COMMENTARY

BARRIERS TO SKILLED BIRTH ATTENDANCE IN INDONESIA: ANY NEW LESSON FOR GHANA?

The presence of a skilled birth attendant at childbirth, backed-up by transport in case emergency referral is required, is perhaps the most critical intervention for making motherhood safer[1]. Defined as the process by which a woman is provided with adequate care during labour, delivery and early postpartum period[1], skilled birth attendance is critical in reducing the high Maternal Mortality Rates in Indonesia and many developing countries. There must be a health worker with midwifery skills and an enabling environment including infrastructure, equipment and logistics with efficient and effective communication and referral systems. The enabling environment broadly includes geographic, political, policy and socio-cultural context in which the skilled personnel operates; as well as the pre- and in-service training, supervision, deployment, regulation, and healthcare financing systems in place[1]. Minimum important skills are those for detailed history and examination, antenatal care, patient education on pregnancy's danger signs, recognition of maternal and fetal complications and appropriate intervention, life saving skills when needed, appropriate and timely referral including transport arrangement; and care during transportation[1].

The World Health Organisation (WHO) Global Health Observatory reported in 2013 that Indonesia is developing country with a population of nearly 250million, 300 ethnic groups living across 13,700 islands with 250 languages [2]. 60% of the population is rural. Political governance is decentralized to 33 provinces made up of 73,405 villages under 497districts[2]. The Maternal Mortality Ratio nationally averages 228/100,000 live births nationally; but figures as high as 608/100,000LB were reported in some province. Skilled Birth Attendance is 40% – 82% reflecting the wealth quintiles, the highest in Java, Indonesia's most populated, modernized province, with over 50% of all doctors, and 66% of Indonesia's obstetricians in the year 2010[3].

In Indonesia, evidence suggests the cost of skilled obstetric care is unaffordable by many poor households and constitute a major barrier to utilization and access to safe maternal care [4]. The introduction of voucher for reproductive health services, the unconditional community cash transfer, and the social health insurance (Jamkesmas) resulted in increased village health centre deliveries attended by doctors or midwives; increased utilization of Reproductive Health Services, facility delivery by 40%[1,5] and large reductions in neonatal and infant mortality rates. However, all these schemes lack provisions for transport and time costs, which have been shown to constitute a significant 50% of total normal delivery expenditure. A similar scheme in India additionally covered transport and wage loss for one accompanying person, and achieved 99.7% facility delivery[5].

Inequitable distribution of doctors; unskilled and experienced midwives, despite heavy government investment in their training, constitute another major barrier. The resulting poor quality of care perceived by patients further reflects the midwives' inadequacies even in normal delivery skills. The midwives therefore lose the confidence of clients, and this further strengthens the barrier [2, 3, 5.] Similar factors prevail in the Ghanaian context.

In Ghana, the introduction of free maternal care services and locating Community Health Planning Services (CHPS) compounds closer to where people live are some of the efforts that have been made to remove barriers to accessing skilled maternity care. Consequently, by the year 2012, approximately two thirds (68%) of women gave birth in health facilities and were assisted by skilled personnel during delivery – this percentage was highest in Greater Accra (90%) and lowest in the Northern Region (37%), (previously 17% in 2008) of Ghana following the implementation of the free maternal care policy in the year 2008[6].

Many sub-district and district facilities in Indonesia lack the logistics to provide Emergency Obstetric Care (EmOC) and the health system also lacks effective referral network with ambulance and communication technology to link Traditional Birth Attendants, village midwives, health centres, private and district facilities for the provision of timely EmOC[6], This unfortunate missing link makes the three delays almost insurmountable, resulting in slowing of progress towards the Millennium Development Goal [5] targets by Indonesia.

Just like in Ghana, the overall lack of adequate development and basic social amenities to guarantee acceptable quality living standards in many rural areas makes it difficult and unattractive for healthcare professional to accept postings there. Consequently, many villages lack a midwife despite government's aggressive "village midwife programme"[2]. This programme reduced socioeconomic inequalities in professional birth attendance, but the gap in access to potentially life-saving emergency obstetric care widened[4].

In conclusion, the factors constituting barrier to skilled birth attendance in Indonesia are numerous and

varied, requiring a holistic concerted multi-sectoral approach, implemented alongside long-term poverty reduction and health systems strengthening. These are largely similar to the Ghanaian context. Specific actions need to improve transport, effective referral-ambulance system, private sector engagement and overall focus on socioeconomic development and family planning. Unlike Indonesia, Ghana has made significant strides in removing the financial barrier through the implementation of the free maternal care policy[6]. In both Indonesia and Ghana, the inclusion of transport cost for the pregnant women needing EmOC may potentially augment the gains by the existing interventions, as the Indian scheme exemplifies[5].

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