. This training is designed to complement, rather than replace existing in –service training (APN). Monthly meetings provide opportunities for all participants to refresh their skills and fill in missing gaps of skills and knowledge.

Photo: Yuliana Soetandang

Village midwives were trained by SNL on how to do Essential Newborn Care, consists of Basic ENC, Resuscitation and Low Birth Weight.

Photo: Krishna Sugiarta

Bupati (District Mayor) Garut, after understood the newborn health problem in his area, declared the reducing of Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) that are priority of Garut's (January 2010).

C. Improving knowledge, changing behavior and neonatal care practices in the community

Home based newborn care practices that promote healthy and hygienic care of newborns is a critical component of newborn care. Mothers and family care givers need basic knowledge and skills related to breastfeeding, keeping baby warm, use of kangaroo method, proper cord care and recognition of newborn and maternal danger signs.

To communicate these important messages to families the capacity of community health volunteers (cadres) and religious leaders was enhanced. Messages communicated by midwives through pre natal and postnatal care visits is then reinforced by trained community leaders and cadres.

D. Enabling environment and policies to support essential neonatal care

Saving the lives of newborns is not feasible without the support of good policies and local leadership at the district, sub-district, village and facility levels.

a. Local Government's Support

Advocacy efforts have resulted in the full support of the Head of Garut District, District Health Office, Head of sub-districts within Garut District and head of villages. This is an essential component of ensuring allocation of resources to implement improved maternal and newborn health programs.

b. Health Center's Leadership and Managerial Capacity Building

Good facility management and supervision for village based midwives is required to deliver postnatal care. Therefore, a training program was developed to improve leadership and managerial capacity a the facility level. The purpose of this program is to align health center management and staff under one vision/mission with a commitment to reduce neonatal and infant mortality.

Photo: Krishna Sugiarta

Bupati was hitting the gong and stating that the district's effort for reducing MMR and IMR was started (January 2010).

c. Improvement on Recording and Reporting

Data management and analysis of trends of maternal and child health indicators is essential for improving quality and planning for allocation of resources at the local level. This type of data management and analysis is often lacking at the district and sub-district level. Prior to the intervention in Garut, data from village to district level was inconsistent and incomplete. Indicator definitions were misunderstood by staff responsible for report and there was little data analysis at the local level.

To ensure improved reporting, recording and analysis neonatal indicators were added to the existing local area monitoring reports and capacity building was provided to staff responsible for reporting and analysis. This was achieved through regular monthly meetings to review and analyze data, identify problems, and seek solutions for reporting challenges.

This has resulted in clear improvement of the recording and reporting activities. Mother and child health data are now consistent from village to district level. The availability of quality data will allow for analysis and evaluation to improve maternal and newborn care. The improvement of the services is a key factor in the efforts of saving newborn lives and reduce infant mortality in Garut District.

Midwife, mother of 1 day old baby, father and traditional birth attendant were happy with their partnership.

Photo: Agus Sasmito

Ministry of Health's Director General of Public Health, Bupati, Local Parliament, Director of Child Health, Head of Provincial Health Office, Head of District Health Office and Country Director of Save the Children Indonesia (January 2010).

Part 2:

ESSENTIAL NEONATAL CARE: A SUCCESS STORY FROM GARUT

Thinking of his five month old baby daughter, Momod remembers the story of her birth.

Baby Mia (5 months old) is a baby girl that is very much awaited by the parents; father Momod and mother Icha (30 years old). This couple has two much older sons aged 15 and 10. It is such a great blessing that this baby is growing and healthy to date. "I thank Midwife Heni, the health worker who saved my child and my wife's life. At that time I have surrendered completely to God. I thought my baby was going to die; I only asked the midwife to save the mother. I only wish that not both of them would die," Pak Momod told his story in deep emotion.

The mother of baby Mia had to endure difficult labor and delivery. Baby Mia was a breech baby and she did not cry at the moment she was born. The mother of the baby, Mia, did not fully helped by midwife during her labor. "When I came at about 10 in the morning, the position the baby was just about to born. Her buttocks has already come out. After the baby was born, she didn't cry nor breathe. I rubbed her chest; there were still faint heartbeats despite the fact that the baby has turned blue. I directly asked the father of the baby to have lamps to keep the room warm, and closed all windows. Then I made preparation for resuscitation process, I sucked the mucus by applying 2 times ventilation for 30 seconds. Thank God! Baby Mia started to cry and breathe. I wrapped baby Mia in blanket and I took her near the lamp to keep her warm. I was so worried because the baby appeared quite blue. I took the baby to her mother bosom and I asked the baby's father to keep the baby close to the lamp no matter how. Thank God! Seconds before sunset prayer the baby's condition got better and better. I kept monitoring her condition for a week by phone as well as by visiting the family," as told by Midwife Heni, a village midwife at Bayongbong Public Health Center, one of the public health centers participating in SNL2 intervention in Garut.

"I now know that delivery must be attended by health workers and I thank the government that has granted

affordable delivery cost through public health insurance card so that I didn't have to spend much for the birth of my child," revealed Momod. "At first I didn't want any midwife to help the delivery because I had 'super natural water' that had the power to help my wife have a normal childbirth. That 'supernatural water' is in fact an ordinary water that I have prayed on for the wellbeing of the childbirth mothers and many pregnant mothers who were about to give birth ask for the water. They did succeed to have normal delivery. My own mother happened to be paraji (traditional birth attendant) but she stopped helping childbirth since the partnership of midwives and paraji was introduced. What my wife had to experience was so depressing. At that time I was so hopeless seeing my wife's condition and my mother could not do anything either. Finally, my mother and I decided to call for Midwife Heni. I saw with my own eyes how the midwife fought to save my wife and child. She is so skillful and that has made me convinced. Thank God she was able to save both of them: my wife and my child." This story was told by Pak Momod with such a great relief and gratitude.

Pak Momod's wife also told her story. "My previous two children were helped by traditional birth attendant (locally known as paraji) because at that time nobody had ever informed me about newborn health. After being pregnant with my third child, I went to the public health center to have my pregnancy examined regularly because the midwife told me to do so. But, for the delivery, I haven't decided yet whether I would choose midwife or not for financial reason," told Bu Icha. "I'm so happy because a daughter that I long hope for was born safe and we don't spend a dime for the delivery," she added.

After baby Mia was born, the midwife visited her three times in a week and she kept monitoring the baby's condition through cellular phone. "In each visit the midwife always informed the parents on how to take care my baby and thank God the breastfeeding also run well up to now. Mia has grown so well, her weight is almost 8 kg and I often go to the Posyandu (integrated care station) to examine my child's health. Thanks to the midwife who has visited my house to help me and my child," Ibu Icha expressed her gratitude.

A successful model of delivering postnatal care in Garut district.

Baby Mias is just one of the newborns that has been saved by improving immediate and early postnatal care in Garut. Success is further evidenced by examining the results of the the Saving Newborn Lives Project. The endline survey showed singinicant increase in postnatal care during the first of week of life when newborns are most vulnerable. (See Figure 1 and 2).

In addition to the above case and the survey result that show the success of the program in Garut, success can also be judged by the high level of political support from the disrict level to national level, cross-sectoral cooperation, and improvement of health care for giving birth mothers and newborns from public health center at village to sub-district level.

Figur 1.
Postnatal chek for woman within 2 days (n=400)

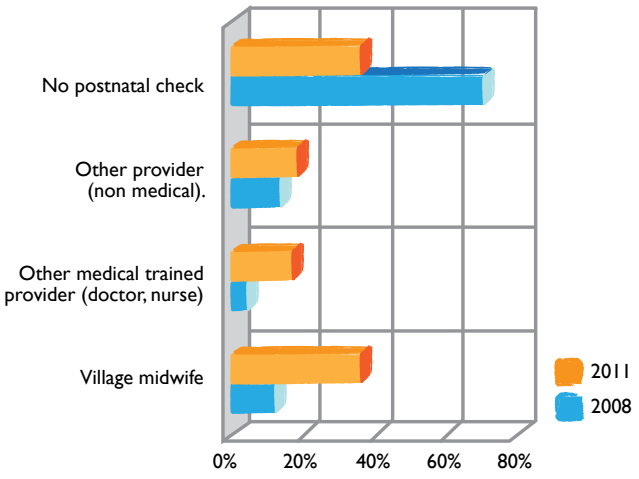
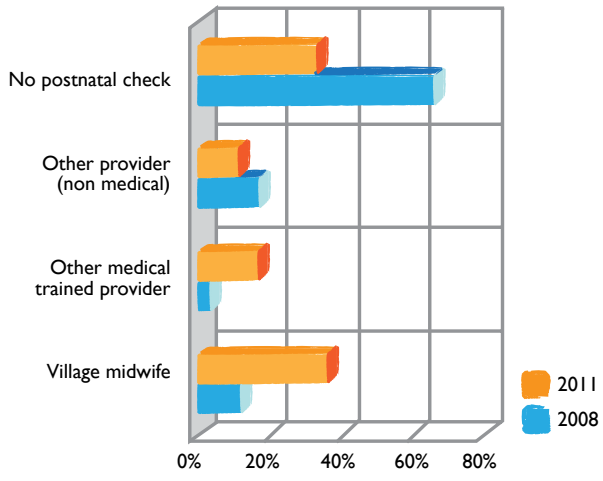


Figure 2.
Postnatal check for newborn at 6-48 hours (n=400)



Source: Baseline and Endline Surveys of SNL2 in Garut

Photo: Agus Sasmito

Responding to Bupati's commitment, several sub-districts initiated activities to reduce IMR/MMR. Bayongbong Sub-district initiated midwife and traditional birth attendant partnership scheme to elevate the number of skill birth attendance (May 2010).

1. Political support from district to national level

A. National Level : Immediate and early postnatal care becomes national policy of the Ministry of Health Republic Indonesia

The Ministry of Health of the Republic of Indonesia has recognized the importance of immediate and early postnatal care as a key component of achieving MDG 4, the reduction of child mortality. The MoH has incorporated postnatal care visits early in the first week of life (KN1 and KN2) and a third visit in the first month (KN3) into the. National Action Plan to achieve MDG 4. In addition, coverage of three postnatal care visits (KN1, KN2, KN3) has incorporated into the national health survey (RISKESDAS) regularly conducted in all Indonesiaian provinces.

This three-time visits-initiative has become national policy for mother and child care because the Ministry of Health Republic of Indonesia sees KN1, KN2 and KN2 introduced by SNL2 as an important measure that save newborn lives and applicable at the district level; and Garut District is a proof of great success.

In addition, the Directorate of Child Health Ministry of Health has incorporated essential neonatal care into the guidelines for the National Child Protection Law. Besides the Directorate of Medical Service, has established standard minimum standard of equipments for newborn care.

B. The District Level : Government leadership committed to decrease neonatal mortality to achieve MDG 4

Senior political leadership in the District of Garut has committed itself for saving the lives of newborns through:

a. Establishing a local movement to save infants (*Gerakan Sayang Bayi*),
b. Established partnership between midwives and traditional birth attendants TBA's, and,
c. Development and implementation of the District Action Plan (RAD) for achieiveing MDG 4 and 5.

Photo: Yuliana Soetandang

Newborn home visit (KN1,KN2,KN3) was then to be intensified.

Box 1.
Quote from The Head of Garut's District's Speech on the Launching of local movement to safe infants (*Gerakan Sayang Bayi*)

Ladies and Gentlemen,

.....

The submitted data and the result of the analysis, the condition of mother and newborn health in Garut District to date is still quite worrying. Maternal mortality rate is still high, not to mention the fact that the neonatal mortality shows an increase in 2008 compared to the previous years. I am sure those two aspects have influenced so much the achievement of Human Development Index in Garut District. Given that the maternal and infant mortality rate is still high, there is a concern that Garut District will become of the regencies that cause Indonesia not able to achieve Millenium Development Goals in 2015. For that reason, we all will join forces to make efforts to address one of the causes of low human development index in Garut District, which is the high infant mortality rate and maternal mortality rate.

..... In view of that, I ask all parties, the stakeholders, including the district heads and welfare family union motivators at the district and sub-district level, to continue increasing cooperation and at the same time support the efforts to improve the level of health indicators through good and regular development and supervision efforts in their respective area.

The key success of the future health development is highly determined by the strong commitment of all parties, both the executives, legislatures and the society including the private sectors, in order to combine cross-sectoral health service components with the support of the community to become strategic policies in reducing infant mortality rate.

Based on the fact that high percentage of infant mortality is contributed by deliveries performed by traditional birth attendants (paraji), so it is necessary to have strategic efforts to minimize the risk of infant deaths through saving infant movement and the program of midwives and traditional birth attendants partnership. In view of that, from this saving infant movement I would like to ask for:

1. More attention of all parties dedicated to this issue
2. Building commitment and improve coordination in the efforts of reducing infant mortality rate in all components both from the government and non-government element.
3. Growing networks at all level by involving all members of the society to support efforts to improve mother and child health.

And so on....

a. Newborn Awareness (Gerakan Sayang Bayi)

In January 2010, the Bupati of Garut launched an awareness movement to save lives of mothers and newborns. This was done in response to Garut's low ranking Human Development Index. The Bupati called for all parties to have a strong commitment and work in partnership to reduce infant mortality rate. (See Box 1).

b. Partnership of midwives and traditional birth attendant

Establishment of a partnership between village midwives and traditional birth attendants is a key strategy to increase skilled attendance at birth, and

Photo: Agus Sasmito

The one behind the success :
H. Aceng Fikri. Bupati Garut.

Photo: Yuliana Soetandang

Newborn referred to the health center.

improve quality of postnatal care, that takes while thaking into account traditional and cultural practices.

To formalize and guide the implementation of the midwife/TBA partnership a local regulation was enacted. Regulating roles, responsibilities and obligations of both midwives and the traditional birth attendants. This includes clarification on the fee received by midwives and TBAs in the framework of the partnership.

On March 2010 the Puskesmas Director, village midwives, and traditional birth attendants in Bayongbong Sub- District agreed to operationalize the midwife/TBA partnership. Local stakeholders recognized that skilled birth attendance and postnatal care remained low. This was in large part due to families trust in traditional birth attendants and lack of awareness of the role of midwives. Thus the partnership aims at promoting acceptability of midwives at the individual and household level.

The head of Sub-district responded the idea so well, besides she was very concerned about mother and child health, she followed up the instruction of the Bupati (Head of Garut District) to reduce mother and infant mortality rate.

Mobilization of community support for midwife/TBA partnership has been a key component of success. This has been demonstrated through the participation of village and community leaders in the drafting and support of local legislation. (See Box 2)

Within the partnership the importance of the traditional birth attendant TBA is still respected. However their role shifts towards assisting midwives and providing support for mothers during labor and in

Photo: Krishna Sugiarta

Bupati conveyed the increased budget for District Health Office to the Head of the District Head Office.

Box 2.

Drafting Village Regulation for Establishment of Midwife/Traditional Birth Attendant Partnership

A participatory process was facilitated to draft village regulation to support s for the establishment of midwife/TBA were established through participatory partnership engaging sub-district and village leaders, health facility directors and staff. The process built upon existing community system such as desa siaga and regular community meeting.

Following the initial drafting of the regulation clarifying roles and responsibilities of midwives and TBAS. Socialization of the partnership was conducted by religious figures and community leaders, traditional birth attendants, UKBM (community-based health initiative)/*desa siaga*, cadres and community.

The process includes discussion with traditional birth attendants, village leaders and midwives. The emphasis is on building a good partnership between midwives and TBAs to reduce infant and maternal mortality. The participatory seasons for those who violate the law and the agreement.

After the discussion at village level, the village regulation is agreed upon. The sub-district prepares the regulation draft, and the village (including paraji, midwives and community leaders) discuss about the sanction and delivery tariff.

Photo: Yuliana Soetandang

Midwife and traditional birth attendant are working together in home visits.

Photo: Doc SNL

A village midwife and traditional birth attendant referred sick newborn to the health center

Box 3.

Partnership of Midwives and Traditional Birth Attendants in the eyes of the traditional birth attendants

"The majority of traditional birth attendants here have engaged in the midwife/TBA partnership," revealed Mak Umi, a traditional birth attendant from a village in Cilimus. "For me, I am willing to accept the partnership because the midwife from the public health center approached me first, she taught me to give proper newborn care, and told me that deliveries are safer when they are assisted by midwives. Although I no longer help delivering babies, I still provide care for the mother up to 40 days, I also bath babies until their umbilical cord detached. I don't loose any income as I still receive my service fee from this partnership. Mothers are willing to give birth assisted by the midwife because the TBA is also there," told Mak Umi.

Box 4.

Doctor's commitment to save newborn lives

As a doctor based in Sukamulya Health Center in Garut District, he never thought that he would be assigned to a mountainous and isolated area. Amidst other health problems, infant mortality is high in Sukamulya. This is due to low skilled birth attendance rate, local culture / traditional beliefs and practices and lack of skills and knowledge of midwives or other health providers to provide essential newborn care. He realized that there should be efforts to overcome this problem.

With the support of Saving Newborn Lives - Save the Children, health providers such as Dr. DWI, they have been trained of essential newborn care including resuscitation, special care for low birth wieight infants and other essential service. This new awareness and knowledge has helped dr. Dwi to save newborn lives and strengthen his commitment to save newborn lives.

As a result of his participation in SNL, Dr Dwi recognizes the significant contribution of of low birth weight to infant mortality in his area.He has now realized his dream of establishing a clinic to specially care for low birth weight infants using simple and appropriate methods. In three months, there have been four low birth weight babies saved in the clinic. "Using kangaroo mother care, babies with low birth weight can be saved. This is a simple, affordable method but it's so effective. Many babies can be saved," he explained.

In addition to the clinic, Dr. Dwi continues to provide counseling on basic newborn care, disseminating messages through the religious gathering in cooperation with religious leaders.

Agus Sasmito

Dr. Dwi Hadi Santoso. A health center doctor.

the postnatal period. These traditional birth attendants (paraji), who are highly respected among the villagers, still maintain their traditional role in performing after-birth and birth rituals. In addition, the TBAs sreceive training on basic newborn care and feeding from the village midwives (See Box 3).

The success of this partnership in Bayongbong Sub-district has been replicated in other sub-districts. Midwives from other additional sub-districts are now in the process of replicating this approach.

c. Drafting of Garut District Action Plan (RAD) to achieve MDG 4 and 5

The Ministry of Health has recognized the District Garut's commitment to achieving MDG 4 and 5. As such Garut has become a pioneer in drafting a road map to achieve MDG 4 and 5 at the district level. The plan to put forward by Garut and supported by the Directorate of Child Health will be promoted as an example at the national level.

2. Cross-sectoral Cooperation

Cross sectoral cooperation between at the district and village level is a key component to the delivery of postnatal care. The participation of the Head of the District, and Heads of Villages and Sub-districts has ensured the allocation of resources (financial and human resources) and commitment throughout the system.

Box 5.

Success story of the village midwife saving newborn's life

Ipah, 30 year-old-old, is a mother of seven children. Her youngest child is only five weeks old. She lives in Desa Cisompet, 120 kms away from Garut, the capital city of Garut District in West Java Province. Cisompet is one of the sub-districts where the SNL 2 works together with the health center to promote the essential newborn care (ENC) focusing on postnatal care in the first weeks of life.

She has been pregnant seven times and has miscarried twice. Four deliveries were assisted by an untrained birth attendant. At the beginning of her seventh pregnancy, she was very worried. "I have a hypertension problem and I was a bit worried about me and my baby ". Fortunately for her, one of her relatives is a local community health volunteer who is knowledgable about where to go for prenatal care. The first time she came to the posyandu (Village Health Post), she saw the community health volunteer promoting newborn awareness and advising pregnant mothers to come and seek medical check up to midwife or doctor. "I decided to come to the posyandu near my house and got some information about newborn awareness, and I realized that I should go to the midwife to check my pregnancy and make sure I am healthy ".

Afterwards, she regularly continued checking her pregnancy to Midwife Een, the village midwife who has been trained on essential newborn care. " Midwife Een told me to keep my baby warm, not to bathe the baby for at least six hours after delivery and do immediate breastfeeding ". Ipah had never been informed of those things on her previous pregnancies. In all of her previous births , the traditional birth attendant bathed the baby right after birth and rubbed traditional medicine on her baby's cord. She had never been advised to immediately breastfeed the baby and never knew that the first liquid that comes out from her breast is a very good nutrition for the baby.

The information provided by Midwife Een has opened her mind to the importance of giving birth with a trained midwife.

In addition, the health center provides the village members with JAMKESMAS (Health Insurance), including for delivery. JAMKESMAS is a health insurance provided by the government to cover all health expenses in the community especially for those who cannot afford to pay and to persuade them to come to health facility when they are sick. "Since we already got a JAMKESMAS (Health Insurance) so I have no doubt to deliver my baby with midwife, because money is not a problem for us anymore ".

Baby Dede was delivered at midwife's home, "Baby Dede was born with 2.3 kg weight and midwife Een put my baby to my breast and I started to breastfeed him " Midwife Een then visited baby Dede and Ipah twice during the fist week to provide counseling and check on the condition of both mother and newborn. "Midwife Een explained to me about the danger sign of newborn and advised me to seek medical treatment if there is something wrong with my babyI am glad that I met Midwife Een who was very patient in explaining to me everything about newborn health during my pregnancy and birth ". Now baby Dede is five weeks of age and weighs 4 Kg. " I am happy now that my baby and I are healthy and I will regularly come to posyandu (Village Health Post) to check my baby's health ". Said Ipah.

3. Improved coverage and quality of immediate and early postnatal care

Within the health sector doctors, midwife coordinators, village midwives, traditional birth attendants and village cadres are each play a key role in mobilizing communities and providing quality services. Their commitment to reduce maternal and neonatal mortality ensures the implementation of quality immediate and early postnatal care services. (See Box 4).

Improving quality and coverage of immediate and early postnatal care in the first hour, days and weeks of life has expanded access to maternal and newborn care in remote areas. Prior to improving home visits, sick newborns did not access facility based services for management of illness, due to geographic and cultural barriers.

Newborns are not brought to health facilities due to strong cultural beliefs that newborns should not leave home pritor to 40 days. Thus in line with the WHO /UNICEF joint statement on postnatal care homevisits, health workers in Garut are now better able to monitor newborn and maternal health, provide important counseling and support to families and refer sick newborns when required.

In terms of quality, the quality of KN care has also improved. Training process that uses 'on the job training' style for midwives and the regular refresher session have improved midwives' ability in newborn essential care and in counseling for mothers and members of families of the newborn. The improvement of skill and knowledge of the midwives has saved newborn babies and their mothers (See Box 5). The improvement of skill and knowledge among doctors and midwives has boosted their self-confidence in helping newborn babies suffering from complications (see Box 6). Midwife counseling skills have also improved allowing for improved support for families and improvement of household level awareness of maternal and newborn health and danger signs. One strategy for communicating is the integration of key messages into regular religious gatherings to . promote healthy newborn practices to fathers, and other care givers.

Immediate and early postnatal care at home is made possible by the allocation of resources through existing funding mechanisms including public health insurance fund (JAMKESMAS) fund and BOK (Health Operational Fund) . To support the budgeting process for allocation of funds for prenatal and postnatal care, draft guidelines for budget calculation have been developed in cooperation with District Health Offices. This activity aims at helping local Health Office to draft health budget plan that include the cost for pregnancy and neonatal check up by village midwives for submission of a proposal to the local house of representatives.

Box 6.
The Training was very usefull

"Since receiving essential newborn care training, I feel much more confident to help mothers in giving birth and to save newborns with complications. Quite a lot of babies have asphyxia and low birth weight problems, and Thank God almost all survived. Some were referred to the hospital after receiving first aid, but most were treated at the health center. Low Birth Weight cases are also be able treated without referred", said Dr. Dwi, medical doctor at the Bayongbong health center.

Dr. Dwi no longer feels alone now that midwives have become much more skiled and confident. "Village midwives already have sufficient skills to help delivery and babies with complications." For more severe cases, at least midwife does first aid for the newborn before referral to BEONC (PONED) health center or hospital". Said Midwife Ugi.

Photo: Andrew Caballero Reynolds

A mother practicing Kangaroo Mother Care Method at home.

Conclusion

Postnatal home visits has been shown to be an important means of ensuring access to critical newborn and maternal services, when geographic, financial and cultural barriers prevent families from accessing this important care. As shown in Garut operational funding to support such care must be allocated from existing sources.

To ensure high quality of care, both midwives and doctors require the up-to-date knowledge and skills on delivery of postnatal care. This information can be provided through 'on job training' as a cost effective learning process which is complementary to existing training programs. Well-executed and consistent recording and reporting works at village to District level is the key to do monitoring and evaluation for this activity. Constraints and problems, along with its progress, can be revealed through this process. Routine supervision from the district to sub-district level can ensure the sustainability of immediate and early postnatal care.

Community engagement is also essential. Community health volunteers (cadres), traditional birth attendants (paraji), community leaders, families and villagers must be engaged in the process of knowledge dissemination on safe delivery and postnatal care. Diverse forum such as religious gathering, regular women gathering , neighborhood/citizens association (RT/RW) meetings and other groups are opportunities for dissemination of key newborn health messages. At last, political commitment from local government, commitment and cross-sectoral cooperation, health workers, parents and other parties to reduce neonatal mortality rate is the key for saving newborn lives.

Who We are
Save the Children is the world's largest independent movement for children.

Our Mission
Save the Children fights for the children's right. We deliver immediate and lasting improvements to children's lives worldwide.

Our Vision
Save the Children looks forward to:
A world which respects and values each child
A world which listens to children and learns
A world where all children have hope and opportunity.

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Africa

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SAVING NEWBORN LIVES AROUND THE WORLD MAKES A DIFFERENCE

Save the Children's Saving Newborn Lives program, supported by the Bill and Melinda Gates Foundation, works in partnership with 18 countries to reduce newborn mortality and improve newborn health

Nearly 4 million newborn die each year; 75 percent of these deaths occur in South Asia and sub-Saharan Africa.

2,5 million newborn deaths could be prevented annually by improving access to low-cost, low-tech interventions currently beyond the reach of families most in need.

Most newborn and maternal deaths occur during childbirth or in the days thereafter, when skilled care is usually absent.

Major causes of newborn death include low birth babies (29%), asphyxia (27%), tetanus and infection (15%) and other causes (29%)

Newborn deaths account for 40 percent of all deaths among children under 5 age.

Save the Children

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