MIDWIFERY CONSULTANCY REPORT
Disclaimer
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Midwives have an important role to play in ensuring planned and safe pregnancy and childbirth, and in setting young people on the right track to fulfill their potential. Midwives play a crucial role in family planning, lending support at every stage of the reproductive cycle. They provide counselling for those looking to start or delay having a family, and help women choose the types of contraceptives best suited to their reproductive goals. They assist women through the processes of pregnancy and childbirth, and provide neonatal care for infants, helping them grow into healthy children and adults.

Equipped with the right training and support, midwives can potentially reduce maternal and newborn deaths by two-thirds, and provide 87 percent of the essential care required by women and newborns. High-quality midwifery saves lives and contributes to healthy families and more productive communities. For midwives to work effectively, focus must be given to the key areas of availability, accessibility, acceptability and quality. Midwives must be available in every village near to the community, their services must be accessible to the public and acceptable in social and cultural terms. And, importantly, they must provide high quality services, backed by training, equipment and support, including an effective and enabling regulatory environment.

Meeting the goals on maternal and child health will be an ongoing challenge of the Post-2015 Development Agenda. The findings in the 2014 consultancy report and the follow up proposal in the 2015 report will provide valuable recommendations for addressing this challenge in Indonesia, particularly on the providers side – the midwifery services. International experience illustrates that midwifery needs to be regulated as an autonomous profession, equipped with the necessary competencies, and must be fully accountable for the services provided. With better coordination and training, midwives can have a huge impact in helping Indonesia meet the SDGs targets on reproductive, maternal, neonatal, child, and adolescent health. Midwives will also be essential partners in meeting the FP2020 goals related to family planning that were agreed upon at London Summit on Family Planning in 2012.

These two reports will be an excellent source of information to refer to when discussing the issues of the midwifery workforce. It is hoped that, in the upcoming Government of Indonesia – UNFPA partnership in the 9th Country Programme, the recommendations can be further elaborated to compliment the work of Indonesian Government, particularly the Ministry of Health, and provide a concrete basis for action on improving the quality of midwifery services nationwide.
In closing, I would like to extend my appreciation to the author who wrote both reports, the Ministry of Health as the main partner to the initiative, UNFPA’s Country Office staff, Dr. Emi Nurjasmi, President of IBI, and also to the midwives across Indonesia who serve the community with dedication. I also would like to draw your attention to the words of Dr Babatunde Osotimehin, Executive Director of UNFPA, who said “Access to quality health care is a basic human right. Greater investment in midwifery is key to making this right a reality for women everywhere.”

Jakarta,

Jose Ferraris
UNFPA Representative
TOWARDS THE DEVELOPMENT OF MIDWIFERY REGULATION IN INDONESIA 2014: STATUS OF THE CURRENT SITUATION

September 2014
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<th>Full Form</th>
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<tbody>
<tr>
<td>ASKesKin</td>
<td>Health Care Insurance for the Poor (Asuransi Kesehatan Warga Miskin)</td>
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<td>AIPKIND</td>
<td>Association of Midwifery Schools (Asosiasi Institutu Pendidikan Kebidanan Indonesia)</td>
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<td>AIPMNH</td>
<td>Australia-Indonesia Partnership for Maternal and Neonatal Health</td>
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<td>ANC</td>
<td>Antenatal care</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>Bappeda</td>
<td>Development Planning Agencies at Province and District levels (Badan Perencanaan dan Pembangunan Daerah)</td>
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<tr>
<td>Bapenas</td>
<td>Indonesian National Development Planning Agency (Badan Perencanaan dan Pembangunan Nasional)</td>
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<tr>
<td>BEmONC</td>
<td>Basic emergency obstetric and neonatal care (Pelayanan Obstetri Neonatus Emergensi Dasar)</td>
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<td>BDD</td>
<td>Village-based midwife (Bidan di desa)</td>
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<tr>
<td>BKKBN</td>
<td>National population and family planning board (Badan Kependudukan dan Keluarga Berencana Nasional)</td>
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<tr>
<td>BPS</td>
<td>Statistics Indonesia (Badan Pusat Statistik)</td>
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<td>BPJS</td>
<td>UHC regulatory body (Badan Penyelenggara Jaminan Sosial)</td>
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<td>BPPSDMK</td>
<td>Agency for Development and Empowerment Human Resources of Health MoH (Badan Pengembangan dan Pemberdayaan Sumber Daya Manusia Kesehatan)</td>
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<tr>
<td>Bupati</td>
<td>Elected Head of District</td>
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<td>CEmONC</td>
<td>Comprehensive emergency obstetric and neonatal care (Pelayanan Obstetri Neonatus Emergensi Komprehensif)</td>
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<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<td>Desa Siaga</td>
<td>Village Alert program to support pregnant women for safe deliveries</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care (Pelayanan Obstetri Emergensi)</td>
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<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care (Pelayanan Obstetri Neonatus Emergensi)</td>
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<td>FGD</td>
<td>Focus Group Discussion (Diskusi Kelompok Terarah)</td>
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<td>GIZ</td>
<td>German International Development Agency</td>
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<tr>
<td>GoA</td>
<td>Government of Australia (Pemerintah Australia)</td>
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<td>GoI</td>
<td>Government of Indonesia (Pemerintah Indonesia)</td>
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<td>HFA</td>
<td>Health Facility Assessment (Asesmen Fasilitas Kesehatan)</td>
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<td>HMIS</td>
<td>Health Management Information System (Sistem Informasi Manajemen Kesehatan)</td>
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<td>HSS</td>
<td>Health systems strengthening (Penguatan Sistem Kesehatan)</td>
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<td>IBI</td>
<td>Indonesia Midwives Association (Ikatan Bidan Indonesia)</td>
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<td>IDHS</td>
<td>Indonesia Demographic and Health Survey (Survei Demografi dan Kesehatan Indonesia)</td>
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<td>IDI</td>
<td>Indonesia Medical Association (Ikatan Dokter Indonesia)</td>
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<td>IHP</td>
<td>International Health Partnership</td>
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<td>IMET</td>
<td>Independent Monitoring and Evaluation Team</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IUD</td>
<td>Intrauterine device (Alat Kontrasepsi Dalam Rahim)</td>
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<td>IQF</td>
<td>Indonesian Qualifications Framework (Kerangka Kualifikasi Indonesia)</td>
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<td>Jamkesmas</td>
<td>National health insurance for the poor (Jaminan Kesehatan Masyarakat)</td>
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<td>Jampersal</td>
<td>National maternal health coverage for all (Jaminan Persalinan)</td>
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<tr>
<td>KKI</td>
<td>Indonesia Medical Council (Konsil Kedokteran Indonesia)</td>
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<tr>
<td>KTKI</td>
<td>Indonesia Council for Health Workers (Konsil Tenaga Kesehatan Indonesia)</td>
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LAPM Long-acting and permanent methods of contraception
(Metode Kontrasepsi Jangka Panjang
dan Permanen)
M&E Monitoring and evaluation
MAMPU Empowering Indonesian Women for Poverty Reduction
(Maju perempuan Indonesia Untuk
penanggulangan kemiskinan)
MCH Maternal and Child Health (Kesehatan Ibu dan Anak)
MCHIP Maternal and Child Health Integrated Program
(Program Terpadu Kesehatan Ibu dan Anak)
MDG Millennium Development Goal
MDGs Millennium Development Goals
MENPAN-RB Ministry of State Apparatus and Bureaucratic Reform
(Menteri Pendayagunaan Aparatur
Negara dan Reformasi Birokrasi)
MRR Maternal Mortality Ratio
MNCH Maternal, newborn and child health (Kesehatan Ibu, Bayi Baru Lahir dan Anak)
MNH Maternal Newborn Health (Kesehatan Ibu dan Bayi Baru Lahir)
MNRH Maternal Newborn and Reproductive Health
MTKI Indonesia Council for Health Professionals
(Majelis Tenaga Kesehatan Indonesia)
MTKP Provincial Council of Health Professionals
(Majelis Tenaga Kesehatan Provinsi)
MoF Ministry of Finance
MoH Ministry of Health
MoH (HUKOR) Law Bureau within the MoH (Biro Hukum dan Organisasi)
MoEC Ministry of Education and Culture
NGO Non-Government Organisation
NPO RH National Program Officer for Reproductive Health
NTB Nusa Tenggara Barat
NTT Nusa Tenggara Timur
PFM Public financial management
PHC Primary Health Care (Puskesmas)
PNC Post-natal care
PONED Basic emergency obstetric and neonatal care
(Pelayanan Obstetri Neonatus Emergensii Dasar)
PONEK Comprehensive emergency obstetric and neonatal care
(Pelayanan Obstetri Neonatus
Emergensii Komprehensif)
Posyandu Integrated health post at village level (Pos Pelayanan Terpadu)
POGi Indonesian ObsGyn Association
(Perkumpulan Obstetri dan Ginekologi Indonesia)
PPNI Indonesian Nurses Association
(Persatuan Perawat Nasional Indonesia)
PPSDM See BPPSDMK MoH
Promkes National and sub-national units for health promotion messaging
(Promosi Kesehatan)
PTT Contract / non civil servant officer (Pegawai Tidak Tetap)
Puskesmas Community health centre (Pusat Kesehatan Masyarakat)
Pustu Sub Centre delivering health (Puskesmas Pembantu)
RHC Rural Health Centre (Pos Kesehatan Desa)
Riskeskes Health facility research (Riset Fasilitas Kesehatan)
Riskesdas Basic health research (Riset Kesehatan Dasar)
SBA Skilled birth attendance (Persalinan oleh Tenaga Kesehatan)
SIKB Midwives license to work (Surat Ijin Kerja Bidan)
SIPB Midwives license to run private practice (Surat Ijin Praktek Bidan)
SoWMy The State of the World’s Midwifery
SPK Sekolah Perawat Kejuruan (3-year Nursing Program)
SRMNCH Sexual Reproductive and Maternal, Newborn and Child Health
(Kesehatan Seksual, Reproduksi,
dan Maternal, Neonatal, dan Anak)
<table>
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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>Stikes</td>
<td>Private Sector health training institutes <em>(Sekolah Tinggi Ilmu Kesehatan)</em></td>
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<tr>
<td>STR</td>
<td>Certificate of Registration <em>(Surat Tanda Registrasi)</em></td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional birth attendant <em>(Dukun Bersalin)</em></td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference <em>(Kerangka Acuan)</em></td>
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<tr>
<td>UGM</td>
<td>Universitas Gajah Mada</td>
</tr>
<tr>
<td>RUU Nakes</td>
<td>Health Workforce/ Practitioners Act <em>(Rancangan Undang-undang Tenaga Kesehatan)</em></td>
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<tr>
<td>UN</td>
<td>United Nations <em>(Perserikatan Bangsa-Bangsa)</em></td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund <em>(Dana Kependudukan Perserikatan Bangsa-Bangsa)</em></td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization <em>(Organisasi Kesehatan Dunia)</em></td>
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EXECUTIVE SUMMARY

Purpose of this Report
UNFPA has commissioned this report to gain a better understanding on how they can support Midwifery in Indonesia to develop as an autonomous profession, governed by midwives. Thus, this report provides information on the status of midwifery in Indonesia and progress made towards the regulation of midwifery as a profession.

Collection of Information
Data collection took place between 17th August and 10th September 2014. Mixed methods were used to gather information and guide questioning. Analysis of data was on an ongoing iterative basis during the consultation process. The use of mixed methods assisted with triangulation and validation of data, thus strengthening the findings.

Context
Indonesia has made considerable progress in improving the health of its population over the last 20 years but there are key indicators that are stagnating. Maternal mortality remains high, and there has been limited progress in reducing neonatal mortality or meeting family planning needs. Rates of maternal and neonatal death are higher in the poorest provinces and among the poorest women and their newborns.

Investing in Midwives
As midwives are the frontline providers of Reproductive Health and Maternal and Newborn Health (RHMNH), they have a key role to play in tackling high maternal mortality. In all countries that have achieved a dramatic decrease in maternal and newborn death, well-trained health professionals have been a key to success. The returns on investing in human resources with midwifery skills are enormous.

Need for Regulation
A mixed picture on the performance of Indonesia’s health system, and a lack of progress on reducing maternal mortality, has signalled to the government that there are quality care issues that go well beyond improving access to health services. Key factors that contribute to poor quality of health care are lack of standardisation of education, health services and the delivery of health care. Thus, for public protection, the need to establish a regulatory authority to enforce uniform standards of health professional education and care became a pressing issue for the MoH. Therefore, in 2011, with World Bank support, the MoH collaborated with the Ministry of Education and culture and embarked on a process of regulatory reform, which involved the development of a regulatory body (under the MoH) to standardise and unify education, health care and health professions across the country.

1 UNFPA, WHO and ICM; The State of the World’s Midwifery 2014
Government Response

Under a Ministerial Decree, a Joint Health Workforce Council (Permenkes 46/2013 on MTKI – Majelis Tenaga Kesehatan Indonesia) was established in 2011 to implement the reforms. As they have their own Councils, doctors, dentists and pharmacists do not come under the decree. Current mechanisms for regulation under MTKI regulatory authority are certification, registration, licensing and accreditation. Other mechanisms, such as credentialing are under consideration. The establishment of similar Councils, with different functions, will follow at the provincial level.

The Health Workforce Council is still evolving and the final model of health professional regulation that the Government of Indonesia will adopt is still not clear. In its current form, the MTKI regulatory framework does not allow each of the health professions to function as an autonomous professional body. However, this might change as the model evolves.

Regulation of Midwifery Profession

The development of a regulatory authority for nurses and midwives has lagged behind the Medical Professions and does not have full support from the MoH. An underlying problem has been continuing debates over governance bodies for these professions, and the need to develop an autonomous structure that does not overlap, i.e. separate midwifery and nursing councils.

The main professional body for midwives in Indonesia is the Indonesian Midwives’ Association (IBI). As a professional association, IBI has no regulatory powers and lacks influence in policy and planning. Its greatest strength is the 220,000 (and counting) midwives it represents and the high status afforded midwives by the public.

Since 2005, IBI has had a draft Act before the Indonesian Parliament, for the establishment of an Indonesian Midwifery Council, which will function as an autonomous body, under the governance of midwives. At the request of the Parliament, the Act underwent revision in 2013. There is also a Nursing Act before Parliament, and there are high expectations from both professions that both Acts would pass through Parliament simultaneously this year. Feedback indicates this is unlikely.

Strengthening the Case for Midwifery in Indonesia: Moving Forward

A strong cadre of educated, licensed and supported midwives, trained to international standards, working in an enabling regulatory and practice environment, across a continuum of Reproductive and Maternal and Newborn Health (RHMNH) care, could contribute significantly to a reduction of maternal and newborn mortality rates throughout Indonesia. However, in an uncertain political and regulatory environment, where quality of care is a key issue, midwives in Indonesia face key challenges and limitations, which impact negatively on their development as an autonomous professional group.

Key Challenges and Limitations

There are key challenges and limitations that need consideration before the midwifery profession can move forward:

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Challenges

- Creating a separate regulatory authority for midwifery is not on the MOH’s agenda, but the MOH has a Health Practitioner Act before Parliament, which, if ratified, might allow a profession like midwifery the opportunity to establish of an autonomous body such as a Midwifery Council under a statutory board. If such a board were established, then all professions in the country would come under this board.

- There is a general acknowledgement that the current education system for midwives in Indonesia does not support the production of good quality graduates and, as a result, does not always provide quality services. There have been moves to address this through the new MTKI structure; however, this has not been enough. The perception is that midwifery is a vocation rather than a profession. This has implications for the level of education they will receive and their status as an autonomous profession within Indonesia and the global community.

- Midwifery in an important and well-regarded profession within Indonesia; it was observed that most of the responsibility for leading the profession was left to senior midwives. It will be important to look toward the next generation of midwives, and develop their capacity as leaders and champion of midwifery in Indonesia.

Limitations

- The current political landscape is not ideal for the development of midwifery regulation. Health professional regulation in Indonesia is in the early stages of development. The MoH has a Health Practitioners Act before parliament; until ratified, it is difficult to determine the level of autonomy each health profession will have.

- Added to this there is a new Government and it not clear what impact this will have on ministries or the regulation of health professions. Thus, the political landscape needs to settle and parliamentary decisions need to be made about different Acts, related to individual health professions, before a clear decision can be made concerning how UNFPA can best support midwifery in Indonesia to develop as an autonomous Profession.

Recommendations

Midwifery 2030 provides Indonesia with a pathway for policy and planning. For Indonesia, the essential building blocks for putting the Midwifery 2030 vision into practice will include: political will, effective leadership and midwifery “champions” who will drive the agenda.

This will need to be supported by the current regional and international momentum for improvements to SRMNH. Keeping this in mind, the following recommendations are made:

UNFPA

- Allow the political landscape to settle; wait until the future structure of MTKI, as the regulatory authority of health professions in Indonesia, is fully determined. Then, based on the level of autonomy that midwifery will enjoy, decide how to move forward.

- Engage in high-level advocacy to support the development of a regulatory body governed by midwives. This will ensure midwives in Indonesia are in a good position to function as an autonomous body. The current MTKI structure does not allow this.
• Support the Indonesian Midwives Association advocate for strengthened midwifery services and practice. In particular, reinforce best practices and advocate for the midwife to be the primary provider of “women centred care” and for the strengthening of pre-service qualifications of midwives to be at a minimum of degree level.

• Invest in technical assistance to support education, regulation and association based on need, and at the request of the Indonesian Midwives Association, Ministry of Health and/or Ministry of Education and culture. Give priority to strengthening pre-service education for midwives and developing the capacity of the midwives to lead and manage the profession as an autonomous midwifery body.

• If the Indonesian Parliament ratifies the Midwifery Council Act, or in preparation for the establishment of a Midwifery Council, assist the Indonesian Midwives Association to develop a regulatory framework that will guide the functioning of a future Midwifery Council in Indonesia.

• Consider supporting a Master’s scholarship program that will foster the next generation of midwifery leaders; only fund scholarships that strengthen midwifery in Indonesia e.g. midwifery education, research of practice related to the Indonesia context.

• Reward champions of midwives with special awards and incentives, e.g. certificates of recognition for midwifery work, sponsorship to a midwifery conference and more.

• Consider funding a model of standardised midwifery education and regulated service delivery in one geographical area of Indonesia. Undertake a study in collaboration with the MCH Directorate within the MOH. Review the gap between midwifery competencies and outcomes, pre-service and in-service training and effectiveness of the different mechanisms of midwifery regulation. Raise issues with the IBI and engage them in problem solving. Once the model is tested, make recommendations for scale-up across the country.

• Consider developing partnerships that will transform policy and planning into reality. Working “upstream”UNFPA is in a good position to do this3. To ensure policy is translated into reality, form strategic partnerships to support implementation “on the ground”, e.g. the SMS messaging supported by the UNICEF Info Bidan project could be used as an advocacy tool for messages and gathering information or used to strengthen referral.

Indonesian Midwives Association

• If technical support is required with matters relating to regulation, education and association, request assistance from UNFPA. For example, a regulatory framework to support a functional Midwifery Council, a workshop to explore the difference between an association and autonomous body, help with standardising a curriculum at a higher level and development of critical thinking skills in midwives.

• Continue to advocate for, and strengthen midwifery services and practice. In particular, reinforce best practices and advocate for the midwife to be the primary provider of “women centred care” and for the strengthening of pre-service education.

• Identify and nominate suitable candidates for a midwifery scholarship program at Masters Level or above. This would be for midwives who will be the future leaders of midwives in Indonesia; only fund scholarships that strengthen midwifery education and practice.

• Identify and gain the support of champions to ensure affirmative action to promote midwifery across society, and in the health sector, through a variety of media.

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3 Take from AusAID review Report on Performance on Donors: The performance of UN agencies in health in Indonesia is mixed. WHO, UNICEF, UNAIDS, UNFPA and FAO all play an important role in policy advocacy with Government, yet where we have supported their operational activities performance has been less than optimal. In particular, our work through UNICEF on maternal and child health did not deliver on outcomes expected. This may be related to their relative inability to work closely with GoI systems and difficulty in retaining staff particularly in remote areas.
• Reward champions of midwives with special awards and incentives, e.g. certificates of recognition for supporting midwives, sponsorship to a midwifery conference and more.

Ministry of Health
• Based on need, request technical assistance from UNFPA to support the development of areas that underpin midwifery regulation in Indonesia. Areas might include task-shifting, scope of midwifery practice, standardisation of midwifery curricular, service delivery guidelines and protocols, synchronising midwifery related documentation between MoH and BKKBN and more.
• As health professional regulation in Indonesia, continues to evolve, make space for a wider input from the professions. The current membership of MTKI does not allow for a profession with more than 220,000 members to have a voice or participate in its own development at a policy level.
• Following the ratification of the Health Practitioners Act by the Indonesian Parliament, consider supporting each health profession to gain a level of autonomy that will allow them to be accountable for their own practice.
• If the midwifery profession gains some degree of autonomy, request from UNFPA technical assistance to strengthen a midwifery regulatory framework. This could include help with defining the scope of midwifery practice, how to discipline members of the profession, the management of registrations and more.
• The Maternal Health Directorate within the MoH could consider requesting support from UNFPA to undertake a study to review the gap between midwifery competencies and outcomes, pre-service and in-service training and effectiveness of the different mechanisms of midwifery regulation. Raise issues with the IBI and engage them in problem solving. Once the model is tested, make recommendations for scale-up across the country.

Ministry of Education and Culture
• Based on need, request technical assistance from UNFPA for the development of education programs for midwives that support education reforms and the Indonesian Qualifications Framework. Areas might include standardisation of current diploma to bachelor’s level, reviewing entry points for midwifery against the Indonesian Qualifications Framework and more.
• Support the strengthening of midwifery pre-service education by advocating for, and supporting midwifery degree programs, that raise the entry level into midwifery to a degree level and graduates who are able to function at a higher level of critical thinking.
• Develop and strengthen the career pathway for midwives, so there will be multiple entry points that will allow midwives flexibility in learning and entry into higher-level education programs, through recognition of prior learning and experience; consider collaborating with the Indonesian Midwives Association for this.
Towards the development of midwifery regulation in Indonesia 2014: status of the current situation.
1. INTRODUCTION

1.1 Purpose of this Report

UNFPA has commissioned this report to gain a better understanding of how they can support Midwifery in Indonesia to develop as an autonomous profession, governed by midwives. Thus, this report provides information on the status of midwifery in Indonesia and progress made towards the regulation of midwifery as a profession.

1.2 Methods and Approach

The methods and approach used to collect information to support the writing of this report included:

- A review of the literature and secondary data, stakeholder consultations and workshops. Documents and secondary data reviewed included, global evidence on midwifery and policies, plans, strategies studies and regulatory instruments relevant to the Indonesian context.

- The development of interview aids and tools to support meetings and workshops. On arrival in Indonesia, these were refined and modified to respond to specific needs (e.g. workshops) and different stakeholders. A brief description of these tools is in Table 1 below.

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<th>Table 1: Summary of Tools</th>
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<td><strong>Interview Aids</strong></td>
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<td><strong>Data Collection Tools</strong></td>
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</tbody>
</table>

The findings draw on both quantitative and qualitative evidence, which includes the viewpoint of key stakeholders and the realities on the ground.

- Analysis of the data was an ongoing iterative basis during the consultation process. The use of mixed methods assisted with triangulation and validation of data, thus strengthening the findings. Triangulation methods applied include:
  - The use of a variety of data sources
  - The use of feedback from UNFPA and/or IBI
  - The use of multiple perspectives to interpret the data
  - The use of multiple methods and stakeholders

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\(^4\) Tools is in Module 1 of the Strengthening Midwifery Toolkit (Module 1: Strengthening Midwifery A Background Paper) WHO; 2011

\(^5\) International Confederation of Midwives Core Document to Support Education, Regulation and Association http://internationalmidwives.org/core-documents (last accessed September 2014)

To gain consensus, a broad range of stakeholders were involved in the consultation process. These included government officials, professional associations, donors and UN agencies.

1.3 Limitations and Challenges

- The current political and environment landscape in Indonesia is changing; universal coverage of health care is in early stages of implementation and there is a new government; the implications of this on the health system in terms of future restructuring are not clear.
- Health professional regulation in Indonesia is in the early stages of development; there are Acts before Parliament for a Health Practitioners Board, and the establishment of Nursing and Midwifery Councils. It is unknown if regulation will evolve in Indonesia and the impact it will have on the education of health providers, service delivery and the professions themselves.
- The consultant does not have Indonesian language skills. This limited the exploration of specific issues.

1.4 Outline of this Document

There are six sections in this report.
1. Addresses the purpose of the report and the approach taken to gather information and limitations encountered when trying to achieve the TOR.
2. Provides a rationale for the paper and global support and evidence that supports the essential role midwives play in reducing maternal and newborn mortality
3. Gives an overview of the status of maternal mortality in Indonesia and health strengthening efforts to address maternal mortality since the 1980s
4. Reviews the development and status of midwifery in Indonesia and key issues facing the midwifery profession
5. Outlines the status of Health Professional and Midwifery Regulation in Indonesia
6. Summarises key challenges facing midwifery in Indonesia and makes the case for strengthening midwifery in Indonesia as an autonomous profession. Recommendations support this case.
2. BACKGROUND AND RATIONALE

2.1 Global Support for Midwifery

Since 2008, UNFPA has been at the forefront of working with the International Confederation of Midwives (ICM) and other global partners to strengthen the quality of midwifery through a number of initiatives (Table 2). A key strategy has been to create an enabling policy environment that supports effective midwifery education, regulation and association development. The ICM competencies and standards, developed in consultation with midwifery associations and maternal health stakeholders in more than 70 countries, have become the benchmarks for strengthening midwifery as a profession worldwide.

Table 2: Global Support for Midwifery from UNFPA and Partners

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Joint Statement: First Global Midwifery Symposium challenges in 2010 called for action by governments to address the vital areas of midwifery education, regulation and association, with the foundation for a strong workforce.</td>
</tr>
<tr>
<td>2011</td>
<td>State of the World Midwifery: Delivering Health, Saving Lives provided the first comprehensive analysis and evidence base for midwifery services and issues in countries that have a maternal and newborn mortality</td>
</tr>
<tr>
<td>2014</td>
<td>State of the World’s Midwifery: A Universal Pathway, A Women’s Right to Health has supported this call. The report shows the progress and trends that have taken place since the inaugural 2011 edition, and identifies the barriers and challenges to future progress.</td>
</tr>
<tr>
<td>2030</td>
<td>State of the World’s Midwifery 2014 has developed Midwifery 2030 as a pathway for policy and planning. Midwifery 2030 focuses on increasing the availability, accessibility, acceptability and quality of health services and health providers to achieve the three components of universal health coverage (UHC): reaching a greater proportion of women of reproductive age (increasing coverage); extending the basic and essential health package (increasing services); while protecting against financial hardship (increasing financial protection).</td>
</tr>
</tbody>
</table>

2.2 Rationale for the Report

A mixed picture on the performance of Indonesia’s health system and a lack of progress on reducing maternal mortality has signalled to the government that there are quality of care issues that go well beyond improving access to health services.

Key factors that contribute to poor quality of health care are lack of standardisation of education, health services and the delivery of health care. Thus, for public protection, the need to establish a regulatory authority to enforce uniform standards of health professional education and care became a pressing issue for the MoH. Therefore, in 2011 with World Bank support, the MoH collaborated with the Ministry of Education and Culture and embarked on the process of regulatory reform, which involved the development of a regulatory body (under the MoH) to standardise and unify education, health care and health professions across the country by Health Professional Education Quality Project (HPEQ).
The development of a regulatory authority for nurses and midwives has lagged behind the Medical Professions, and does not have full support from the MoH. An underlying problem has been a continuing debate over governance bodies for these professions, and the need to develop an autonomous structure that does not overlap, i.e. separate midwifery and nursing councils.

The main professional body for midwives in Indonesia is the Indonesian Midwives’ Association (IBI). As a professional association, IBI has no regulatory powers and lacks influence in policy and planning. Its greatest strength is the 220,000 (and counting) midwives they represent, and the high status afforded midwives by the public.

In recognition of the need for a strong cadre of educated, licensed and supported midwives, trained to international standards, UNFPA has commissioned this paper, to gain a better understanding on how they can support Midwifery in Indonesia to develop as an autonomous regulatory body, governed by midwives.

### 2.3 Evidence to Support strengthening Midwifery

In all countries that have achieved a dramatic decrease in maternal and newborn death, well-trained midwives or others with midwifery skills have been a key to success. The returns on investing in human resources with midwifery skills are enormous. Driving this momentum is a growing body of evidence. Some of this evidence in summarised below:

- First level facilities can manage 80% of obstetric emergencies effectively, using simple clinical procedures. The provision of timely obstetric first aid before timely referral to the next level of care could prevent up to 50% of maternal and newborn deaths.

- Through contraceptive use, an estimated 32% of maternal deaths can be prevented. Family planning reduces the lifetime risk of maternal death and the highest risk births, in younger and older women. It is also one of the most cost-effective ways to reduce births.

- Spacing family planning also has a positive impact on infant and child mortality. Birth intervals of less than 24 months; contribute to an increased risk of negative outcomes at birth for both the mother and baby. Short birth intervals are associated with increased risk of maternal death, miscarriage, low birth weight, and preterm birth.

- The World Bank estimates that maternal deaths would decrease by 75%, if coverage of key interventions rose to 99%. Equally, WHO has recently concluded that almost half of all perinatal deaths could be prevented with skilled care at birth. Properly trained and supported, midwives working in an enabling environment at a community level can deliver many of the interventions needed to address maternal health.

- Midwives, who are educated and regulated to international standards, can provide 87% of essential care needed for women and newborns.

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8 UNFPA, WHO and ICM; The State of the World’s Midwifery 2014
10 The cost effectiveness of avertly a disability-adjusted life year (DALY) is an approach used to assess the impact of a health program. One DALY can be to represent one lost year of health life due to disease or injury; averting a DALY is preventing the loss of a year of health life.
12 Macro International Inc. Demographic and Health Surveys
14 UNFPA, WHO and ICM; The State of the World’s Midwifery 2014
• Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver, and thus protects women’s health. High-quality midwifery care for women and newborns saves lives and contributes to healthy families and communities that are more productive\textsuperscript{15}.

• The returns on investment are a “Best Buy”:
  - Investing in midwifery education, with deployment to community-based services, could yield a 16-fold return on investment, in terms of lives saved and costs of caesarean sections avoided, and is a “Best Buy” in primary health care.
  - Investing in midwives frees doctors, nurses and other health cadres to focus on other health needs, and contributes to achieving a grand convergence: reducing infections, ending preventable maternal mortality and ending preventable newborn deaths\textsuperscript{16}.

\textsuperscript{15} Ibid
\textsuperscript{16} Ibid
Towards the Development of Midwifery Regulation in Indonesia 2014: Status of the Current Situation
3. MATERNAL HEALTH AND HEALTH SYSTEM STRENGTHENING EFFORTS

3.1 Status of Maternal Health

Since the launch of the Safe Motherhood Program is 1987, reducing mortality has been a national priority of the government. Between 1990 and 2013, maternal mortality decreased by 56%, although in recent years the decrease seems to be slowing down. Between 1990 and 2012, maternal deaths dropped from an estimated 27,720 to 9,812. Mothers who die are typically young, rural, less educated and poor. The poorest mothers still have a MMR that is more than three times that of the richer. At the same time, neonatal mortality dropped by almost a half, from 32 down to 19, with less of a drop in the lower than in the richer quintiles.

Facility birthing has tripled, from 21% in 1991 to 63% in 2012. The smallest gains have been made in the poorest quartiles (Figure 1), in 2012, 30% of births were in the poorest quartiles while 88% were the richest quintile. Out of the 46% of women who were using “health facilities” in the mid-2000s, only one out of four gave birth in a hospital, 70% of “facility births” were in private midwifery clinics and village birthing posts or village midwife homes (90% of these private “facilities” lacked a steriliser or resuscitation equipment and 80% lacked magnesium sulphate). A further 7% gave birth in health centres, 85% of which had no staff trained for providing BEmONC. It would therefore appear that, in the mid-2000s, a substantial proportion of facility births’ actually occurred in unequipped or inappropriate facilities.

Caesarean section rates have increased, from 0.8% (1986-89) to 12.3% (2007-2011). Most caesareans are in private facilities, with a large gap between the poor and rich: 3.7% of those in the poorest quintile gave birth by caesarean section, against 23% of the richest. Although women with severe obstetric complications typically rely on public hospitals, in a normal population 5% of all women will need a caesarean section. The increase in the rate of caesareans, with a disparity between the poor the rich, suggests that there are women who need this life saving procedure, but are not getting it.

23 Ibid
27 The Lancet 23 June 2014(Article in Press DOI: 10.1016/S0140-6736(14)60919-3
In 2012 a doctor, midwife or nurse attended 85% of all births, this represents an increase of 32% from 1991. There persists a disparity between provinces, between the rich and the poor (97% against 58%), and between mothers with a secondary education (97%) and those without education (32%).

**Figure 1: Gains in facility births and in the proportion of birth attended by midwives**

Gains in facility birthing and proportion of births primarily attended by midwives, auxiliary midwives, or nurse-midwives by wealth asset quintiles when compared with eight different countries.

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29 Ibid
32 Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality
Wim Van Lerberghe, Zoe Matthews, Endang Achadi, Chiara Ancona, James Campbell, Amos Channon, Luc de Bernis, Vincent De Brouwere, Vincent Fauveau, Helga Fogstad, Marge Kohlinsky, Jerker Liljestrand, Abdelhay Mechihi, Susan F Murray, Tung Rathavay, Helen Rehr, Fabienne Richard, Petra ten Hoope-Bender, Sabera Turkmani The Lancet 23 June 2014(Article in Press DOI: 10.1016/S0140-6736(14)60919-3

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Gains in facility birthing and proportion of births primarily attended by midwives, auxiliary midwives, or nurse-midwives by wealth asset quintiles when compared with eight different countries.
3.2 Financial Barriers

Families in Indonesia face very substantial transport and inpatient costs: typically US$111 for a normal birth and US$423 for a caesarean section\textsuperscript{33}. Financial barriers to access became a prominent issue, with the economic collapse of 1997 that resulted in almost a quarter of the population living in poverty. In 2005, a financial safety net for health was designed and implemented. It has since morphed into national and district-level insurance programmes for the poor and near poor,\textsuperscript{34} with the ambitious goal of universal health coverage by 2019. In 2011, the national insurance program has expanded to include 44\% of pregnant women without maternity insurance. These insurance programs have reduced the equity gap in accessing services—but not eliminated it. They also cover transport costs, but only partially and not to the first level of care, costs of which are borne by families\textsuperscript{35}.

3.3 Health Systems Strengthening Efforts

Maternal health is one of the top ten priorities of the Government. This commitment is reflected policy strategies, and plans such as the National Action Plan for Maternal Mortality Reduction 2012-2015. Despite a sustained commitment, maternal mortality remains high (Table 3) and the rate of decline when compared with other countries is disappointing.

<table>
<thead>
<tr>
<th>Country</th>
<th>GNI per capita</th>
<th>Maternal mortality ratio (per 100,000 live births)</th>
<th>Neonatal Mortality rate (per 1,000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>3,600</td>
<td>359</td>
<td>19</td>
</tr>
<tr>
<td>Philippines</td>
<td>3,900</td>
<td>94</td>
<td>14</td>
</tr>
<tr>
<td>Malaysia</td>
<td>13,740</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>Vietnam</td>
<td>2,2900</td>
<td>56</td>
<td>12</td>
</tr>
<tr>
<td>Thailand</td>
<td>7,770</td>
<td>48</td>
<td>8</td>
</tr>
</tbody>
</table>


Since the 1980’s, the Government of Indonesia (GoI) has implemented a number of strengthened health systems (Figure 2) aimed at improving maternal and newborn survival in Indonesia. These include:

- The expansion of a network of health facilities
- The scaling up of education and deployment of midwives
- Reductions in financial barriers
- Improvements in quality of care

Efforts have resulted in impressive gains in expanding the reach of health services. Since the 1980s, the GoI has constructed around 7,600 health centers (Puskesmas), 22,100 sub centers (Pustu) and 560 hospitals employing in 2005 a total of 415,000 staff (245,000 in health centers and 170,000 in hospitals)\textsuperscript{36}. The private


\textsuperscript{34} World Bank. “...and then she died”: Indonesia maternal health assessment. Washington, DC: The World Bank, 2010

\textsuperscript{35} Ibid

\textsuperscript{36} Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality

Wim Van Lerberghe, Zoe Matthews, Endang Achadi, Chiara Ancona, James Campbell, Amos Channon, Luc de Bernis, Vincent De Brouwere, Vincent Fauveau, Helga Fogstad, Marge Koblinsky, Jerker Liljestrand, Abdelhay Mechbal, Susan F Murray, Tung Rathavay, Helen Rehr, Fabienne Richard, Petra ten Hoope-Bender, Sabera Turkmani The Lancet 23 June 2014(Article in Press DOI: 10.1016/S0140-6736(14)60919-3
Towards the Development of Midwifery Regulation in Indonesia 2014: Status of the Current Situation

The health sector has grown even faster, partly because government policy allows public sector staff to work part-time as private providers.

However, health outcomes have not kept pace with the country’s economic growth and increased investment in health. Outpatient utilization rate, at both public and private facilities, declined sharply in 1997/8 with the financial and economic crisis, and has not been restored to pre-crisis levels. The slow pace in the reduction in maternal mortality is disappointing.

A recent study compares the health strengthening efforts of four countries (Burkina Faso, Cambodia, Indonesia and Morocco), to reduce maternal mortality since 1980. Each country has implemented a number of measures to strengthen health systems, including:

- Governance and resource mobilisation (Recognition by government and donors that maternal mortality was a priority issue)
- Access and uptake: (Removal of barriers to access, through e.g. financial schemes and deployment of midwives)
- Effective coverage: (Effectiveness and safe interventions through e.g. quality interventions and training and strengthening services closer to the community)
- Outcomes: Better maternal and newborn outcomes

As can be seen by Indonesia’s efforts (Figure 2 midwifery deployment efforts have been a key intervention. The findings for each country were similar.

- Health system strengthening over a long period of time, and investment in midwives, is a realistic and effective strategy to reduce maternal mortality.
- Government responses to quality of care have included improvements in technical standards, competencies, and equipment, and carrying out systematic death and near-miss audits.
- However, The time lag between expansion of coverage and improvement in quality, and these improvements being limited to technical dimensions and essential interventions, is concerning. In all countries, a substantial gap exists between the attributes of quality care and the realities on the ground.

Key factors that contribute to poor quality of health care are lack of standardisation of education, health services and the delivery of health care. That is, the link between standards of education, health services and competency standards are poor. Standardisation is now high on the Government of Indonesia agenda. Thus, for public protection, the need to establish a regulatory authority to enforce uniform standards of education and care has been a pressing issue. Since 2011 with World Bank support, the MoH and MoEC have embarked on a process of regulatory reform to address issues of quality, through standardisation of education and health care. Section 5 of this document provides more information on these reforms.

37 AusAID draft concept note: Australia-Indonesia Maternal and Newborn Health and Nutrition Program, January 2013
38 Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality
Wim Van Lerbergh, Zoe Matthews, Endang Achadi, Chiara Ancona, James Campbell, Amos Channon, Luc de Bernis, Vincent De Brouwere, Vincent Fauveau, Helga Fogstad, Marge Koblinksy, Jerker Liljestrand, Abdelhay Mechbal, Susan F Murray, Tung Rathavay, Helen Rehr, Fabienne Richard, Petra ten Hoope-Bender, Sabera Turkmani The Lancet 23 June 2014(Article in Press DOI: 10.1016/S0140-6736(14)60919-3
Figure 2: Health Systems Strengthening and Midwifery Deployment Efforts INDONESIA (1980-2011)

OUTCOMES
- More equitable maternal and newborn outcomes
- Better maternal and newborn outcomes
- Improved social inclusion, gender equity, participation

EFFECTIVE COVERAGE
- Mother and baby centred care
- Effective and safe interventions and skills
- Hospital backup and parsimonious referral

ACCESS AND UPTAKE
- Midwives: supply deployment, remuneration retention
- Removal of barriers to access
- Close-to-client facilities, equipped and supplied

STEERING AND RESOURCE MOBILISATION
- Strategic information and intelligence
- Recognition as priority
- Translation into budget allocation and regulation

Commitment of political leadership

Aid sensitive to MNH priorities

Late 2000s: in-service training programme by MOH & midwifery association; accreditation; quality circles; maternal death audits.

Massive “village midwife” programme: pre-service training and deployment of midwives, both to health facilities and as private practice at village level.

Pay per delivery financial incentives for public sector midwives. Market prices for private midwives.

Regular DHS; multiple studies and surveys since 1980s; confidential enquiries.

High priority for leaders within health sector since mid 1980s.

2011: health centres and hospitals brought under joint funding and management.

2005: health insurance safety net for the poor. Special arrangements for remote populations.

By 1997: 20,000 village maternity clinics established.

Late 1980s: recognised as priority in legal frameworks.

1989 onwards: increased earmarking for maternal health, with particular focus on midwives.

1990an: development partner priority.

Comment: The village midwife program is a government program, however, some Bidan Di Desas may end up opening private practice, and however this is unlikely in remot/rural areas – particularly for eastern Indonesia.
Towards the development of midwifery regulation in Indonesia 2014: status of the current situation
4. MIDWIFERY IN INDONESIA

4.1 Number and Distribution

The Indonesian Midwives Association (IBI) recently reported there are 212,000 midwives across the country\(^ {40}\). However, the new central registry suggests that there are more than 220,000 midwives (and counting) in Indonesia. This meets the coverage need of Indonesia. However, this aggregate figure masks imbalances in distribution. There is a need to redistribute some midwives to address service delivery gaps\(^ {41}\).

4.2 Different Cadre of Midwives

There are two main cadres of midwives in Indonesia:

1. The first midwife is the Pegawai Negeri Sipil (PNS; Government Permanent Employee) midwife who the government employs on a permanent contract. They are usually more experienced and work in clinics and villages. Due to their greater level of experience, some of run their own private practice.

2. The pegawai tidak tetap (PTT; contract) cadre of midwives emerged from the government Village Midwife Program. The government employs these midwives on a temporary three-year renewable contract. They are often recent graduates with little experience\(^ {42}\).

4.3 Village Midwives

Midwives typically serve one or more villages, catering for 3,500 people, and attend 36 deliveries a year\(^ {43}\). Midwives working in rural areas often have a large workload, with one midwife being responsible for up to five villages. Only 29% of villages have their own resident midwife\(^ {44}\). While this means that there is a higher ratio of midwife to population, it also means that midwives working in rural areas have the potential to bring in a higher income as they have a greater patient load\(^ {45}\).

4.4 Private Practice Midwives

Private practice midwives have existed as long as professional midwifery has been in Indonesia. In the 1988, the government trained and deployed over 50,000 midwives to villages on three-year government contracts. The expectation was that after their contracts were over they would remain in the villages and continue in private practice. As a result, the delineation between the public and private sectors in Indonesia is blurred. Midwives often practice in both sectors simultaneously—working in government facilities in the morning and in their birthing houses in the afternoons and evenings. Upon retirement from the

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\(^{40}\) Reported in UNFPA, WHO and ICM; The State of the World’s Midwifery 2014


\(^{44}\) Impact 2007, Indonesia: Resident Midwives Help Avert Maternal Deaths When Financial Barriers are Removed, Impact International, Population Reference Bureau

government, many midwives devote their time entirely to private practice. Private-sector midwives have been providing family planning services for decades; a service the government trained them to perform. Currently, 31.7% of Indonesian women obtain family planning services from private-sector midwives. In addition, the government subsidises private midwives for providing specific services to indigent citizens.

4.5 Policy Context

The needs of society and the advancement of science and technology and government reforms and policy are shape the practice on Indonesian midwives the most recent developments being education reforms and the regulation of health professions in line with global standards. Key ministry regulations are below (table 4).

Table 4: MoH Regulation Shaping Midwifery Practice in Indonesia

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Minister of Health Regulation No. 5380/IX/1963, midwives' authority is limited to normal self-help labour, accompanied by another task.</td>
</tr>
<tr>
<td>B</td>
<td>Minister of Health Regulation No. 363/IX/1980, modified into Minister Regulation No. 623/1989, states that midwife authority is divided into general and specific authority, which is determined when a midwife undertakes special measures under the supervision of a physician. The implementation of this regulation is that midwives carry out individual practice under the supervision of a physician.</td>
</tr>
<tr>
<td>C</td>
<td>Minister of Health Regulation No. 572/VI/1996 governing the registration and practice of midwives in performing their practice, midwives are given an independent authority. This power come with the ability to carry out an action, which includes: • Midwifery services that include maternal and child care. • Family planning services • Public health services</td>
</tr>
<tr>
<td>D</td>
<td>Minister of Health Decree no. 900/Menkes/SK/VII/2002 concerning registration and practice of midwives, revision of Minister of Health Regulation No. 572/VI/1996 In performing their duties, midwives make collaboration, consultation and referral according to the patient's condition, authority and ability. In an emergency, midwives given authority to provide midwifery services aimed at saving lives. This regulation also confirms that the practice of a midwife is based on professional standards and in accordance with their authority, ability, education, and experience The required midwives' ability in accordance with this regulation is not simple, because the authority granted by the Health Ministry implies a demand for the ability of midwives as professional and independent workforce.</td>
</tr>
<tr>
<td>E</td>
<td>Minister of Health Regulation No. 369 of 2007 states that midwife practice focuses on prevention, health promotion, normal childbirth assistance, detection of complications in mother and child, taking action as appropriate with the given authority or other assistance, if needed, and taking necessary measures in emergency.</td>
</tr>
</tbody>
</table>

4.6 Education and Training

There are 465 schools offering midwifery education and 682 schools offering nursing education in Indonesia. Of these, 389 midwifery schools (84%) and 354 nursing schools (52%) are privately managed. While government-managed schools are distributed more or less evenly throughout the country, privately-
owned schools are heavily concentrated in Java with 52% of all private midwifery schools and 52% of all private nursing schools located in Java. After decentralization, more local governments established midwifery and/or nursing schools. There are currently 14 midwifery schools (representing 3% of the total number of schools) and 64 nursing schools (9.4% of the total) belonging to local governments.

The majority of midwifery and nursing schools offer a D3 education (academy) level. This is consistent with the policy decision taken by MoH in the late 1990s to abolish SPK level education for nurses and D1 level education for midwives. Lately, the Indonesian Nurses Association (PPNI) has been pushing for an even higher qualification for nurses as reflected in the growing number of schools offering a bachelor degree program in nursing. Currently, 174 schools or 25.5% of all nursing schools offer an S1 education.

The midwifery and nursing schools are producing 10,000 midwives and 34,000 nurses per year. It is unclear what percentage of these numbers is absorbed annually by the public sector and it is likely that many of them work in private facilities or open their own private practice. A large number of publicly and privately-employed midwives and nurses are known to also have their own private practice.

4.7 Quality of Midwifery Training

There is a general acknowledgement that the current education system for midwives in Indonesia does not support the production of good quality graduates and, as a result, does not always provide quality services. The capacity to train midwives has improved in terms of quantity, but Midwifery education is low quality and the system of accreditation of schools and certification of graduates is weak. More detail on the quality of midwifery training is in the next section of the report.

4.8 Deployment of Midwives and the Bidan Di Desa Program

A prominent feature of Indonesia’s programs since the late 1980s has been the substantial scale-up of midwives. Between 1991 and 2012 births by midwives increased from 29% to 62%. Births by midwives in the three lowest quintiles increased by 31 percentage points, in the fourth by 10 percentage points. In the richest quintile, there was a 12-percentage point’s decrease as women switched to doctor-assisted childbirth: in the mid-2000s, 20% of births were assisted by an obstetrician.

The Bidan di desa or village midwife program was the focus of this scale-up. Bidans (midwives) were to provide a range of primary care services including antenatal, labour, birth and postnatal care, family planning promotion and services, and other basic primary health care services for newborns and children. In its early stages, the program required that a trained midwife receive one year of midwifery training after nine years of schooling and three years nurse training. In the mid 1990s, the training of midwives offered through midwifery polytechnics as a three-year diploma course (an extension of the one-year program). New midwifery graduates were being three-year contracts by the government; on completion of their contracts, they could apply for vacant civil service posts or a local government position.

The village program was attractive to females who saw in midwifery employment an opportunity for dual practice. The promise of a good career, good income and work that allowed family life was attractive to

49 Ibid
50 Ibid
many women\textsuperscript{53}. The program contributed to a proliferation of Midwifery academies and by 2008; there were nearly 600 midwifery schools across the country. The speed of the scale-up was such that clinical training sites and qualified clinical teachers could not match need and midwives reportedly graduated without actively assisting at childbirth\textsuperscript{54}.

Over 54,000 midwives had been deployed by 1997 and about 20,000 village maternity clinics established (12 per 1000 expected births) across Indonesia. By 2012, the number of midwives had risen to over 135,000: 31 per 1000 expected births\textsuperscript{55}. As there was, no proper registration process in place at that stage the number is possibly higher will about half working as village midwives while others work in health centres or private practice.

The increased supply of midwives led to increased use of maternity services\textsuperscript{56}, but the program had flaws. Confidential inquiries in western Java found village midwives’ emergency diagnostic skills were good but clinical management of complications was not up to standard\textsuperscript{57}. Little or no information is available on the provision of compassionate and respectful care, but persistent sub-optimal technical quality of care is well documented\textsuperscript{58,59,60,61,62,63}.

4.9 Factors Contributing to Poor Performance

The pace of the scale up and expansion of the Bidan di desa program and associated deficiencies in basic training and poor deployment attributes to poor performance by midwives. Many midwives posted have posted to single village clinics in remote areas, or have gone into private practice (or both) —all of which necessitates a scope of practice that extends well beyond basic midwifery training.

Lack continuing education and low volumes of work have exacerbated performance problems for many midwives (village midwives average 30 births per year)\textsuperscript{64}. This in turn has contributed to a lack of experience with obstetric emergencies. Poor communications channels between midwives and the facilities they refer to; has also contributed in poor referrals. Added to this, employment status is variable — from civil servants to short-term contract staff (local or national) to private practitioners—and hence supervision has often been inadequate\textsuperscript{65}.  

\textsuperscript{55} IBI Indonesian Midwives Association. Info Kegiantan IBI. Mon Arch Oct 2012
\textsuperscript{57} Ministry of National Development Planning/National Development Planning Agency (BAPPENAS). The Roadmap to Accelerate Achievement of the MDGs in Indonesia. Indonesia: Jakarta, 2010
\textsuperscript{58} World Bank. “…and then she died”: Indonesia maternal health assessment. Washington, DC: The World Bank, 2010
\textsuperscript{59} Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. Indonesia demographic and health survey 2007. Indonesia: Jakarta, 2008
\textsuperscript{60} Ensor T, Nadjib M, Quayyum Z, Megraini A. Public funding for community-based skilled delivery care in Indonesia: to what extent are the poor benefiting?. Eur J Heal Econ 2008; 9: 385-392. PubMed
\textsuperscript{63} Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality
\textsuperscript{65} Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality

Towards The development of midwifery regulation in Indonesia 2014: Status of the current situation
Other problems have not addressed. The deployment of midwives was poorly coordinated with the parallel expansion of the hospital network (a 22% increase in the number of hospitals between 1998 and 2008, with most of the increase in larger size hospitals\textsuperscript{66}) and the continuation of the expansion of the health centre started during the 1980s. The network of facilities itself continued to face major coordination problems further complicated by the way decentralisation has been “rolled out”.

Equipment and supplies systems for maternal health care also lagged behind. In 2011, a national facility survey showed that of the nearly 9000 health centers only 19\% could provide basic EmONC, 20\% had no transportation available for referral, and less than 50\% could provide 24-hour services\textsuperscript{67}. While 83\% of public hospitals had at least one obstetrician, only 21\% met the nine comprehensive EmONC criteria, including a 24 hour operating room, blood, laboratory and radiology services, and 24/7 availability. More than half lacked qualified human resources, equipment and blood. Feedback from the president of POGI was that even where there are resources the capacity to use the equipment is sometimes an issue. This can be due to a lack of confidence and/or practice in the use of specific equipment and supplies. The Government has recently launched measures to upgrade hospital and health centre services. These include rationalisation of recruitment and distribution of staff, accreditation of hospitals and health centres, introduction of quality improvement cycles and maternal and perinatal audits, and increased financial support from central as well as local government to address the gaps in infrastructure, equipment and supplies.

4.10 Current Issues Facing Midwives in Indonesia

This section summarises the findings of a rapid situational assessment of the status of midwifery in Indonesia (Table 5). A WHO tool\textsuperscript{68} was the basis of the assessment. For each benchmark, there was a scoring scale of 0-3. Based on feedback during a workshop the overall score for Indonesia was 17 out of a possible 36.

<table>
<thead>
<tr>
<th>No</th>
<th>Benchmark</th>
<th>Current Status</th>
<th>Gap /Emerging issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Legislation for licence to practise as defined according to global regulation standards\textsuperscript{69} including scope of practice in place and assessed as operating well</td>
<td>Rules/Regulations governing authority to practice midwifery are in place. A system of registration and licensing of midwives is functioning under a joint Health Workforce Council (MTKI) established by the Ministry of Education and Culture (MoEC) and MOH. The process of registration and licensing is relatively new and the effectiveness of the system will need assessment to ensure the full scope of practice of the midwife is subject to regulation</td>
<td>The model of regulation that is evolving under the MTKI structure does not support autonomous midwifery practice. However regulation is still evolving and legislation to support the Workforce Council under a Health Professions Act has been submitted to the Indonesian Parliament</td>
</tr>
</tbody>
</table>


\textsuperscript{67} Risfaskes. MOH, Health facility survey. Indonesia: Jakarta, 2011

\textsuperscript{68} Tools is in Module 1 of the Strengthening Midwifery Toolkit (Module 1: Strengthening Midwifery A Background Paper) WHO; 2011

\textsuperscript{69} Adapted from Module 1 of the Strengthening Midwifery Toolkit (Module 1: Strengthening Midwifery A Background Paper) WHO; 2011

\textsuperscript{70} ICM Definitions of Midwife
<table>
<thead>
<tr>
<th>No</th>
<th>Benchmark</th>
<th>Current Status</th>
<th>Gap /Emerging issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Re-licensing procedure is in place and linked to continued competency to practice. This procedure is operating and assessed as being effective</td>
<td>A 5-year re-licensing procedure is in place that promotes the maintenance of continued competence; and plans are in place to ensure re-licensing procedures linked to competent practice. The process included self-reporting, proof of practice log book and continuing education credit points</td>
<td>Midwives in Indonesia can graduate at two levels (Diploma III or Diploma IV). It is unclear how these diplomas align with the Indonesian Qualification Framework and other midwifery courses (pre-service, in-service and continuing education) in Indonesia.</td>
</tr>
<tr>
<td></td>
<td>A competency based midwifery curriculum is in place. The Indonesian Midwives Association have had input into the standards, but no evidence exists that they meet current needs of the country or the curriculum is “fit for purpose”. Standardisation of this curriculum is its early stages of development. A revision process in place and there will be an opportunity to revise the curriculum in two years.</td>
<td>Standards vary considerably between training institutions. Accreditation is in place, the degree to which it is enforced will be a measurement of the success of this mechanism. The D3 diploma is not been upgraded to a bachelor’s degree. Feedback is that the GoI wants midwifery to be a vocational course – If midwifery is to gain recognition as a professional group this will need further consideration, as the Indonesia Qualifications Framework defines a profession as having a degree level qualification.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Evidence based standards are in place and are regularly audited; action is taken based on audit findings.</td>
<td>Midwifery competency standards are in place but audit procedures need improvement</td>
<td>Need strengthening through research, best practice and a defined scope of practice.</td>
</tr>
<tr>
<td>5</td>
<td>Clinical areas provide quality midwifery care and all experiences required for students of midwifery, including supportive supervision of students.</td>
<td>Studies show that the quality of care in clinical area is variable. Competency tests show poor results. This suggests training and supportive supervision need strengthening.</td>
<td>Before registration, an Objective Structured Clinical Examination (OSCE) is undertaken followed by online test of knowledge in seven areas of competence. This form of competency testing has just commenced and the results have been disappointing with only about half of the applicants passing the testing.</td>
</tr>
<tr>
<td>6</td>
<td>Norms have been established and are being met in all districts, with only minimal shortfalls of midwifery staffing in some areas</td>
<td>Staffing norms are in place but current numbers of staff are below that required to meet service delivery needs in all areas of the country.</td>
<td>There is a needed to train or attract midwives to fill specific gaps e.g. management, teaching, and supervision.</td>
</tr>
<tr>
<td>7</td>
<td>Realistic map of all midwives currently in practice is known at national and district level. Special efforts are in place to meet the needs of hard-to-fill/long-term vacant posts</td>
<td>The numbers of midwives in clinical post (both government and private) known, but many vacant posts exists and no realistic plan in place to address the shortfall.</td>
<td>There are adequate numbers of midwives in Indonesia. However, there is a need to redistribute midwives to cover current gaps in coverage.</td>
</tr>
</tbody>
</table>

71 Fitness-For-Purpose means the curriculum has been designed to meet the specific socio-ethnographic and epidemiological needs to the country, as well as professional competency (see Sherratt DR. 1998. Improving Women’s Health in South-East Asia: A need for Midwifery Trained Personnel.)
<table>
<thead>
<tr>
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<th>Benchmark</th>
<th>Current Status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Job descriptions specific to midwifery practice are in place; they are based on provision of EB standards of care, are in place in all areas, including the community</td>
<td>Job descriptions of midwives at all levels of services are vague and do not specify statements about minimum standard of midwifery practice required by the post holder.</td>
<td>There is confusion about the difference between a Job description and scope of work and documentation is often out of date. In the longer term, this will need addressing.</td>
</tr>
<tr>
<td>9</td>
<td>A realistic student teacher ratio has been established and is being met in most places</td>
<td>Student teacher norms are established, but not in place in most areas</td>
<td>There is a need to develop the capacity of midwives as teachers and educators of midwives to meet fill current gaps.</td>
</tr>
<tr>
<td>10</td>
<td>All teachers of midwifery have successfully completed specialist preparation as a midwife teacher.</td>
<td>No real program for preparation of midwife teachers is in place that ensures that midwife teachers are competent in all aspects of midwifery practice and education.</td>
<td>Very few teachers of midwifery have received training and been assessed as competent in all aspects of midwifery, as well as competency to teach</td>
</tr>
<tr>
<td>11</td>
<td>Sufficient and varied teaching and learning materials of good quality are available and being used in all centres</td>
<td>Limited teaching and learning resources available in most centres, but many are out of date</td>
<td>There is need to develop and implement a standardised list of teaching and learning materials for use in all training/education venues for midwives.</td>
</tr>
<tr>
<td>12</td>
<td>Midwives at all levels of the service have the opportunity to participate fully in continuing education programs or advanced education programs</td>
<td>Continuing and advanced education programs are available for midwives are available but are limited, particularly at bachelors, Masters and PhD Levels</td>
<td>Specialist midwifery studies at both Master’s and PhD level and specialist programs for midwifery leadership, management, research development and policy making need strengthening</td>
</tr>
</tbody>
</table>
5. STATUS OF THE REGULATION OF HEALTH PROFESSIONS IN INDONESIA

5.1 Regulation of a Profession in the Context of Reforms

Regulation of a health profession in the context of regulatory reform, as is the case in Indonesia, is complex. The scope of regulation spans education, health practice and health services at all levels of government, and the mechanism for regulating a profession involves both a professional and legal framework (Figure 3).

Figure 3: The Relationship Between Professional and Legal Regulation

![Diagram showing the relationship between professional and legal regulation]

Adapted from a tool developed by Jhpiego Reproline Plus; http://reprodlineplus.org (last accessed August 2014)

The extent which regulation is institutionalised into government systems depends on the model of regulation, the autonomy given to a particular health profession and the strength of the links between the different institutions involved in the regulation. These include links between the education sector, health sector, and a professional association, and/or another regulatory body.

There is no one model of health profession regulation, as the model usually evolves from within a country and along a continuum of control. Regulation can be anything from a profession self-regulating itself, to government having full control, with each health profession having different levels of autonomy. Broadly speaking there are three models of regulation, evolving globally.
Figure 4 shows the models accommodate different levels of autonomy. For example, in Model 1 each profession has its own ACT with no coordinating mechanism. In Model 2, there is a multidisciplinary single board. Under this model, it would be possible for a health profession to have limited or no autonomy. Model 3 is a variation of Model 2 but provides more autonomy for a profession.

**Figure 4: Emerging and Different Models of Regulation**

**Model 1: Profession/Occupation-Single Board/Council Model**

- Medical Act
- Nursing & Midwifery Act
- Pharmacist Act

Profession-specific legislation with delegated power to a single profession-based board

**Model 2: Multi-Disciplinary Single Board**

- HEALTH PROFESSIONS ACT
- Umbrella legislation covering multiple disciplines with a single governance board that provides for uniform procedures.
- Single governance board for all health disciplines
- Regulates All Health Disciplines

**Note:** Currently this is how MTKI seems to be evolving. The level of autonomy each profession will have in this model is unclear. It is possible under this model for a profession to be autonomous. E.g. the New Zealand Midwifery Council [http://www.midwiferycouncil.health.nz/](http://www.midwiferycouncil.health.nz/) (accessed Sept 2014)

**Note:** In this model, midwifery usually comes under a joint council with two divisions, one for nursing and one for midwifery.
5.2 The Need for Regulation

Poor Quality of Care

A study on quality\(^{72}\) conducted in district hospitals, health centers and midwifery clinics in 20 districts confirmed the need for major efforts to improve the quality of care in order to reduce maternal and neonatal mortality. Weaknesses that related specifically to the scope of practice of midwives included: inadequate counselling during antenatal and post-natal care; lack of knowledge and skills to manage normal deliveries; need to recognise obstetric and neonatal complications; performance of life-saving procedures; and shortages of equipment and supplies. Inadequate training and inadequate implementation of standardised care are key factors, which contribute to poor quality of care.

Inadequate training: The overall quality of Midwifery education is low. A quality of health care provision and health worker study\(^{73}\) indicated that the quality of services has only improved marginally, and that overall quality is low. This includes the ability of midwives to correctly diagnose and treat key maternal and child health problems. The study concluded that the quality of education, for midwives, is insufficient.

Other evidence\(^{74}\) suggests that training for midwives, including that provided by the many private training schools, is often sub-standard, producing midwives without the skills and competencies to manage normal deliveries or obstetric emergencies. Many midwives lack experience in supervising deliveries, prior to deployment, and are therefore not well equipped to recognise, manage and refer maternal and neonatal complications. Concerns\(^{75}\) have reported about the quality of training in family planning and the extent to which midwives are informed about contraceptive methods.

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\(^{72}\) WHO for the MoH The 2012 Maternal Health Services Quality Assessment


\(^{74}\) Risfaskes. MOH, Health facility survey. Indonesia: Jakarta, 2011

Inadequate implementation of standards: Not all *Puskesmas* and hospitals are implementing standards of care that would ensure effective management of obstetric and neonatal complications. Efforts are required to standardise quality of care throughout the system, improve supervision and monitoring, and strengthen accreditation and regulation of public and private providers.

Quality of the Education System

The capacity to train midwives has improved in terms of quantity, but there are major quality concerns: There are serious quality concerns about the education system itself and the subsequent certification and accreditation of health workers. In addition, there is a serious gap in capacity. There is a general acknowledgement that the current education system for midwives in Indonesia does not support the production of good quality graduates and, as a result, does not always provide quality services.

Midwifery education needs attention, especially with a view to improving maternal health, which is a major challenge in Indonesia: There is a significant involvement by the private sector in midwifery education. During the last decade, a large number of new, mostly privately funded, midwifery schools were established. Following decentralisation in 2001, more districts started establishing their own midwifery schools. Despite the large number of schools, the accreditation for these schools and system to certify graduates as competency need strengthening. This means thousands of midwives of questionable quality are entering the market each year.

Licensing and Accreditation of Schools: There is also a lack of uniformity in the accreditation of midwifery schools as the Centre for Health Workforce Education (Pusdiknakes), MOH accredits the public Poltekkes, while BAN-PT accredits non-Poltekkes and privately owned schools. While both Pusdiknakes and BAN-PT are working to improve accreditation procedures, there is not yet a common approach; nor is the accreditation process aligned with international standards of independence, credibility and transparency to the public.

The government recognised this and introduced measures to standardise education and accredit medical and other training schools. However, the enforcement of standardisation and accreditation is not uniform across the country. There are a significant number of new public and private schools without proper oversight - many for commercial gain. This was and still is particularly so for private schools, as public nursing and midwifery schools are organised under 33 Health Polytechnics (Poltekkes). The perception is that training provided by these schools is more affordable and better quality.

There are great variations in the quality and standards of pre-service training for nurses throughout the country. The education law stipulates that all education above high school level (D3 level and above) is under the jurisdiction of MoEC. In reality, the MoH Centre for Health Workforce Education (Pusdiknakes) continues to control the publicly-owned D3 level education of nurses delivered through 33 Poltekkes, while the accreditation of other midwifery and nursing education institutions, including those that are privately owned, is done by BAN-PT in collaboration with the professional associations, IBI and PPNI. Pusdiknakes and BAN-PT do not use the same instruments to accredit the schools; the former uses a more technical instrument allowing a more clinical focus, while BAN-PT places more emphasis on the administrative aspects.

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77 Ibid
**Alignment with international standards:** While both Pusdiknakes and BAN-PT are working to improve accreditation procedures, there is not yet a common approach and criteria for either public or private schools and it is widely acknowledged that the accreditation processes do not align with international standards of independence, credibility and transparency to the public.

**Government Response**

This mixed picture on performance of Indonesia’s health and education systems, and a lack of progress on reducing maternal mortality, signalled to the government that there was and still is quality of care challenges, which go well beyond improving access to health services. Key factors that contribute to poor quality of health care are lack of standardisation of education, health services and the delivery of health care. Thus, for public protection, the need to establish a regulatory authority to enforce uniform standards of health professional education and care became a pressing issue for the MoH. Therefore, in 2011, with World Bank support, the MoH collaborated with the Ministry of Education and Culture and embarked on a process of regulatory reform, which involved the standardisation, and unification of education, health services and health professions across the country.

**5.3 Establishment of a Regulatory Authority to Implement Reforms (MTKI)**

In 2011, under a Ministerial Decree, a Medical Joint Workforce Council (Permenkes 46/2013 on MTKI – Majelis Tenaga Kesehatn Indonesia) was established to implement the reforms. Similar councils will follow at the province level. As they have their own Councils, doctors, dentists and pharmacists do not come under the decree.

The Joint Workforce Council, hereafter abbreviated as MTKI is in the early stages of development. MTKI duties are to assist the Ministries of Health and Education in formulating policies, and strategies in order to improve quality of health services provided by health care providers. The structure of the council will look something like Figure 5; with similar structures in each province (Figure 6).

**Figure 5: Structure of MTKI: National Level**

As can be seen by Figure 6 there are three divisions under Chairman, i.e.:

1. Division of Registration
2. Division of Competency Test
3. Division of professional Development
The disciplinary committee will be external to the MTKI structure. The appointment of the head of disciplinary committee and the functioning of this committee is still under consideration.

Membership of the MTKI will be at least 23 persons. There will be one member from each profession; for a cadre of more than 220,000, this will only give midwives a limited voice in the opportunity to participate in their own development.

Current mechanisms for regulation under MTKI regulatory authority are certification, registration, licensing and accreditation (Figure 7). Other mechanisms, such as credentialing are under consideration. These recent education reforms lay the foundation for regulatory reform for midwives and improvement of midwifery education.
The Health Workforce Council is still evolving and the final model of health professional regulation that the Government of Indonesia will adopt is still not clear. In its current form, the MTKI regulatory framework does not allow the health professions to function as an autonomous professional body. However, this might change as the model evolves.

5.4 Licensing and Certification of Midwives

Until recently, no legal entity existed in Indonesia to regulate the midwifery practice. Midwifery students would receive a graduation certificate from their training schools without going through any kind of nationally standardised test of skills and knowledge. Based on the certificate, the Provincial Health Office would issue a license to the midwife or nurse (Surat Ijin Bidan-SIB and Surat Ijin Perawat-SIP). This license allowed them to practice in a mainly unsupervised work environment, with little accountability for the quality of services they provided.

Since establishment, MTKI has been working closely with professional associations to develop competency standards for ten health professions including those for midwives. MTKI introduced a policy requiring midwives to pass a competency test as a prerequisite to obtaining their professional license.

Before registration, an Objective Structured Clinical Examination (OSCE) is undertaken, followed by an online test of knowledge in seven areas of competence. This form of competency testing has just commenced and the results have been disappointing, with only about half of the applicants passing the testing.

5.5 Regulation of the Midwifery Profession

In Indonesia, the development of a regulatory authority for Nurses and Midwives has lagged behind the Medical Professions. An underlying problem has been continuing debates over governance bodies for these professions and the need to develop an autonomous structure that does not overlap, i.e. separate midwifery and nursing councils.

Furthermore, creating a separate regulatory authority for midwifery is not on the MOH’s agenda, but the MOH has a Health Practitioner Act before Parliament, which, if ratified might allow a profession like midwifery the opportunity to establish an autonomous body such as a Midwifery Council, under a statutory board. If such a board were established then all professions in the country would come under this board.

The main professional body for midwives in Indonesia is the Indonesian Midwives’ Association (IBI). As a professional association, IBI has no regulatory powers and lacks influence in policy and planning. Its greatest strength is the 220,000 (and counting) midwives it represents, a strong network of branches that spans 34 provinces across Indonesia, and the high status afforded midwives by the public.

Since 2005, the IBI has had an Act before the Indonesian Parliament for the establishment of an Indonesian Midwifery Council that will function as an autonomous body under the governance of midwives. At the request of the Parliament, the Act underwent revision in 2013. There is also a Nursing Act before Parliament and there are high expectations from both professions that both Acts would pass through Parliament simultaneously this year. Feedback indicates this is unlikely.

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78 Since being established regulations governing the council have changed four times
There is overwhelming support for a Midwifery Council within the midwifery profession. However, there is a limited understanding about the difference between a Professional Association and a Regulatory Authority such as a Midwifery Council; in terms of the functions performed by each body (See Table 6).

### Table 6: Difference and Shared Responsibilities Between Council and Association

<table>
<thead>
<tr>
<th>Indonesian Women and Families</th>
<th>Indonesian Midwives Council (IBC)</th>
<th>Indonesian Midwives Association (IBI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public safety</strong></td>
<td><strong>Act</strong></td>
<td><strong>Authority</strong></td>
</tr>
<tr>
<td>• Regulation of midwifery practice</td>
<td>• Professional Leadership</td>
<td></td>
</tr>
<tr>
<td>• Protection of public safety by ensuring midwives are competent</td>
<td>• Representation for midwives</td>
<td></td>
</tr>
<tr>
<td>• Register midwives &amp; maintain the register of midwives.</td>
<td>• Develop philosophy of midwifery</td>
<td></td>
</tr>
<tr>
<td>• Issue Practicing Certificates (Competency based).</td>
<td>• Policy development, influence and advice</td>
<td></td>
</tr>
<tr>
<td><strong>Standards of practice</strong></td>
<td><strong>Purpose</strong></td>
<td><strong>Set standards:</strong></td>
</tr>
<tr>
<td>• Set standards: (code of ethics in collaboration with the IBI, code of conduct)</td>
<td>• Professional behaviour standards: code of ethics in collaboration with the Indonesian Midwives Council</td>
<td></td>
</tr>
<tr>
<td>• Standards of competency (for each scope of practice)</td>
<td>• Set standards of education: pre-service and in-service, curriculum, school, teachers</td>
<td></td>
</tr>
<tr>
<td>• Monitoring the standards</td>
<td>• Accreditation of curriculum, institutions</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td><strong>Constitution</strong></td>
</tr>
<tr>
<td>• Set standards of education: pre-service and in-service, curriculum, school, teachers</td>
<td>• Conferences, seminars, newsletters</td>
<td></td>
</tr>
<tr>
<td>• Accreditation of curriculum, institutions</td>
<td>• Library service</td>
<td></td>
</tr>
<tr>
<td><strong>Complaints &amp; notifications about the practice of midwifery</strong></td>
<td>• Education/study grants</td>
<td></td>
</tr>
<tr>
<td>• Disciplinary role: receive, assess and manage complaints about the practice of individual midwives</td>
<td>• Continuing Education of members</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td><strong>Policy development</strong></td>
</tr>
<tr>
<td>• Policy development</td>
<td>• Provide indemnity insurance cover to individual members.</td>
<td></td>
</tr>
<tr>
<td>• International regulatory collaboration</td>
<td>• Provide professional advice and advocacy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide legal and competence advice and representation</td>
<td></td>
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<tr>
<td></td>
<td>• Wage negotiation and conditions of employment</td>
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</tbody>
</table>

Lack of understanding has resulted in an inability to make a clear decision on how an independent midwifery regulatory body might operate and still maintain their autonomy under different structures. On a number of occasions, the IBI has had the opportunity to form a joint council with nursing, but has declined because they believed they could not function as an autonomous midwifery authority. This is not the case; in many countries, midwifery has a joint council with nursing and manages to maintain its autonomy.

### 5.5 Unfinished Business

Although midwives in Indonesia have a well-established Association to represent over 220,000 midwives, it is difficult to understand why they continue to struggle to be recognised as a professional body. Thus, there is unfinished business that needs high-level advocacy and support based on need. Areas of unfinished business needing support are below.
An Autonomous Midwifery Authority

There is overwhelming support for a Midwifery Council within the midwifery profession. However, creating a separate regulatory authority governed by midwives is not on the MOH’s agenda, but the MOH has a Health Practitioner Act before Parliament, which, if ratified might allow a profession like midwifery the opportunity to establish an autonomous body such as a Midwifery Council under a statutory board. If such a board were established then all professions in the country would come under this board.

Education Needs Strengthening

There is a general acknowledgement that the current education system for midwives in Indonesia does not support the production of good quality graduates and, as a result, does not always provide quality services. There have been moves to address this through the new MTKI structure; however, this has not been enough. The perception is that midwifery is a vocation rather than a profession. This has implications for the level of education they will receive and their status as an autonomous profession within Indonesia and the global community (Table 7).

<table>
<thead>
<tr>
<th>Table 7: International Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are concerns about the acceptability of Indonesian nurses and midwives in the international labour market. The liberalization of goods and services trade in the ASEAN region for the health sector—one of the agreed priority sectors—has materialized with the signing of the Mutual Recognition Arrangement (MRA) on Medical Practitioners in August 2008. The MRA facilitates the free movement of skilled medical practitioners within the ASEAN region. The MRA also regulates their quality through adoption of best practices on standards and qualification by member countries. This means that health professional education and certification in Indonesia needs to meet the agreed standards to be able to compete in the regional health market. In addition, regulations to oversee the practice of foreign medical practitioners need to be strengthened. Collectively, these changes in demand put additional pressure on current health workers, emphasizing the need to look at the health system comprehensively, including private sector provision in future planning.</td>
</tr>
</tbody>
</table>

Development of Midwifery Leaders

Midwifery is an important and well-regarded profession within Indonesia; it was observed that most of the responsibility for leading the profession was left to senior midwives. It will be important to look toward the next generation of midwives and develop their capacity as leaders and champion of midwifery in Indonesia.
6. STRENGTHENING THE CASE FOR MIDWIFERY IN INDONESIA

6.1 Moving Forward

A strong cadre of educated, licensed and supported midwives, trained to international standards, working in an enabling regulatory and practice environment across a continuum of Reproductive and Maternal and Newborn Health (RHMNH) care, could contribute significantly to a reduction of maternal and newborn mortality rates throughout Indonesia.

SoWMMy 2014 has developed Midwifery 2030 as a pathway for policy and planning. Midwifery 2030 focuses on increasing the availability, accessibility, acceptability and quality of health services and health providers to achieve the three components of universal health coverage (UHC): reaching a greater proportion of women of reproductive age (increasing coverage); extending the basic and essential health package (increasing services); while protecting against financial hardship (increasing financial protection).

Central to this is an enabling policy environment that supports effective midwifery education, regulation and association development and an enabling practice environment that provides access to effective consultation, with referral to the next level of SRMNH services. Effective management of the workforce, including professional development and career pathways, should underpin this. Implementing the recommendations of Midwifery 2030 can lead to significant returns on investment; however, the political and regulatory environment needs to be supportive.

6.2 Key Challenges and Limitations

There are key challenges and limitations that need consideration before the midwifery profession can move forward:

Challenges

- Creating a separate regulatory authority for midwifery is not on the MOH’s agenda, but the MOH has a Health Practitioner Act before Parliament, which, if ratified might allow a profession like midwifery the opportunity to establish an autonomous body such as a Midwifery Council under a statutory board. If such a board were established, then all professions in the country would come under this board.

- There is a general acknowledgement that the current education system for midwives in Indonesia does not support the production of good quality graduates and, as a result, does not always provide quality services. There have been moves to address this through the new MTKI structure; however, this has not been enough. The perception is that midwifery is a vocation rather than a profession. This has implications for the level of education they will receive and their status as an autonomous profession within Indonesia and the global community.

- Midwifery is an important and well-regarded profession within Indonesia; it was observed that most of the responsibility for leading the profession was left to senior midwives. It will be important to
look toward the next generation of midwives and develop their capacity as leaders and champion of midwifery in Indonesia.

Limitations

- The current political landscape is not ideal for the development of midwifery regulation. Health professional regulation in Indonesia is the early stages of development. The MoH has a Health Practitioners Act before parliament; until ratified, it is difficult to determine the level of autonomy each health profession will have.

- Added to this there is a new Government and it not clear what impact this will have on ministries or the regulation of health professions. Thus, the political landscape needs to settle and parliamentary decisions need to be made about different Acts related to individual health professions before a clear decision can be made, regarding how UNFPA can best support midwifery in Indonesia develop as an autonomous Profession.

6.3 Recommendations

Midwifery 2030 provides Indonesia with a pathway for policy and planning. For Indonesia, the essential building blocks for putting the Midwifery 2030 vision into practice will include political will, effective leadership and midwifery “champions” who will drive the agenda, supported by the current regional and international momentum for improvements to SRMNH. Keeping this in mind, the following recommendations are made:

UNFPA

- Allow the political landscape to settle; wait until the future structure of MTKI, as the regulatory authority of health professions in Indonesia, is fully determined. Then, based on the level of autonomy that midwifery will enjoy, decide how to move forward.

- Engage in high-level advocacy to support the development of a regulatory body governed by midwives. This will ensure midwives in Indonesia are in a good position to function as an autonomous body. The current MTKI structure does not allow this.

- Support the Indonesian Midwives Association advocate for strengthened midwifery services and practice. In particular, reinforce best practices and advocate for the midwife to be the primary provider of “women centred care” and for the strengthening of pre-service qualifications of midwives to be at a minimum of degree level.

- Invest in technical assistance to support education, regulation and association based on need, and at the request of the Indonesian Midwives Association, Ministry of Health and/or Ministry of Higher Education. Give priority to strengthening pre-service education for midwives and developing the capacity of the midwives to lead and manage the profession as an autonomous midwifery body.

- If the Indonesian Parliament ratifies the Midwifery Council Act, or in preparation for the establishment of a Midwifery Council, assist the Indonesian Midwives Association to develop a regulatory framework that will guide the functioning of a future Midwifery Council in Indonesia.

- Consider supporting a Master’s scholarship program that will foster the next generation of midwifery leaders; only fund scholarships that strengthen midwifery in Indonesia e.g. midwifery education, research of practice related to the Indonesia context.

- Reward champions of midwives with special awards and incentives, e.g. certificates of recognition for midwifery work, sponsorship to a midwifery conference and more.
• Consider funding a model of standardised midwifery education and regulated service delivery in one geographical area of Indonesia. Undertake a study in collaboration with the MCH Directorate within the MOH. Review the gap between midwifery competencies and outcomes, pre-service and in-service training and effectiveness of the different mechanisms of midwifery regulation. Raise issues with the IBI and engage them in problem solving. Once the model is tested, make recommendations for scale-up across the country.

• Consider developing partnerships that will transform policy and planning into reality. Working “upstream” UNFPA is in a good position to do this. To ensure policy is translated into reality, form strategic partnerships to support implementation “on the ground”, e.g. the SMS messaging supported by the UNICEF Info Bidan project could be used as an advocacy tool for messages and gathering information or used to strengthen referral.

Indonesian Midwives Association

• If technical support is required with matters relating to regulation, education and association, request assistance from UNFPA. For example, a regulatory framework to support a functional Midwifery Council, a workshop to explore the difference between an association and autonomous body, help with standardising a curriculum at a higher level and development of critical thinking skills in midwives.

• Continue to advocate for, and strengthen midwifery services and practice. In particular, reinforce best practices and advocate for the midwife to be the primary provider of “women centred care” and for the strengthening of pre-service education.

• Identify and nominate suitable candidates for a midwifery scholarship program at Masters Level or above. This would be for midwives who will be the future leaders of midwives in Indonesia; only fund scholarships that strengthen midwifery education and practice.

• Identify and gain the support of champions to ensure affirmative action to promote midwifery across society, and in the health sector, through a variety of media.

• Reward champions of midwives with special awards and incentives, e.g. certificates of recognition for supporting midwives, sponsorship to a midwifery conference and more.

Ministry of Health

• Based on need, request technical assistance from UNFPA to support the development of areas that underpin midwifery regulation in Indonesia. Areas might include task-shifting, scope of midwifery practice, standardisation of midwifery curricular, service delivery guidelines and protocols, synchronising midwifery related documentation between MoH and BKKBN and more.

• As health professional regulation in Indonesia, continues to evolve, make space for a wider input from the professions. The current membership of MTKI does not allow for a profession with more than 220,000 members to have a voice or participate in its own development at a policy level.

• Following the ratification of the Health Practitioners Act by the Indonesian Parliament, consider supporting each health profession to gain a level of autonomy that will allow them to be accountable for their own practice.

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Take from AusAID review Report on Performance on Donors: The performance of UN agencies in health in Indonesia is mixed. WHO, UNICEF, UNAIDS, UNFPA and FAO all play an important role in policy advocacy with Government, yet where we have supported their operational activities performance has been less than optimal. In particular, our work through UNICEF on maternal and child health did not deliver on outcomes expected. This may be related to their relative inability to work closely with GoI systems and difficulty in retaining staff particularly in remote areas.
• If the midwifery profession gains some degree of autonomy, request from UNFPA technical assistance to strengthen a midwifery regulatory framework. This could include help with defining the scope of midwifery practice, how to discipline members of the profession, the management of registrations and more.

• The Maternal Health Directorate within the MoH could consider requesting support from UNFPA to undertake a study to review the gap between midwifery competencies and outcomes, pre-service and in-service training and effectiveness of the different mechanisms of midwifery regulation. Raise issues with the IBI and engage them in problem solving. Once the model is tested, make recommendations for scale-up across the country.

**Ministry of Education and Culture**

• Based on need, request technical assistance from UNFPA for the development of education programs for midwives that support education reforms and the Indonesian Qualifications Framework. Areas might include standardisation of current diploma to bachelor’s level, reviewing entry points for midwifery against the Indonesian Qualifications Framework and more.

• Support the strengthening of midwifery pre-service education by advocating for, and supporting midwifery degree programs, that raise the entry level into midwifery to a degree level and graduates who are able to function at a higher level of critical thinking.

• Develop and strengthen the career pathway for midwives, so there will be multiple entry points that will allow midwives flexibility in learning and entry into higher-level education programs, through recognition of prior learning and experience; consider collaborating with the Indonesian Midwives Association for this.
7. ANNEX
CHALLENGES AND ISSUES FOR MIDWIVES IN INDONESIA

This Annex summarises challenges midwives in Indonesia face, based on a review of the literature. The review is by no means comprehensive. It is a work in progress, which provides an understanding of issues from a nursing perspective and will be added onto and refined over the course of the consultancy.

Quantity and Distribution

While physicians and nurses have a key role to play in maternal health, the most prominent health service provider is the midwife. There are currently approximately 220,000 midwives in Indonesia. Most of these midwives were trained then employed under the village midwife program. The program no longer receives budgetary support from the central government in terms of training large numbers of midwives and the payment of contracts has been shifting between the centre and districts. Nevertheless, midwives remain the key provider in almost all strategies.

The intent of the BDD program was to provide a midwife in every village but this has not yet been achieved. In 2005, data from the MoH indicated that only 40 percent of the 68,816 villages in Indonesia had midwives in place and in some places, such as North Sumatra, less than 10 percent of the 5,360 villages had a midwife. In 2006, the Indonesia health profile showed a national ratio of midwives at 49 per 100,000 population with a range from 8.9 per 100,000 in Banten to 74 per 100,000 in Papua. However, the high ratio of midwives in Papua is largely due to the remoteness of areas and this analysis should keep this in mind.

In 2006, 44,616 midwives were in private practice nationally, a 158 percent change from 1996 for all midwives. The majority of this change was found in urban areas, a 1,791 percent change nationally and a 2,347 percent change in outer islands alone. The World Bank report found that the distribution of midwives in the public sector had decreased. Nationally, the average number of midwives at a health center was 3.7 in 2007, a decrease from 5.8 in 1997. These figures should be interpreted with caution; however, as the private-public workforce distinction is not as clear-cut in Indonesia as in other countries. The national policy allows for dual practice and many midwives in the public sector open private practices after hours. Very few midwives obtain their income exclusively from either their private or public practice.

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81 Feedback from the World Bank – this is the number registered on the newly established database
84 Outer islands means all islands except Java, Bali and Sumatera
86 Ibid
Training and Skills

At the onset of the BDD program, nursing school graduates (equivalent to a high school degree) received a one-year crash program, referred to as a Diploma-1 or D1. The push for rapid deployment of midwives compromised candidate selection and the quality of training. One study found that the midwifery educators’ clinical skills were “limited and out of date”, training equipment was old and in need of repair and there was a shortage of textbooks. In addition, the study found that the village midwife was only required to perform 15 deliveries under supervision, and some of those were on models. This compared to the 50 deliveries older midwives had performed during their training. Midwife training also did not include education in client interactions, which is a significant contributor to client satisfaction and perception of quality.

In 1997, the government and donors began a series of initiatives to increase skills, with the introduction by the government of in-service competency-based training on skills such as normal birth and basic emergency obstetric care. Donors supported training in lifesaving skills (Mother Care project), training staff at midwifery schools and developing supervision skills. The GoI changed the basic midwifery training to be a three-year post-high school program. This became known as the “D3” diploma and is now the basic level of education required for midwifery. This change was espoused in a national congress of the Indonesian Midwives’ Association (IBI) in 1998.

IBI does not have aggregate data on the proportion of its overall membership trained to D1 level versus D3 level although, presumably, the numbers of D3 trained midwives are increasing given that this is now the normative standard.

Evaluation and program reviews have repeatedly found that midwives practicing in Indonesia lack basic competency in core skills. A 2002 paper found that “over 90% of the nurses and midwives sampled had had no post basic or continuing professional development training in the past three years, which in the global era of rapid health care development means that much midwifery care in Indonesia may not be conducted according to evidence-based best practices”.

A study of 338 midwives in North Sulawesi, North Sumatra and East Kalimantan found that the entire sample population had training needs in all of the 40 core tasks. As the paper states: “the respondents perceived themselves to have skill deficits in all the areas covered.” Compounding the difficulties in training is the fact that “there is no statutory regulatory authority for nurses and midwives, and consequently there are no regulatory standards for education and clinical competence (although work is in progress to develop these authorities) … the vast majority of nurses and midwives (60%) have inadequate training and preparation for the role, which creates the potential for substandard care delivery.”

A recent government and donor initiative has been the development of a training program for normal delivery, Asuhan Persalinan Normal (APN). This is a ten day training course that has four days of classroom instruction and six days of practicum. Trainees do a minimum of three supervised deliveries. The training includes the active management of the third stage of labour and newborn care. It is based on WHO clinical materials and international standards. Trainees are limited to 12 to 15 in a class, and there is

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91 Core tasks include patient education, assessment of clinical data, setting up equipment for procedures, serving liaison with other medical professions and recognizing and managing risks in clinical care. The core tasks found in all the expected competencies of midwives such as antenatal care, obstetrical care and family planning.
clinical accreditation that takes place two to six weeks after training. The National Clinical Training Network records show that 12,479 midwives have received APN training through their network, which is 14 percent of the total number of midwives in Indonesia. Other organizations have also trained midwives in APN, using different trainers. Accurate data is not available as IBI doesn't have records, even though the MoH and IBI have suggested that APN training be mandatory for all midwives.

**A National Clinical Training Network, which is doing the training nationwide, has reported significant improvement in delivery skills.** One local assessment of results in Cianjur and Tangerang (West Java) found that 81 percent of the 120 midwives trained were able to perform active management of the third stage of labour, compared to 34 percent of 109 midwives who had not received the training or a follow-up supervisory visit. In three districts in NTT, 78.5 percent of the midwives had received in-service training in APN, and 18.6 percent of those same midwives had received training in how to conduct a maternal and perinatal audit. Only 11 percent of the midwives had received in-service training in basic emergency obstetric care and 7 percent had training in lifesaving skills for maternal health.

**There continues to be concerns over the functions and skills of midwives, especially in the performance of non-midwifery tasks.** Midwives were initially intended to focus on midwifery services but they now also undertake primary preventative care, curative care for common childhood diseases, vaccinations and family planning along with their other tasks. One paper found: “most midwives perform many tasks (including providing nutrition advice and immunizations) and attend few births, so their capacity to manage complications and recognize the need for referral may be compromised.”

**The Ministry of National Education (MoNE) in 2008 reported that there were 595 schools offering midwifery training, however, there are questions regarding their performance.** There is no national standard for the training curricula and graduates do not take a competency test prior to licensing. The quality and skills level of many of the new graduates is questionable. There are pilot programs underway in West Java where graduates can register with the provincial health authority but cannot practice at the district level until they have passed a competency exam administered by IBI. In a 2008 review of midwives in Aceh, East and Central Java, 129 midwives indicated that their pre-service training at midwifery schools was not in compliance with an established and standardized curriculum. Midwifery academy staff in Yogyakarta stated that there are currently too few competent instructors available for pre-service education and not enough practice sites for students in urban areas.

**Retention**

**Midwives trained under the BDD program are moving out of their village posts.** They are becoming civil servants and working in the community health centre, entering private practice, entering academia and teaching midwifery or leaving clinical services for administrative posts. Whatever the reason, the intended target of one midwife in every village has fallen short.

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While the utilization of village midwife services remains an essential element of most proposed maternal health interventions, formal central-level support was supposed to end in 2007. Government policy now states that midwives should either make the transition to local district staff or they should be established enough that they are able to stay in their villages but earn an income from private practice. However, the concept of “local district staff” is very nuanced. Public sector health staff were “transferred” to the districts under decentralization, however, the reality is that the centre retained control over salaries, conditions and hiring and firing98. In addition, the central government has been following up on an earlier promise to convert those on contract (including both PTT and local contracts) to permanent civil service status by the end of 2009.

Heywood’s (2009) study99 in 15 districts in Java found that the overwhelming majority of midwives were civil service (PNS) or contract (PTT) workers. A total of 3,388 midwives were civil servants (PNS), 1,662 were contract (PTT), 209 were local contract, 164 were daily contract (a category of worker not seen in any other province but West Java) and 593 were privately employed. In 2004, there were 5,707 contract midwives in remote areas; by 2006 there were only 437 contract midwives in remote areas (MoH 2007). In 2004, the total number of contracted bidans was 12,345 and by 2006, this had fallen to 2,505. There were 52,168 midwives employed at puskesmas in 2006. If we extrapolate from the trends found in Java, then approximately 56 percent of those midwives would be PNS and 34 percent would be contract midwives.

The MoH has warned against interpreting a reduced number of midwives in the BDD program as an overall reduction in the availability of midwives (personal communication, Dr. Lukman, April 2009). It is their opinion that services remain available as long as the professional is on-site, even if they are no longer part of the formal village midwife program. Retention has been viewed as a function of integration into the community and the ability of a midwife to earn sufficient income. While integration into the community was problematic at the onset of the program, research100 indicated that this was not an overall problem and acceptance rates for the midwives were good a decade into the program. Retention is also a function of job satisfaction, career opportunities, salary benefits and continued professional opportunities. In the 2003 Nursing and Midwifery Workforce Management Survey conducted by WHO101, Indonesia did not score well on most of these parameters, suggesting there is significant improvement possible in the system for retaining midwives.

One study found that more established midwives were reluctant to move from their villages because of family reasons and disturbance to their private practices if they moved more than one hour away. The younger midwives, who did not have as many community ties, were more inclined to consider moving102. UNICEF also found103 that a midwife’s marital status had an impact on retention; those midwives who either were married or got married during their tenure were more likely to stay in the village where they were placed.

A further study104 found a paucity of midwives in the more remote areas and a high turnover rate, in part caused by the demanding and isolated professional environment.

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99 Ibid
Retention rates are also a factor of adequate mentoring and supervision and a clear understanding of role expectations. In Indonesia, “ongoing lack of supervision coupled with diverse duties and unclear job descriptions meant that many midwives worked in isolation, with few opportunities for job support and learning, thereby affecting retention as well”\(^{105}\).

Salaries

Parker and Roestam (2003) reported\(^{106}\) government estimates that 60 to 75 percent of the village midwives placed since 1994 were still in their villages, however, what role salary plays in their retention is unclear. Initially, village midwives received a three-year commitment from the government to cover their salary (PTT). This contract could be renewed twice at most, at which point they could either become a civil servant or continue in private practice. At the end of their PTT contract some village midwives moved from the village to the health centre to become a civil servant at the facility, thereby leaving some villages without midwives. A 2007 initiative supported the concept of Bidan Siaga, paying incentives from the central budget for PTT midwives to practice in remote locations. Under MoH Regulation No. 508/2007, midwives could receive IDR2.5 million per month for service in remote locations\(^{107}\).

To enter a private practice, it was expected that a midwife would need to take a three-year D3 midwifery course after completing their PTT contract. This additional education requirement was in line with IBI’s policy\(^{108}\) recommendation of 1998 that only D3 trained midwives be allowed to have a private practice. A 1998 study found, however, that PTT midwives would have to pay US$1,391 for tuition and living costs if they wanted to complete the course. Ironically, the tuition portion of this training exceeded what they could earn at that time as a village midwife\(^{109}\).

Research on net incomes for midwives has found income difficult to quantify accurately. As is common practice in Indonesia, public sector midwives who earn a government salary also supplement their income through private practices. Even during their contract years, midwives were permitted to have a private practice; in effect doubling their sources of income.

Various studies\(^{110;111;112}\) have reported widely varying incomes between districts and between urban and rural locations within districts. Private income is affected by location as those closest to urban centers face competition for services while in more rural areas, less competition allows midwives to capture a greater market share. In the most remote areas, ability to pay tends to decline because of reduced income among the population. However, overall, even in rural areas, midwives are able to capture enough market share to earn an adequate income.

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108 The 1998 IBI policy made a decision that private practice midwives would only be granted a license to practice if they finished the D3 training program. Until now, however, the policy has never been implemented and there are D1 trained midwives in private practice
The IMMPACT study\textsuperscript{113} found that basic salary differed depending on contract status. A civil servant (PNS) employee earned the most with an annualized salary of US$1,768. Contractors for three years (PTT) who had central-level contracts earned US$1,179 compared to contractors who had local contracts, who earned just US$1,072. Of these earnings, base salary contributed on average 79 percent to the total; the additional money was earned through bonuses and re-imbursement for services provided to the poor under the Askeskin program. Government salaries contributed 35 percent of total income, while private clinical services contributed 56 percent and private nonclinical services the balance of 9 percent. Total annual incomes, including public sector salary, private practice income and private nonclinical income varied significantly across the sample population. The mean private sector income was US$2,508 per year but 10 percent of the sample had an annual income of over US$11,000.

Levels of income appear to be closely related to number of years since qualification; a midwife with 15 years of experience earns more than twice the income of a midwife with less than five years of experience\textsuperscript{114}. IBI indicates that there is a salary differential between public sector midwives who have only received a D1 degree and those who have had lengthier training and received the D3 (personal communication, Harni, May 11, 2009,) However in the private sector, midwives charged similar tariffs and received payment, irrespective of their educational background and training.

Quality of Services

The basic elements required to ensure quality of care—such as a national examination to determine competency—have recently been implemented in Indonesia. There are pilot projects in place to improve quality and IBI is providing significant support to the Bidan Delima program. This quality improvement and accreditation program establishes facility standards and skills competencies necessary before a midwife can be certified as a member of the program. Approximately 10 percent of midwives in Indonesia have already earned this certification and the program is active in 15 provinces\textsuperscript{115}. The Bidan Delima program is considered valuable by midwives because it is an external validation of improved quality although accredited midwives do not charge more for their services.

In a study done in 1994 in Kalimantan, poor quality of care was a contributory factor in 60 percent of 130 maternal deaths\textsuperscript{116}. This study helped local decision makers to understand that village midwives alone were not responsible for maternal deaths and lead to a change in the working relationships of health providers at different levels of the system. A 2004 study done in Lombok found that among the 100 respondents, there was a positive correlation between their perception of quality of care and their willingness to use the free medical services. The same study found that even if the care was free, those respondents in the higher economic groups would not use the services if they perceived quality to be lacking. The quality issues they identified included lack of empathy on the part of health centre staff, failure to do a thorough examination and an inadequate supply of drugs\textsuperscript{117}. More recently, WHO has undertaken a study\textsuperscript{118} on quality of maternal care in 20 randomly selected districts. The study found that quality of care still needs attention.

\textsuperscript{113} IMMPACT. 2007. Laporan Hasil Penelitian IMMPACT Indonesia. IMMPACT Indonesia, Pusat Penelitian Keluarga Sejahtera (PUSKA), Faculty of Public Health, University of Indonesia, Jakarta.


\textsuperscript{115} Health Services Program. 2008. The 2008 Annual Report for the Health Services Program. Arlington,Virginia: USAID and John Snow International


\textsuperscript{117} Saimi. 2006. Faktor-Faktor yang mempengaruhi pemanfaatan pelayanan persalinan gratis di puskesmas Kabupaten Lombok Tengah Provinsi Nusa Tenggara Barat. Medical Faculty, University of Gadjah Mada, Yogyakarta.

\textsuperscript{118} WHO for the MoH, the 2012 Maternal Health Services Quality Assessment
A confidential inquiry done by IMMPACT found that while village midwives’ emergency diagnostic skills were accurate; they were less capable in the clinical management of complications. In a paper looking at differences in the quality of care provided by midwives in the private and public sectors in Pekalongan, researchers found that clients were equally satisfied except on one dimension, that private sector midwives provided greater empathy and assurance. The rationale for use, however, depended less on quality than access and it was easier to obtain a consultation with the private midwives.

Conventional wisdom in Indonesia states that the quality of care in the private sector is significantly better than the public sector but studies are beginning to challenge this. The World Bank’s Health Workforce study found there is no significant difference between private and public providers on the vignette score related to prenatal care and child curative care. It states that “private sector providers may simply have better knowledge and training than those in public health clinics. This assumes that quality of private providers is higher, however, for which there is little evidence from comparison of diagnostic vignette scores across public and private practices.”

Motivation for Service

The success of the midwife program rests in large part on being able to capitalize on the social motivation of Indonesian women. In one study in Banten, the reasons for being a midwife fell into four categories: ability to have a career and earn an income, convenience for family reasons (proximity to husband’s job or children’s school), an altruistic desire to do good for the community and parental demands. Interestingly, while career, family and community motivations were approximately equal when deciding to become a midwife, this shifts radically when remaining a midwife. Seventy-one percent of the midwives interviewed said they remained a midwife for career and income reasons, while community altruism was given as a reason by only 11 percent of the midwives.

In a 2009 focus group discussion with 10 midwives in Yogyakarta, researchers found that salary and income were not the primary determinants for providing service. Midwives acknowledged that they could make significantly more money in the private sector but retained their positions in the public sector because of job security. They continued in the private sector because they thought their practices were a contribution to overall community well-being irrespective of the financial gain. The midwives emphasized that a primary motivation was the service they rendered the community. They were willing to put up with difficult hours and delayed payment because they perceived a critical role for themselves in the health of the community. In addition, they said that being a midwife provided them with enhanced social status within the community.

121 As part of the child curative care vignette, researchers asked an indicative question whether the health worker asks about the nature of the stool when a child has a diarrhoea, Only 42 percent of Puskesmas health workers and 43% private physicians responded they would ask this question
Other factors cited for staying in the profession included excellent working relations and a desire for job security by becoming a civil servant. Researchers have also examined extrinsic factors, which compelled a midwife to consider leaving the profession. Some reasons given for leaving include:

- Lack of autonomy
- Only being called by the community to do difficult births
- Poor supervision and support from supervisors and managers
- A feeling that there was a difference between the compensation and the very large amount of responsibility they had in delivering expanded care programs

STRENGTHENING MIDWIFERY IN INDONESIA AS A REGULATED PROFESSION

May 2015
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EXECUTIVE SUMMARY

Background
The Indonesian Midwives Association (IBI) has had a draft Law to establish an Indonesian Midwifery Council before the Indonesian Parliament since 2005. The Council if approved will function as an autonomous body, under the governance of midwives. As, yet this has not been ratified by Parliament. The reason for this is now known.

More recently, the Indonesian Parliament passed a Law in October 2014 supporting a new regulatory authority known as the Indonesian Council for Health Workers (KTKI-Konsil Tenaga Kesehatan Indonesia). KTKI will function as an umbrella organization, under which 13 health professions can establish their own Council. One of these professions is Midwifery.

Further details on the management of KTKI will be provided by a Presidential or Ministerial Decree. Until then, it will be difficult for each health profession to establish a Council or determine its level of autonomy.

It is clear that a Midwifery Council can be established under Law relating to the regulation of Health Workers. Each profession will have two years (until October 2016) to establish a Council. To meet the two year time-line and/or the requirements of an autonomous Midwifery Council it is imperative that midwives begin planning for the establishment of their Council.

Moving Forward
Initial steps as Indonesian Midwives develop an autonomous profession are:
1. Formation of a midwifery taskforce to inform planning. It is envisaged the taskforce will inform the establishment of a collegium which will help guide the Midwifery Council described in Law 36/14.
2. Undertaking a “gap analysis” using an ICM toolkit and development of a strategic action plan which identifies steps and actions required to move to a fully functioning regulatory system.

The output from the gap analysis should be a step-by-step strategic action plan to inform planning for the establishment of Midwifery Council and provide a process which will:
• Allow stakeholders to engage more effectively in the planning process
• Allow IBI to request support if needed for specific areas of development

Without a plan, funding of activities to support midwifery regulation may not be possible and, it may be more efficient for UNFPA to work directly with the MoH to address coverage and quality of Sexual, Reproductive and Maternal and Newborn and Child Health (SRMNCH) service issues.

Once the action plan is available, components of the midwifery regulation framework will be able to be strengthened in a strategic way; policy and planning dialogue, development and implementation will begin, through IBI or the MoH, to address the gaps. Key areas for support should be the development of

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125 Article 36 of the Law on the Council for Health Workers
126 Article 11 of the Law on the Council for Health Workers
127 Articles 36 and 42 of the Law on Council for Health Workers
a scope of practice for Indonesian midwives and the review and alignment of standards with the scope of practice. New standards may be needed for practice and/or education.

The Indonesian Midwifery Council will be an independent regulatory body. However, to implement the functions and duties of the Council, robust linkages with other partners should be developed. These partners might include other health professions and government, particularly the MoH. Areas for partnership and networking include: the midwifery scope of practice, standards of midwifery practice, competency of midwives, accreditation and certification of courses, pre-service training and education standards, workforce planning etc.

Potentially, linkages may enable a policy and planning environment, implementing the Midwifery 2030 agenda, resulting in opportunities for research and best practice.

The focal point for policy, planning and research activities will depend on who is responsible for the area of interest. It could be IBI or the MoH. Areas targeted should be those that will have the biggest impact on coverage and quality SRMNCH services.

**Key Recommendations**

**Indonesian Midwifery Association (IBI)**

- IBI should continue to advocate for the ratification of the Law currently before the Indonesian Parliament for the establishment of their own Midwifery Council.
- That a taskforce be established under the leadership of the President of IBI. Consider structuring the taskforce to include high level executive leadership to oversee working groups which support the functions of a regulatory authority. (See below).

**Taskforce showing four working groups under executive leadership**

- That the ICM toolkit, which helps Midwifery Associations assess and plan the actions required to move to a fully functioning regulatory system, be used by IBI to undertake a gap analysis and develop a plan which provides a clear pathway to the development of a Midwifery Council.

The plan should include a time-line and roles and responsibilities of all stakeholders (IBI, MoH or whoever) and **consensus from key stakeholders** to support the implementation of the plan

- That a scope of practice for a midwife in Indonesia is developed and then standards and competencies are reviewed, refined or developed to align with this. This should take into consideration different levels of education and models of midwifery practice.
UNFPA

- Provide advocacy support for the Midwifery Law currently before the Indonesian Parliament. Work with IBI to engage international Midwifery Associations and Councils to write letters to the President of Indonesia and high level parliamentarians for the ratification of the law.

- Support IBI to undertake a gap analysis and plan for a Midwifery Council. Ensure there is consensus among all stakeholders. Support outputs which show progress toward the establishment of a midwifery regulatory authority. Give priority to the development/revision of standards and competencies which align with the scope of practice.

- There are a number of opportunities which could be pursued by UNFPA through the MoH or IBI. Areas might include:
  - Policy and planning dialogue meetings between IBI and the MoH.
  - Map all levels of SRMNCH services (which include midwifery) from certificate to the highest level of SRMNCH based on local needs.
  - Practice standards need to align with the scope of practice, then education and health service standards. Work with government to ensure this is the case.
  - Enter into policy dialogue on how life saving procedures for obstetric emergencies can be best delivered in areas where there is no midwifery coverage.
  - Review registration data to determine where gaps in service delivery exist, and reasons in terms of demographic characteristics of midwives.

- Provide support to the MoH for requests that relate to the quality and coverage of midwifery services as per the recommendations to the MoH. Ensure IBI is involved in the process.

- The focal point for policy, planning and research activities will depend on who is responsible for the area of interest. It could be IBI or the MoH. The starting point should be to work with the education and training department in the MoH to map SRMNCH services and levels of knowledge and skills to support service delivery.

Ministry of Health

- It is unclear how the health professions should move forward, according to the Law 36/2014. As there is only two years to establish Councils it would be helpful if the decree could be issued and the process for establishment of Councils be shared with the professions.

- The organisational structure of the proposed health professions Councils, under Law 36/2014, is a concern. Indonesia is a geographically diverse country with a big population. Consider establishing sub-branches in each of the 34 provinces.

- Request support from UNFPA and other development partners to explore options when experiencing bottlenecks with current midwifery initiatives, relating to the maldistribution and the quality of services they provide.

- Enter into policy dialogue with IBI for agreement on regulation of midwives. Include scope of practice, standards professional development, career pathways and more. Outputs of such dialogue should be a position paper or written agreements.
1. INTRODUCTION

1.1 Background

The State of the World’s Midwifery Report 2014 supports Midwifery 2030, an approach to increasing the availability, accessibility, acceptability and quality of health services and health providers to achieve universal health coverage. Central to Midwifery 2030 is an enabling policy environment that supports effective midwifery education, regulation and association development. This is an enabling practice environment underpinned by health systems strengthening efforts such as effective management of the workforce, professional development and career pathways.

Since the 1980’s, the Government of Indonesia (GoI) has strengthened the health system, to improve maternal and newborn survival. Efforts, such as the deployment of midwives through the Bidan Di Desa (BDD) program, have expanded the reach of health services. Despite such efforts and almost universal coverage by Skilled Birth Attendants (over 80%), Indonesia is off track to achieve MDG 5 targets. Maternal and neonatal mortality remain high and the quality and coverage of SRMNCH services being provided to women and their newborns needs improvement.

A strong cadre of educated, licensed and supported midwives, trained to international standards, working in an enabling regulatory and practice environment, across a continuum of Reproductive and Maternal and Newborn Health (SRMNCH) care, could contribute significantly to a reduction of maternal and newborn mortality throughout Indonesia and improve the quality of care they provide.

1.2 Regulatory reform

To improve the quality of health care and protect the public from harm, the need to establish a regulatory authority to enforce uniform standards of education and care is a pressing issue for the government of Indonesia. Since 2011, with World Bank support, the MoH and Higher Education have embarked on a process of regulatory reform, involving a regulatory body to standardise and unify education, health across the country, against international standards.

To help implement the reforms a Joint Health Workforce Council (Permenkes 46/2013 on MTKI – Majelis Tenaga Kesehatan Indonesia) was established in 2011 under a Ministerial Decree. Under the decree MTKI has administrative control over most of the health professions through registration, and associated processes.

To provide health professions with more autonomy, the Indonesian Parliament passed a Law128 in October 2014, which supports a new regulatory authority under which all Indonesian health workers will be regulated. Known as the Indonesian Council for Health Workers (KTKI-Konsil Tenaga Kesehatan Indonesia) KTKI will function as an umbrella organisation under which 13 health professions129 will be able to establish their own Council.

128 Article 36 of the Law on the Council for Health Workers
129 Article 11 of the Law on the Council for Health Workers
There will be a maximum of nine members for each Council. These will comprise representatives from Government, Professional Organisations, Collegiums, Education Institutions, the association of Healthcare Facilities, and Community Leaders. An indicative representation of the structure is in figure 1.

**Figure 1: Indicative structure of KTKI**

1. **LAW OF REPUBLIC OF INDONESIA NUMBER 36 OF 2014 ON HEALTH PROFESSIONS**
   - Umbrella Law covering multiple disciplines with delegated authority to 13 health profession Councils that support regulation, practice and quality of services provided by a profession

2. **13 Separate Health Councils (One of the Councils is Midwifery)**

According to Law 36/2014, responsibilities of government will relate to planning, procurement and utilisation of health workers, while each health profession will have responsibilities relating to the practice of the profession and improving the quality of health services\(^{130}\). The funding for the activities of the Council at a national level will be charged to the national budget.

The exact structure and how KTKI will function will need clarification; in particular the linkages between each Health Worker Council and MTKI. A major limitation of the structure is its focus at the national level. Indonesia is a geographically diverse country with a big population. For a profession like midwifery with over 220,000 midwives, spread over 34 provinces, it will be a challenge to regulate the profession from a Council at the national level, with no sub-branches.

Further provisions on the organisational structure, appointment, dismissal, and membership of a Council will be determined through a Presidential or Ministerial Decree\(^ {131}\). Until the Decree is issued it will be difficult for each health profession to establish a Council or determine the level of autonomy each profession will enjoy.

### 1.3 Midwifery regulation

Society grants the midwifery profession authority and autonomy to regulate itself. In return, society expects the midwifery profession to act responsibly, ensure high standards of midwifery care and maintain trust of the public. (ICM, 2011)

The main professional body for midwives in Indonesia is the Indonesian Midwives’ Association (IBI). As a professional association, IBI has no regulatory powers and lacks influence in policy and planning. Its greatest strength is the 220,000 (and counting) midwives it represents and the high status afforded midwives by the public. Strengthening the regulatory power of IBI and working through the Associations network of branches has the potential to impact significantly on the coverage and quality of SRMNC services.

Since 2005, the Indonesian Midwives Association (IBI) has had a draft Law before the Indonesian Parliament, for the establishment of an Indonesian Midwifery Council, which will function as an autonomous body.

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\(^{130}\) Article 37 of the Law on the Council for Health Workers  
\(^{131}\) Articles 36 and 42 of the Law on Council for Health Workers
under the governance of midwives. At the request of the Parliament, the Law underwent revision in 2013. At the same time there was a Nursing Law before Parliament, and there were high expectations that both Laws would pass through Parliament simultaneously at the end of 2014. The Law on Nursing was passed however the midwifery Law was not approved. The reason for this is not clear.

According to Article 37 of Law 36/2014, each Council will have functions of regulation, and development and performance of Health Workers they represent in terms of their practice and the quality of services they provide. In performing these functions, the Midwifery Council will perform the following duties.

1. Maintain the registration of midwives
2. Provide guidance to midwives on performance of midwifery practice
3. Set the standards for higher education in midwifery
4. Set the standards for practice and standards for competency
5. Enforce discipline in midwifery practice

Under Law 36/2014, each profession will be given two years (October 2016) to establish a Council. The starting point for this will be for IBI to make a commitment to plan for the Council, strategically and in an orderly fashion.
Strengthening Midwifery in Indonesia as a Regulated Profession
2. PATHWAY TO MIDWIFERY REGULATION

2.1 Formation of a midwifery taskforce

A regulatory authority is both the watch-dog (policing) and guard-dog (protecting) of the profession thus ensuring the safety of the public (women & children). It seeks to sustain a professional identity of midwives that is seen as skilled and safe.

To meet the two year time-line it is imperative that midwives begin planning for the establishment of their Council. There are policies, procedures and guidelines to support the development of the Midwifery Council that will take time to develop and will need to be ready to support the functioning of the Council. To achieve this, IBI has agreed to establish a taskforce within their organisational structure. In time, the taskforce will be able inform the development of the collegium described in Law 36/2014. A collegium is an autonomous body within a professional organisation, which each profession will establish to inform the Council.\(^{132}\)

2.2 Gap analysis and development of a strategic action plan

In order to plan successfully for a Midwifery Council, local midwives will need to take control of the process for developing their own Council. IBI has expressed a willingness and preference to do this and has been encouraged to ask for technical support if needed.

ICM has developed a toolkit to enable the Midwives’ Associations to assess and plan the actions required to move to a fully functioning regulatory system. This would provide a quality framework which ensures that the development of the profession conforms to international standards and women and babies receive the best possible midwifery care.

The toolkit\(^{133}\) is designed to help Midwives’ Associations to:

- Understand regulation and how a Council is different from an Association (table 1)
- Assess IBI’s current status in relation to the Global Standards for Midwifery Regulation
- Use the results of the self-assessment to identify goals
- Make a strategic action plan towards achieving those goals
- Help monitor and evaluate and sustain actions into the future.
- Provide information, skills, and tools

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\(^{132}\) Article 51 of the Law on Health Workers

\(^{133}\) ICM Regulation Toolkit Draft Version 2. Sally Paiman Co-chair of ICM Regulation Committee, May 2014
The output from the gap-analysis should be a step-by-step strategic action plan which will inform planning for the establishment of Midwifery Council and provide a process which will:

- Allow stakeholders to engage more effectively in the planning process
- Allow IBI to request support if needed for specific areas of development
- Allow IBI and other stakeholders to identify areas for collaboration

Without such a plan, funding of activities to support midwifery regulation may not be possible and it might be more strategic for UNFPA to work directly with the MoH to address coverage and quality of SRMNCH service issues.

### Table 1: Difference and shared responsibilities between a Council and Association

<table>
<thead>
<tr>
<th>Indonesian Women and Families</th>
<th>Indonesian Midwives Council</th>
<th>Indonesian Midwives Association</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public safety</td>
<td>Professional support</td>
</tr>
<tr>
<td>Law</td>
<td>Authority</td>
<td>Constitution</td>
</tr>
<tr>
<td>• Regulation of midwifery practice</td>
<td>• Professional Leadership</td>
<td>• Professional leadership</td>
</tr>
<tr>
<td>• Protection of public safety by ensuring midwives are competent</td>
<td>• Representation for midwives</td>
<td>• Representation for midwives</td>
</tr>
<tr>
<td>• Register midwives &amp; maintain the register of midwives.</td>
<td>• Develop philosophy of midwifery</td>
<td>• Develop philosophy of midwifery</td>
</tr>
<tr>
<td>• Issue Practicing Certificates (competency based).</td>
<td>• Policy development, influence and advice</td>
<td>• Policy development, influence and advice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Standards of practice</th>
<th>Education</th>
<th>Complaints &amp; notifications about the practice of midwifery</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Set standards of education: pre-service and in-service, curriculum, school, teachers</td>
<td>• Professional behaviour standards: code of ethics in collaboration with the Indonesian Midwives Council</td>
<td>• Conferences, seminars, newsletters</td>
<td>• Provide indemnity insurance cover to individual members.</td>
<td></td>
</tr>
<tr>
<td>• Accreditation of curriculum, institutions</td>
<td>• Standards of competency (for each scope of practice)</td>
<td>• Library service</td>
<td>• Provide professional advice and advocacy.</td>
<td></td>
</tr>
<tr>
<td>• Monitoring the standards</td>
<td>• Practice standards: (code of ethics in collaboration with the IBI, code of conduct)</td>
<td>• Education/study grants</td>
<td>• Provide legal and competence advice and representation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complaints &amp; notifications about the practice of midwifery</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Disciplinary role: receive, access and manage complaints about the practice of individual midwives</td>
<td>• Wage negotiation and conditions of employment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>• Policy development</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>• International regulatory collaboration</td>
<td>• Wage negotiation and conditions of employment</td>
</tr>
</tbody>
</table>
2.3 Strengthening components of the midwifery regulation framework

Once the step-by-step action plan is available, components of the midwifery regulation framework will be strengthened in a strategic way. Policy and planning dialogue, development and implementation will be able to begin through IBI or the MoH, to address gaps in the regulation framework for midwives.

The Indonesian Midwifery Council is advanced in performing selected duties to support the functions of a Council. In collaboration with the MoH, higher education and other stakeholders, developments include the following:

- A system of registration has been established but is owned by the MoH
- Planning for re-registration and continuing education has commenced but is incomplete
- Standards for midwifery practice have been reviewed or developed, but work is incomplete
- The development of a career structure for midwives which aligns with the Indonesian qualifications framework (IQF) but is incomplete.

Most of these developments are incomplete; for example the IQF has only considered higher education not lower levels and has been driven by an agenda outside the midwifery profession. There is a pressing need to look at the preparation required to deliver the full range of SRMNCH services, at all levels of service delivery. If midwives are not available to deliver these services then the delivery of life saving services by another cadre needs to be considered.

There are also components of the regulatory framework that are mostly out of the control of the profession e.g. regulation and accreditation. IBI has been involved in developing these areas; but the degree to which the midwifery profession has ownership for selected elements of the functions of a Council is questionable.

IBI needs to begin planning and taking more ownership for the development of a midwifery regulatory authority in readiness to start implementing procedures, guidelines and policies to support a regulatory framework for midwifery which provides women and babies with the best possible midwifery care. Two areas requiring particular attention are described below.

Key areas for support should be the development of a scope of practice for Indonesian midwives and the review and alignment of standards with the scope of practice. This may require the development of new standards for practice and/or education and the refinement of health standards. The next priority should be complaints and discipline.

Scope of practice and standards

The need for strategic direction and orderly progression in planning can be demonstrated by the lack of a scope of practice for Midwifery in Indonesia. The scope of practice for any profession lays the foundation for the development of standards and competencies. The coverage and quality of services provided by midwives will be limited, until standards and competencies are developed, and a career structure covers the scope of practice from the village to the highest levels of midwifery leadership. Figure 2 shows the Midwifery Council will need to consider a range of standards and different levels of competence.
Practice standards are particularly complex. Midwives in Indonesia have different scopes of practice according to their level of education or where they work. Each scope of practice will have different roles, functions, responsibilities and activities and will have different levels of education. The Council will need to regulate each of these scopes of practice in line with accepted minimum international standards. Competencies for each scope will also need to be developed. While IBI has developed some standards and competencies the work needs to be aligned with a scope of practice.

Complaints and discipline

Perhaps the most challenging area for a Council is the management of complaints and discipline of the profession. A range of procedures, guidelines and standards will need to be developed for receiving and managing complaints and hearing cases referred to the Council. This is a complex area and will require careful consideration of the legal ramifications before discipline can be enforced. Work in this area has barely begun but may require legal inputs at a later date.

2.4 Partnerships and networking

The Indonesian Midwifery Council will be an independent regulatory body. However to implement the functions and duties or the Council there will be a need to develop robust linkages with other associated partners. These partners might include other health professions and government, in particular the MoH. Areas for partnership and networking include developing the midwifery scope of practice, standards of midwifery practice, competency of midwives, accreditation and certification of courses, pre-service training and education standards, workforce planning etc. These linkages have the potential to create an enabling policy and planning environment for implementing the Midwifery 2030 agenda and could result in opportunities for research and implementing best practice.
There are a number of opportunities which could be pursued by UNFPA through the MoH or IBI. These opportunities have potential to solve some of the difficult issues impacting on the services midwives provide and the coverage and quality of SRMNCH services. In particular; areas related to task shifting, training, education, workforce planning and quality improvement. Examples of areas for engagement include:

- Identifying the minimum life saving procedures for obstetric emergencies and then training a local health provider in how to initiate “first-aid” then refer on. Obstetric first aid has been successful in some countries as most women who die in childbirth are within 2 hours of the birth. Simple rubbing a fundus, giving oxytocin and referring on, have saved lives.

- Through the registration system there is an opportunity to access databases from education, MoH and IBI to determine where gaps in service delivery exist and reasons for this in terms of demographic characteristics of midwives. If demographic data is not being developed then this will need to be collected to support workforce planning.

- The qualifications framework for midwives below degree level needs review. The education and training department within the MoH is currently struggling to align their midwifery courses with the qualifications framework. There is an urgent need to map all levels of courses from certificate to PHD level. The mapping from degree level has been completed for higher education but there are diploma and lower level courses and continuing education which need to be considered.

- The scope of practice for midwives will need to reflect the needs of mothers and their babies across Indonesia. Practice standards need to align with the scope of practice, then education and health services standards need to support the practice standards. Achieving this will be a challenge and requires collaborative efforts of all stakeholders.

The focal point for policy, planning and research activities will depend on who is responsible for the area of interest. It could be IBI or the MoH, depending on who has primary responsibility for the area. Then, within the MoH it could be a particular partner. Areas targeted should be those that will have the biggest impact on the coverage and quality SRMNCH services.

### 2.5 Advocacy and communication

Currently, IBI has limited regulatory powers and lacks influence in policy and planning. Its greatest strength is the 225,000 (and counting) midwives it represents, and a strong network of branches that spans 34 provinces across Indonesia. Regulating a profession in such a geographically diverse country like Indonesia, and communicating and disseminating information to midwives across Indonesia will be a challenge.

A further challenge will be the ratification of the Law for an independent Midwifery Council currently before the Parliament. To facilitate the Nursing Law, the nursing profession gained support from other countries in the region. Midwifery should do the same.

### 2.6 Financial sustainability

The Midwifery Council at a central level will be funded by the MoH. However, the Council will be at a central level. To perform the functions of the Council, IBI will need to work through an extensive network of 34 branches across the 34 provinces of Indonesia. This will cost money, so IBI working with the Midwifery Council will need to explore ways of generating funds through mechanisms such as:

- Registration fee collected from individual membership
- Re-registration fee every five years
• Fee collected from issue of Practice Certificate
• Certification of courses/training
• Possible donation from Philanthropist organisations
• Support from Pharmaceutical and other Companies
• Donation as seed money by the Government
• Support from NGOs/INGOs that have stake in SRMNCH
• Fundraising activities including midwifery students
3. CHALLENGES AND RECOMMENDATIONS

3.1 Challenges

Key challenges facing the development of midwifery as a profession include:

- Currently midwifery leaders are more focused on the ratification of the midwifery law before Parliament than the work that needs to be done to establish a Council. Efforts are fragmented as there is no strategic direction or orderly progression to the development of a profession. This, and lack of transparency in processes, makes it difficult for stakeholder to engage effectively with IBI and provide much needed support.

- The exact structure of KTKI needs clarification. This will be determined through a Presidential or Ministerial Decree\(^\text{134}\). Until the Decree is issued it will be difficult for each health profession to establish a Council or determine the level of autonomy they will enjoy.

- Midwifery is a well respected profession within Indonesia. It was observed that most of the responsibility for leading the profession was left with senior midwives. It will be important to look toward the next generation of midwives and develop their capacity as leaders and champions of midwifery in Indonesia.

- UNFPA has provided support to midwives worldwide for more than a decade. The original intent was to provide skilled birth care close to the community. Currently, efforts relating to the regulation of midwifery in Indonesia are at the national level. As midwives get more qualified, their motivation to work at community level, particularly in remote areas, could be lost. The challenge for UNFPA is to provide support for the development of Midwifery as a profession, but not lose the focus of quality skilled care close to where women live and work.

3.2 Recommendations

Midwifery 2030 focuses on increasing the availability, accessibility, acceptability and quality of health services and health providers to achieve universal health coverage. Central to this is an enabling policy environment that supports effective midwifery education, regulation and association development, and an enabling practice environment underpinned by effective management of the workforce, including professional development and career pathways. In alignment with Midwifery 2030 the following recommendations are made:

Indonesian Midwifery Association (IBI)

- There are components of a regulatory framework which are common to all models of regulation, which will take time to develop, so Indonesian Midwives should begin to plan for the establishment of the new Midwifery Council in a strategic and orderly way.

- That a taskforce be established under the leadership of the President of IBI. Consider structuring the taskforce to include high level executive leadership, who will oversee working groups which support the functions of a regulatory authority. It is envisaged the taskforce will become a collegium as described in Law 36/2014. A proposed structure is below (figure 3).

\(^{134}\) Articles 36 and 42 of the Law on Council for Health Workers
- It is further recommended that the taskforce begin to work together to develop policies, procedures and guidelines to support the development of the Midwifery Council. From the outset, the planning process should be transparent, to allow continued donor support.

- The ICM toolkit, which helps Midwifery Associations assess and plan the actions required to move to a fully functioning regulatory system, should be used by IBI to undertake a gap analysis and then develop a strategic action plan which provides a clear pathway to the development of a Midwifery Council.

The plan should include a time-line and roles and responsibilities of all stakeholders (IBI, MoH or whoever) and consensus from key stakeholders of their commitment to support the process, before moving forward.

- It is important that Midwives in Indonesia have a Law to support their own Midwifery Council so it can be refined as they evolve as a recognised professional group. So IBI should continue to advocate for the ratification of the Law currently before the Indonesian Parliament for the establishment of their own Midwifery Council.

- That a scope of practice for a midwife in Indonesia is developed and then midwifery standards and competencies are reviewed, refined or developed to align with this. In developing a scope of practice, take into consideration different levels of education and different models of midwifery practice throughout Indonesia.

- Standards and core competencies, developed under the Decision of the Ministry for Health of the Republic of Indonesia number 369/Menkes/SK/111/2007 on Professional Standards for Midwives, should be given priority.

- That the taskforce work to develop a regulatory framework for the Midwifery Council using the findings of the “gap analysis” and the ICM Standards for Midwifery regulation be a checklist to guide the process. Where required, collaborate with key stakeholders such as other professions, higher education and the MoH and involve them in decision making.

- It was noted that the Midwifery Code of Ethics is included in the Decision of the Minister Number 369/ Menkes/SK/III2007. It is recommended that the Indonesian Midwifery Council adopt the ICM Code of Ethics135 as the professional, rather than the legislated, code to be used for the Council. In reviewing the Code of Ethics, consider adapting a code such as the Code of Conduct for midwives developed by the Australian Nursing and Midwifery Councils136.

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UnFPA

- Provide advocacy support for the Midwifery Law currently before the Indonesian Parliament. Work with IBI to engage other international Midwifery Associations and Councils, to write letters to the President of Indonesia and high level parliamentarians, for the ratification of the law.

- IBI has expressed a desire to develop their Midwifery Council with limited technical inputs. To help IBI in understanding the regulatory process, support in the translation of key ICM regulation documents from English into the local language.

- Support IBI to undertake a gap analysis for the development of a strategic plan to achieve a Midwifery Council. Ensure there is consensus on how the plan will be implemented among all stakeholders. Then support outputs which show progress toward the establishment of a midwifery regulatory authority. Give priority to the development/revision of standards and competencies which align with the scope of practice.

- Support the dissemination of documentation, information and messages relating to the establishment and functioning of the Midwifery Council and implementation of best practices throughout branches to midwives across Indonesia.

- There are a number of opportunities which could be pursued by UNFPA through the MoH or IBI. These opportunities have potential to solve some of the difficult issues impacting on the coverage and quality of SRMNCH services (which includes midwifery). Consider supporting:
  - Policy and planning dialogue meetings between IBI and the MoH. Outputs of such dialogue should be a position paper or written agreement.
  - The qualifications framework for SRMNCH needs review. The education and training department within the MoH are currently struggling with how to align their midwifery courses with the IQF. There is a need to map all levels of SRMNCH services (which includes midwifery) from certificate to the highest level, based on local needs.
  - The scope of practice for midwives will need to reflect the needs of mothers and their babies across Indonesia. Practice standards needs to align with the scope of practice, then education and health service standards. Work with government to ensure this is the case.
  - Enter into policy dialogue on how life saving procedures for obstetric emergencies can be best delivered in areas where there is no midwifery coverage. Obstetric first aid has been successful in many countries where access is a problem. Simple procedures such as rubbing a fundus, giving oxytocin and referring on, has saved lives.
  - Support workforce planning, review registration data to determine where gaps in service delivery exist and reasons in terms of demographic characteristics of midwives. If demographic data is not being collected then help plan for this.

- Provide support to the MoH for requests that address issues related to the quality and coverage of midwifery services as per the recommendations to the MoH. Ensure IBI is involved in the process. If needed mobilise technical support.

- The focal point for policy, planning and research activities will depend on who is responsible for the area of interest. It could be IBI or the MoH. Areas targeted should be those that will have the greatest impact on the coverage and quality SRMNCH services. The starting point should be to work with the education and training department in the MoH to map SRMNCH services and levels of knowledge and skills to support service delivery.
Ministry of Health

- For the health professions, there is a lack of clarity on how they should move forward, according to the Law 36/2014. As there is only two years to establish Councils, it would be helpful if the decree could be issued and the process for establishment of Councils be shared with the professions.

- The organisational structure of the proposed health profession Councils, under Law 36/2014, is a concern. Indonesia is a geographically diverse country with a big population. Consider establishing sub-branches in each of the 34 provinces.

- Request support from UNFPA and other development partners to explore options, when experiencing bottlenecks with current midwifery initiatives, relating to the maldistribution and the quality of services they provide.

- Enter into policy dialogue with IBI and come to an agreement on areas which relate to the regulation of midwives. Include scope of practice, standards professional development, career pathways and more. Outputs of such dialogue should be a position paper or written agreements.

A plan of suggested activities is in Annex.
## 4. ANNEX

**PROPOSED ACTIVITIES TO SUPPORT MIDWIFERY AS A PROFESSION IN INDONESIA**

<table>
<thead>
<tr>
<th>Results</th>
<th>Key Activities</th>
<th>Responsible</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law for an autonomous midwifery council ratified by the Indonesian parliament</td>
<td>• Lobby countries in the region to advocate to the president for the ratification of the midwifery ACT</td>
<td>IBI/UNFPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collegium of local midwifery to support the development and functioning of a midwifery council</td>
<td>• Establish a taskforce to work under the direction of IBI (executive committee with 4 subgroups which represent regulatory functions, i.e., registration, education, practice and discipline)</td>
<td>IBI</td>
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<tr>
<td>A step-by-step strategic plan for the establishment of a midwifery council</td>
<td>• Gap analysis and development of a step-by-step action plan which maps out the process for the establishment of a midwifery council</td>
<td>IBI</td>
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<tr>
<td>Consensus on how to move forward</td>
<td>• Review of the plan by key stakeholders</td>
<td>IBI/MoH</td>
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<tr>
<td>List of SRMCH services to meet local needs</td>
<td>• Defining the SRMCH services that meet local needs. Take into consideration evidence of what works and best practices</td>
<td>MoH/IBI/</td>
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<tr>
<td>Agreed scope of practice for a midwifery in Indonesia</td>
<td>• Development of scope of practice including different models of midwifery practice and different education.</td>
<td>IBI/MoH</td>
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<tr>
<td>Standards supporting different levels of education and models of midwifery practice</td>
<td>• Review and refinement of practice standards and competencies</td>
<td>IBI/MoH/</td>
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<tr>
<td>Results</td>
<td>Key Activities</td>
<td>Responsible</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
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<tr>
<td>Standards and curricular align with local service needs and IQF</td>
<td>• Mapping and aligning midwifery standards and curricular to the IQF at a higher education level and below</td>
<td>MoH/IBI</td>
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<tr>
<td>A regulation framework which supported Indonesian midwives as an autonomous profession</td>
<td>• Strategic support for elements of the regulatory framework based on the gap analysis</td>
<td>IBI/MoH</td>
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<tr>
<td>Activities which support quality and coverage of services undertaken.</td>
<td>• Support for MoH for activities which support the quality of coverage of midwifery services</td>
<td>MoH/IBI</td>
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