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ESSENTIAL PACKAGE OF HEALTH SERVICES
COUNTRY SNAPSHOT: INDONESIA

July 2015
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Photo: A mother carries her child in Tumpang Village, Malang, Jawa Timur province, Indonesia.
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ACRONYMS

BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
EPHS	Essential Package of Health Services
JKN	Jaminan Kesehatan Nasional (National Health Insurance)
MSS	Minimum Service Standards
RMNCH	Reproductive, Maternal, Newborn and Child Health

ABOUT THE ESSENTIAL PACKAGES OF HEALTH SERVICES COUNTRY SNAPSHOT SERIES

An Essential Package of Health Services (EPHS) can be defined as the package of services that the government is providing or is aspiring to provide to its citizens in an equitable manner. Essential packages are often expected to achieve multiple goals: improved efficiency, equity, political empowerment, accountability, and altogether more effective care. There is no universal essential package of health services that applies to every country in the world, nor is it expected that all health expenditures in any given country be directed toward provision of that package. Countries vary with respect to disease burden, level of poverty and inequality, moral code, social preferences, operational challenges, financial challenges, and more, and a country's EPHS should reflect those factors.

This country snapshot is one in a series of 24 snapshots produced by the Health Finance and Governance project as part of an activity looking at the Governance Dimensions of Essential Packages of Health Services in the Ending Preventable Child and Maternal Death priority countries. The snapshot explores several important dimensions of the EPHS in the country, such as how government policies contribute to the service coverage, population coverage, and financial coverage of the package. The information presented in this country snapshot feeds into a larger cross-country comparative analysis undertaken by the Health Finance and Governance project to identify broader themes related to how countries use an EPHS and related policies, and to identify programs to improve health service delivery and health outcomes.

Each country snapshot includes annexes that contain additional information about the EPHS. When the following information is available, the snapshot includes the country's most recently published package; a comparison of the country's package with the list of priority reproductive, maternal, newborn, and child health interventions developed by the Partnership for Maternal, Newborn and Child Health (RMNCH) in 2011; and a profile of health equity in the country.

THE ESSENTIAL PACKAGE OF HEALTH SERVICES (EPHS) IN INDONESIA

Indonesia is an archipelago of 13,466 islands with a population of 255.5 million. The country has 34 provinces with 514 districts and municipalities (National Bureau of Statistics 2015). In 2001, Indonesia underwent further decentralization, and since then, local governments have been responsible for providing public services.

The government of Indonesia has specified an EPHS through Minimum Service Standards (MSS) for health, and through the benefit package of its mandatory social health insurance program, Jaminan Kesehatan Nasional (JKN; National Health Insurance). Annex A includes the major MSS indicators for health and the services covered under JKN.

MSS are sets of basic services, established by central government ministries and institutions from various sectors,[1] that local district and municipal governments must provide to all citizens. The current health-related MSS documents are Ministry of Health (MOH) Regulation 741/2008, MOH Decree 129/2008, and MOH Decree 828/2008.[2] The MOH included deadlines of 2010 or 2015 for local governments to meet targets for each service. An updated MSS for health is currently being formulated.

MOH Decree 828/2008 provides technical guidelines for 18 health-related MSS. It includes definitions of services and targets, formulae to calculate achievement, data source specifications, references, activities, and human resources required to meet targets. Community health centers known as Puskesmas and their networks are the main stakeholders invested in seeing that district health offices achieve the MSS targets in the district. Derivative indicators of these MSS later will be developed at the Puskesma/sub-district level, except the indicator for coverage of obstetric complications treated, which will be defined by the district hospital (Laksono et al. 2010).

Puskesmas, hospitals, community health care units, private clinics, private physician practices, and other health care units report on the MSS indicators to the district health officer. The district health officer then reports to the MOH (through a Web-based system), provincial health offices and the district/municipality leader.

Efforts are under way to strengthen enforcement and monitoring and evaluation of the MSS targets. Late and incomplete data submission by local governments and poor data quality proved to be challenges in the first iteration of the MSS. The next round of the MSS is expected to better address this issue, as provincial government will play a bigger role in monitoring and evaluation of district and municipal governments (Law 23/2014—replacing Law 32/2004 on regional government).

[1] MSS 2008 was formulated by 13 ministries/institutions: public housing, home affairs, social, health, women empowerment and child protection, environmental health, family planning, worker, education, public works, food sustainability, culture and tourism, and communication and information.

[2] MOH Decree 828/2008 refers to Government's Regulation 65/2015 on MSS guidelines for districts/municipalities.

MOH Regulation 75/2014 on Puskesmas lists health services that Puskesmas must provide. Puskesmas provide community and individual health services at the primary care level, focusing primarily on health promotion and preventive efforts.

Community health services include any activity aimed at sustaining and improving health of families, groups, and communities. Roughly translated from Bahasa Indonesian into English as "essential public health services," community health services cover five essential activity areas: health promotion; environmental health; maternal health, child health, and family planning; nutrition; and disease control and prevention. Extended public health services are adjusted based on health care priority and resources in each area.

Individual health service includes any activity to improve health or to treat and prevent disease of any individual. This includes outpatient care, emergency care, one-day care, home care, and inpatient care.

At the hospital level, MOH Decree 129/2008, complemented by Hospital MSS Guidelines 2012, regulates minimum services that hospitals must provide.

Reproductive health services are regulated with Government's Regulation 61/2014, which covers services for teenagers, reproductive system-based services, services before and during pregnancy, services during and after delivery, services related to sexual health, and services for infertile couples. Services for teenagers include information, education, and communication; counseling; and medical services (screening, treatment, and rehabilitation). Contraceptive services are limited to married couples.[3] Other services are listed in Annex A.

In 2008, the MOH issued operational guidelines on integrated services involving reproductive health in Puskesmas. National policy on reproductive health includes five programs under this area: maternal and newborn health, family planning, reproductive health for teenagers, sexually transmitted infection prevention and management (including for HIV and AIDS), and reproductive health for older persons. The first four programs are covered under "essential reproductive health services," or PKRE. If all five are covered, it is called "comprehensive reproductive health services," or PKRK. These integrated services are provided at the Puskesmas level. The indicators are listed in Annex A.

In 2014, Indonesia launched JKN—a social health insurance program with mandatory enrollment. JKN lists individual health services provided at primary facilities (through capitation payment) and referral health care facilities (through case-based group and fee-for-service payment systems). Services are provided by all public entities and contracted private entities.

There are additional regulations supporting EPHS, and guidelines that have established detailed quality of care standards for reproductive, maternal, newborn and child health services. We referred to these for the analysis in Annex B.

[3] Note that condoms and contraceptive pills can be purchased at stores without ID cards. In practice, some facilities also provide family planning services for unmarried couples.

Priority Reproductive, Maternal, Newborn and Child Health Interventions

Indonesia's maternal mortality rate is still among the highest in the region: 359 per 100,000 live births in 2012 (Statistics Indonesia 2013), an increase from 228 in 2007. To help reduce maternal mortality, the MOH, supported by the United States Agency for International Development (USAID), launched the Expanding Maternal and Neonatal Survival program in provinces with the highest maternal mortality rate and neonatal mortality rate. The three biggest causes of maternal mortality in Indonesia are postpartum hemorrhage, gestational hypertension, and infection (Indonesia's Health Profile 2014).

We compared Indonesia's EPHS to the priority RMNCH interventions using various regulations and guidelines (Annex B). The government regulations are not available in English.

Status of Service in EPHS	Status Definition	# of Services
Included	The literature on the essential package specifically mentioned that this service was included.	57
Explicitly Excluded	The literature on the essential package specifically mentioned that this service was not included.	1
Implicitly Excluded	This service was not specifically mentioned and is not clinically relevant to one of the high-level groups of services included in the essential package.	2
Unspecified	The literature on the essential package did not specifically mention this service, but this service is clinically relevant to one of the high-level groups of services included in the essential package.	0

Use of Selected Priority RMNCH Services

The table below presents the country's data on common indicators. Empty cells signify that these data are not available.

Indicator	Year	Value	Urban Value	Rural Value
Pregnant women sleeping under insecticide-treated nets (%)				
Births attended by skilled health personnel (in the five years preceding the survey) (%)	2012		91.8	74.6
BCG immunization coverage among one-year-olds (%)	2012		93.7	85.1
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among one-year-olds (%)	2012		77.3	67.4
Median availability of selected generic medicines (%)—private	2007–2013	57.8		
Median availability of selected generic medicines (%)—public	2007–2013	65.5		

Source: Global Health Observatory, World Health Organization.

How the Health System Delivers the EPHS in Indonesia

Indonesia's EPHS, including RMNCH services from the EPHS, are delivered through:

- ✓ Public and private sector primary care facilities
- ✓ Public and private sector referral care facilities

Health care services are provided by public and private entities. Public entities include primary health care facilities (Puskesmas, i.e., community health centers); and secondary and tertiary care facilities. The public sector generally assumes the more dominant role, particularly in rural areas and for secondary levels of care. In the public sector, provision is decentralized to the district level (Harimurti et al. 2013). In order to improve service accessibility, a Puskesma is supported by its networks: supporting Puskesmas (minimum one midwife and one nurse), mobile Puskesmas, and village midwives.

In 2004, the MOH initiated the programs PONED (Basic Emergency Obstetric and Newborn Care—BEmONC) and PONEK (Comprehensive Emergency Obstetric and Newborn Care—CEmONC),[4] both of which aimed to reduce infant and maternal mortality. PONED is operated at the Puskesmas level, and Puskesmas receive referred cases from health care workers or facilities at the village or community level. For Puskesmas and hospitals to be BEmONC and CEmONC certified, they must meet certain qualifications (MOH Decree 1051/2008 on PONEK). There are 2,855 Puskesmas with BEmONC qualification (29.34 percent of total Puskesmas). PONEK is operated at the hospital level and is also part of a referral system in maternal and neonatal emergency care.

Among all government CEmONC hospitals, only 7.6 percent met the complete CEmONC standards (Health Facility Research 2011). Eighty-two percent work with operation theater and 24-hour doctor teams, and 58 percent are without 24-hour blood bank services (MOH 2012). Among all BEmONC Puskesmas, only 70 percent have lab service to check hemoglobin, and only 42.6 percent have magnesium for hemorrhage and eclampsia management. Further, 55 percent do not have trained health care workers, and 66 percent are without complete equipment and drugs (MOH 2012).

In 2015, MOH launched the latest maternal and child health book (MCH book) and technical guidelines. The MCH book is used as an information, education and communication tool regarding care for pregnant women and for children up through six years of age. This book is given to every pregnant woman to help her detect health problems she or her children may have; it is used to help her track the standard and referral services she will receive. Husbands, caregivers, cadres, and health care workers may also use this book (MOH Decree 284/2004 and MCH book technical guidelines 2015).

In 2014, Indonesia began restructuring three of its existing public and quasi-private insurance providers under a single social health insurance scheme called JKN (National Health Insurance).[5] The country aims to scale to universal coverage by 2019, covering a projected 257.5 million people. JKN is funded predominantly through premiums paid by its participants. While enrollment is mandatory, premiums will be offset by government subsidies for those eligible. As of now, there are more than 158 million

[4] Puskesmas PONED means Puskesmas with an inpatient facility with the ability to provide basic emergency and newborn care 24/7. "Hospitals PONEK 24 hours" have the capacity to provide basic and comprehensive emergency and newborn care for pregnant women, women in labor, and postpartum women who come by themselves or are referred by the community, the village midwife, or Puskesmas PONED.

[5] These providers were Askes (health insurance) for civil servants and military personnel, active and retired, and their dependents; Jamsostek (Workers' Social Security Health Insurance); and Jamkesmas (Community Health Protection Program) for the poor.

enrollees (Social Security Management Agency for Health (BPJS-K) 2016).[6] JKN is integrated under the National Social Security System, which is responsible for providing social security to all citizens under principles of justice and prosperity. The Social Security Management Agency for Health (BPJS-K) is the body responsible for implementing JKN.

BPJS-K does not cover drugs and medical devices related to national programs covered by the central or local governments; these include basic contraceptives, vaccines for basic immunization, and certain drugs (e.g., for tuberculosis and HIV) (Presidential Regulation 12/2013 and MOH Regulation 71/2013). Thus, for the above MSS-related services, BPJS coordinates with governments and private facilities. For example, on basic immunization care, BPJS coordinates with district health offices on vaccine provision. Contracted facilities may provide additional nongovernment-provided vaccines, but enrollees must pay out of pocket. For family planning services, BPJS-K pays for medical consultation and procedures, and the National Family Planning Agency (BKKBN) supplies the contraceptives.[7] Annex A lists services provided by JKN. To be covered by JKN, enrollees must seek care in facilities contracted by BPJS (all public facilities and some private facilities) and follow a referral procedure.

About one-third of the country's Puskesmas provide inpatient care, and the government is working to improve the capacity of these health centers to ensure the availability of high-quality primary and secondary care across the country's dispersed archipelago (Harimurti et al. 2013). Secondary care services are provided through secondary care hospitals. Most of the country's tertiary care hospitals and centers of excellence are public.

Puskesmas	9,731 (3,378 inpatient)
Puskesmas ratio	1.16 per 30,000 people
Puskesmas with BEmONC qualification	2,855
Districts/municipalities with at least four Puskesmas with BEmONC qualification (WHO standard)	347 (67.77%)
Physician's private practices registered with BPJS	4,441
Private clinics registered with BPJS	3,280
Public hospitals	2,406
Private hospitals	807
Specialized hospitals	233 (20.51% MCH hospitals, 9.26% maternity hospitals)
Hospital bed ratio	1.07 per 1,000 people

Source: Indonesia's Health Profile 2014, BPJS-K 2016.

Delivering the EPHS to Different Population Groups

The government's strategy for implementing the EPHS lays out specific activities to improve equity of access for specific populations, including women and rural populations.

In Annex C, we provide the World Health Organization's full health equity profile of Indonesia based on data from a 2012 Demographic and Health Survey.

[6] JKN enrollees are divided into a government-subsidized group (PBI) and a non-subsidized group (non-PBI). PBI covers poor and disabled people; their premium is paid by the government. The non-PBI group covers formal sector workers and their dependents; non-formal sector workers and their dependents; and non-workers and their dependents.
[7] Contraceptive services (other than tubectomy) are claimed through a non-capitation payment system (fee for service), and tubectomy is through the Indonesian case based groups system.

Key findings from the health equity profile include:

- There is some evidence of inequity of health service coverage in the country. For example, only about 60 percent of births among families in the poorest wealth quintile are attended by skilled health personnel. Coverage of this service among the wealthiest approaches 100 percent.
- Education level of mothers appears to have a stronger association with immunization and maternal health services coverage than wealth quintile or rural versus urban residence. At the same time, education level of the mother does not show a strong association with coverage of reproductive health services.
- Indicators suggest that rural versus urban residence is not a factor in health-seeking behavior for children under five years old (i.e., in their parents' behavior on their behalf).

The National Medium Term Development Program 2015–2019 document reported that the main challenges in improving mother, baby, and adolescent health include:

- Ensuring a continuum of care through adolescence, beginning with neonatal visits and immunization for the baby
- A growing elderly population
- Ensuring provision of health care facilities and workers
- Improving quality of services
- Reducing the fertility rate and improving female teenagers' and pregnant women's nutritional status
- Ensuring synchronized MCH service at the central, province, and district/municipality level

Governments and the community are responsible for ensuring that every mother has access to qualified maternal health care services, which include antenatal, delivery, postpartum, obstetric complication, and contraceptive care (Indonesia's Health Profile 2014).

The government of Indonesia has stated that one purpose of decentralizing the responsibility for health care provision to the districts was to accelerate the realization of public welfare by empowering communities to improve services (Governments' Regulation 65/2005). Decentralization is intended to ensure that all populations, including remote and hard-to-reach populations, can obtain basic health services. Districts have the autonomy to determine how health budgets are spent, and they can use different service delivery mechanisms such as mobile health clinics and community midwives.

Providing Financial Protection for the EPHS

The central budget covers MSS funding related to reporting, monitoring and evaluation, assistance and supervision, information system development, and capacity-building, which are part of the central government's responsibilities. One example of central to local transfer to support MSS is Bantuan Operasional Kesehatan (BOK), the health operational assistance fund. MSS funding related to implementation, reporting, monitoring and evaluation, assistance and supervision, information system development, and capacity-building comes from local budgets.

BOK is used mainly to support operational costs for health promotion and prevention activities: maternal and child health and family planning, immunization, nutrition, health promotion, environmental health, disease control, and others, according to MSS and health-related Millennium Development Goals.

BOK only partially supports Puskesmas; local governments are still obliged to allocate their funds for operational costs (Indonesia's Health Profile 2014, MOH Regulation 11/2015).

Also, Puskesmas receive capitation payment allocated from JKN. At a minimum, 60 percent of these funds are used for health worker incentives (on top of salary), and a maximum of 40 percent are used for operational costs (MOH Regulation 19/2014). In Annex A, we list items that the capitation payment can cover. Private facilities contracted by BPJS receive only a capitation payment.

Local governments provide local health insurance (Jamkesda) for those people not covered by JKN; some Jamkesda schemes cover only poor people, while other Jamkesda schemes cover all in the locality. Some Jamkesdas are already integrated into JKN (full integration is expected in 2016).

Recently, the central government rolled out a "village fund," which is transferred to villages through local governments to improve the village's ability to meet basic needs. One may assume that in the long term, this will help achieve MSS targets (Ministry of Village, Lagged Area, and Transmigration Regulation 5/2015).

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ANNEX A. INDONESIA'S EPHS

Minimum Service Standards for Health at Districts/Municipalities

(MOH Reg 741/2008 and MOH Decree 828/2008)

NO	INDICATORS	TARGET COVERAGE	TARGET YEAR	2014	2015
	PRIMARY HEALTHCARE				
1	Coverage of pregnant women who had at least four antenatal care visits	95%	2015	89.62	56.73
2	Coverage of obstetric complications treated	80%	2015	65.44	67.28
3	Coverage of deliveries assisted by skilled birth attendants	90%	2015	90.27	57.11
4	Coverage of postpartum care (6−42 hours after delivery)	90%	2015	89.37	56.08
5	Coverage of newborns (0-28 days) with complications who received care	80%	2010	49.30	44.82
6	Coverage of baby visit	90%	2010	93.66	57.75
7	Coverage of Universal Child Immunization at village/subdistrict	100%	2010	69.43	23.82
8	Coverage of growth monitoring for children <5 years	90%	2010	71.12	44.27
9	Coverage of provision of complementary foods for children aged 6-24 months in poor families	100%	2010	49.20	31.56
10	Coverage of malnourished children who received treatment	100%	2010	32.08	82.90
11	Coverage of elementary students health examination by healthcare workers or trained staff (teachers or students)	100%	2010	82.62	28.68
12	Coverage of active family planning users	70%	2010	71.75	87.86
13	Coverage of disease diagnostics and management	100%	2010		
	Coverage of case finding for acute flaccid paralysis per 100,000 people aged <15 years old			43.23	50.19
	Coverage of case finding for pneumonia in children <5 years old			23.57	17.36
	Coverage of case finding for tuberculosis with positive BTA			2.79	31.74
	Coverage of dengue patients who received treatment			4.82	2.19
	Coverage of case finding for diarrhea			9.31	24.14
14	Coverage of primary healthcare for the poor	100%	2015	70.51	30.69

	HEALTH CARE REFERRAL				
15	Coverage of patient referral healthcare for the poor	100%	2015	11.93	10.45
16	Coverage of level 1 emergency services provided in health facilities (hospitals) in districts/municipalities	100%	2015	7.90	0.18
	EPIDEMIOLOGY INVESTIGATION AND OUTBREAK PREVENTION				
17	Coverage of villages/subdistricts with outbreaks handled within 24 hours	100%	2015	2.44	44.57
	HEALTH PROMOTION AND COMMUNITY DEVELOPMENT				
18	Coverage of active/aware villages	80%	2015	79.08	86.51

Activities and Human Resources for Each MSS Indicator

1. Coverage of pregnant women who had at least four antenatal care visits
    a. Activities
        i. MCH book provision (with P4K sticker (delivery and complication prevention program))
        ii. Surveillance of pregnant women
        iii. Standard ANC
        iv. Home visits for dropped-out cases
        v. Delivery envelope/pocket (for midwife to track expecting mothers)
        vi. Interpersonal communication/counseling training
        vii. Reporting
        viii. Supervision, monitoring, and evaluation
    b. Human resources
        i. GP
        ii. Midwife
        iii. Nurse

2. Coverage of obstetric complications treated
    a. Activities
        i. Complication detection for pregnant women, women in labor, and postpartum women
        ii. Referral case for complicated labor
        iii. Obstetric complication management
        iv. Clinical training center provision
        v. BEmONC training for village midwife and Puskesmas team
        vi. CEmONC training at districts/municipalities' hospitals
        vii. BEmONC and CEmONC equipment provision in Puskesmas and hospital, respectively
        viii. Hospital blood bank provision
        ix. BEmONC and CEmONC provision
        x. Reporting
        xi. Monitoring and evaluation
    b. Human resources
        i. Hospital CEmONC team (one obstetrician, one pediatrician, one GP, three midwives, two nurses)
        ii. Puskesmas BEmONC (one GP, one midwife, one nurse)
        iii. Village midwife

3. Coverage of deliveries assisted by skilled birth attendants
    a. Activities
        i. Witchdoctor and midwife partnership
        ii. Delivery and complication prevention planning program
        iii. Delivery service
        iv. Delivery equipment provision (midwife kit)
        v. Normal labor training
        vi. Supervision, monitoring, and evaluation
    b. Human resources

i. Obstetrician
ii. GP
iii. Midwife

4. Coverage of postpartum care (6−42 hours after delivery)
    a. Activities
        i. Standard postpartum care (mother and newborn)
        ii. FP service postpartum
        iii. Training on maternal and neonatal health
        iv. Postpartum referral care
        v. Home visits for dropped-out cases
        vi. Reporting
        vii. Supervision, monitoring, and evaluation
    b. Human resources
        i. GP
        ii. Nurse
        iii. Midwife

5. Coverage of newborns (0-28 days) with complications who received care
    a. Activities
        i. Complication detection for pregnant women, women in labor, and postpartum women
        ii. Standard postpartum care for mother and newborn
        iii. Provision of essential equipment, lab, drugs, and transport
        iv. Low birth weight training for midwife, asphyxia in newborn, integrated management for sick children <5 years old, BEmONC for Puskesmas team, and CEmONC for district/municipality hospital team
    b. Human resources
        i. Hospital CEmONC team (one obstetrician, one pediatrician, one GP, three midwives, two nurses)
        ii. Puskesmas BEmONC (one GP, one midwife, one nurse)
        iii. GP
        iv. Nurse
        v. Midwife

6. Coverage of baby visit
    a. Activities
        i. Scaling up clinical competence on early stimulation, detection, and intervention for growth and development and on management for sick children <5 years old
        ii. Follow-up post training in item 6.a.i
        iii. Standard services for baby
        iv. Referral care
        v. Death and disease tracking of babies
        vi. Home visits for those who do not come to facility
    b. Human resources
        i. Pediatrician
        ii. GP
        iii. Midwife
        iv. Trained nurse

7. Coverage of Universal Child Immunization at village/subdistrict
    a. Activities
        i. Routine immunization
        ii. Extended immunization
        iii. Immunization during outbreak
        iv. Immunization for certain diseases
    b. Human resources
        i. GP
        ii. Nurse
        iii. Midwife

8. Coverage of growth monitoring for children <5 years
    a. Activities
        i. Surveillance for children aged 12-59 months
        ii. Growth monitoring for children 12-59 months a minimum eight times per year
        iii. Development monitoring for children 12-59 months a minimum every six months
        iv. Prompt intervention when abnormality detected
        v. Referral care when intervention shows no improvement
        vi. Screening kit provision for early stimulation, detection, and intervention for growth and development
        vii. Targeted high dose vitamin A (200,000IU)
        viii. Reporting form
        ix. Monitoring and evaluation
        x. Training
    b. Human resources
        i. Pediatrician
        ii. GP
        iii. Midwife
        iv. Nurse

9. Coverage of provision of complementary foods for children aged 6-24 months in poor families
    a. Activities
        i. Surveillance
        ii. Training on complementary feeding and breastfeeding counseling
        iii. Complementary feeding provision
        iv. Complementary feeding storage
        v. Complementary feeding distribution
        vi. Reporting
        vii. Monitoring and evaluation
    b. Human resources
        i. Nutritionist or trained healthcare worker

10. Coverage of malnourished children who received treatment
    a. Activities
        i. Nutrition surveillance to find cases
        ii. Early response for malnourished cases
        iii. Training on malnourishment management

iv. Mineral mix provision
v. Malnourishment management in TFC (therapeutic feeding center) in hospital
vi. Assistance post malnourishment management (community therapeutic center)
vii. Comprehensive supervision and assistance

b. Human resources
i. Nutrition tea (GP, nutritionist, midwife/nurse)

11. Coverage of elementary students health examination by healthcare workers or trained staff (teachers or students)
a. Activities
i. Surveillance
ii. Healthcare kit provision and maintenance
iii. Training
iv. Disease detection
v. Healthcare services
vi. Reporting
b. Human resources
i. GP
ii. Dentist
iii. Nurse

12. Coverage of active family planning users
a. Activities
i. Surveillance for fertile couple
ii. FP counseling for fertile couple
iii. Standard FP services
iv. Contraceptives provision
v. Clinical training on contraceptives
vi. Training on FP services
vii. Training on FP decision tool
viii. FP information system strengthening
ix. Supervision, monitoring, and evaluation
b. Human resources
i. GP
ii. Midwife
iii. Nurse

13. Coverage of disease diagnostics and management
a. Coverage of case finding for acute flaccid paralysis per 100,000 people aged <15 years old
i. Activities
1. Socialization
2. Case finding
3. Specimen for lab
ii. Human resources
1. Specialist
2. GP
3. Epidemiologist
4. Nurse

5. Lab technician

b. Coverage of case finding for pneumonia in children <5 years old
    i. Activities
        1. Healthcare services: early detection, treatment, referral services, care seeking assistance
        2. Equipment provision
        3. Healthcare worker training: upper respiratory tract infection management, integrated management for sick children <5 years old, verbal autopsy (for children <5 years old) training, pneumonia in children <5 years old
        4. Community outreach
        5. Networking and partnership
        6. Data gathering and analysis
        7. Monitoring and supervision
        8. Evaluation
        9. Reporting
    ii. Human resources
        1. Pediatrician
        2. GP
        3. Midwife
        4. Nurse
c. Coverage of case finding for tuberculosis with positive BTA
    i. Activities
        1. New case management: case finding and treatment
        2. Sputum analysis
        3. Training
        4. Outreach
        5. Reporting
        6. Monitoring and evaluation
    ii. Human resources
        1. Specialists (pediatrician, pulmonologist, obstetrician, internist)
        2. GP
        3. Nurse
        4. Epidemiologist
        5. Lab technician
        6. Radiographer
d. Coverage of dengue patients who received treatment
    i. Activities
        1. Diagnosis, treatment, and referral at Puskesmas and hospital level
        2. Human resources training
        3. Case management by Puskesmas staff
        4. Epidemiology
        5. Reporting
        6. Monitoring and evaluation
    ii. Human resources
        1. Specialists (internist, pediatrician, anesthesiologist, clinical pathologist)
        2. GP
        3. Nurse
        4. Midwife

5. Lab technician
6. Entomologist

e. Coverage of case finding for diarrhea
   i. Activities
      1. Case management
      2. Form provision
      3. Data gathering and analysis
      4. Staff training: case management and program management
      5. Promotion/outreach
      6. Networking and partnership
      7. Evaluation
   ii. Human resources
      1. Pediatrician
      2. Internist
      3. GP
      4. Midwife
      5. Nurse
      6. Epidemiologist
      7. Sanitarian

14. Coverage of primary healthcare for the poor
    a. Activities
       i. Surveillance (population, healthcare facility, and visit)
       ii. Basic services for the poor
       iii. Outreach
       iv. Training
       v. Monitoring and evaluation
       vi. Reporting
    b. Human resources
       i. GP
       ii. Nurse
       iii. Midwife
       iv. Other healthcare worker

15. Coverage of patient referral healthcare for the poor
    a. Activities
       i. Surveillance (population, healthcare facility, and visit)
       ii. Basic services for the poor
       iii. Outreach
       iv. Training
       v. Monitoring and evaluation
       vi. Reporting
    b. Human resources
       i. Specialist
       ii. GP
       iii. Nurse
       iv. Other healthcare worker
16. Coverage of Level I emergency services provided in health facilities (hospitals) in districts/municipalities

a. Activities
    i. Emergency care service standardization in districts/municipalities and provinces
    ii. Disaster plan formulation
    iii. Service cost calculation
    iv. Fundraising (multiple sources)
    v. Reporting
    vi. Training
b. Human resources
    i. Emergency care team (GP and nurse)

17. Coverage of villages/subdistricts with outbreaks handled within 24 hours
    a. Activities
        i. Data gathering
        ii. Data analysis
        iii. Dissemination
        iv. Outbreak prevention and control
        v. Monitoring and evaluation
        vi. Training
    b. Human resources
        i. GP
        ii. Nurse
        iii. Epidemiologist

18. Coverage of active/aware villages
    a. Activities
        i. Preparation
            1. For healthcare workers
                a. Midwife training (one midwife per village)
                b. Cadre and public figure training (two cadres and one public figure per village) for four days (three days in class and one day in the field)
            2. For community
                a. Forum at village level (three times per year)
                b. Survey (twice per year)
                c. Community gathering (twice per year)
        ii. Execution
            1. Basic healthcare services
            2. Cadre and public figure conduct community-based surveillance (simple observation) on MCH, nutrition, environmental health, disease, clean and healthy life style
            3. Follow up post meeting to raise public awareness (once per month)
            4. Training (twice per year)
            5. Forum at community level to discuss health problem (once per month)
    b. Human resources
        i. Midwife or other healthcare worker
        ii. Cadre
        iii. Public figure

Reproductive health services (Government's Regulation 61/2014)

Reproductive health services for teenagers

a. Information, education, and communication on:
   - Healthy life
   - Mental health
   - Reproductive system
   - Safe and healthy sexual behaviors
   - Risky sexual behaviors and their consequences
   - Family planning
   - Other risky behaviors related to reproductive health
b. Counseling
c. Medical services for screening, treatment and rehabilitation

Pre-pregnancy services

a. Physical examination
b. Immunization
c. Health consultation

During pregnancy services

a. Antenatal care services, minimum four times

Delivery services

a. Infection prevention
b. Early detection on risk factors and possible complication
c. Standardized delivery services
d. Early breastfeeding
e. Referral services

Postpartum services

a. Postpartum care
b. Exclusive breastfeeding support
c. Services for children under two years old

Family planning services

a. Information, education, and communication
b. Counseling
c. Contraceptive services for married couple, considering age, parity, number of children, health status, and religious norms. Contraceptives include IUDs, implants, tubectomy, and vasectomy.
d. Emergency contraceptives are given for mothers without contraceptive or rape victims

Sexual health services

a. Social skills
b. Information, education, and communication
c. Counseling
d. Drugs
e. Treatments
f. Services also cover rape victims

Reproductive health services
Aims to protect reproductive organs and functions from disease and disability

Abortion services
Only under medical emergency and for rape victims

Services for infertile couple
Services are conducted according to current knowledge and technology and not against religious norms

Health Services at Puskesmas (MOH Regulation 75/2014)

MOH Regulation 75/2014 on Puskesmas lists health services which are based on MSS and must be provided by Puskesmas. Puskesmas provides community and individual health services at the primary care level, focusing more on health promotion and preventive efforts.

Community health service covers five essential areas called "essential public health services"–(1) health promotion, (2) environmental health, (3) MCH and family planning, (4) nutrition, and (5) disease control and prevention.

Individual health service includes any activity to improve health, treat, and prevent disease of any individual. These services are translated into Puskesmas programs (Annex A). In order to improve service accessibility, Puskesmas is supported by its networks: supporting Puskesmas (minimum one midwife and one nurse), mobile Puskesmas, and village midwives.

Puskesmas Programs

Compulsory programs	Extended programs (not all Puskesmas)
Medical service	School health
Health promotion	Physical health
MCH and FP	Integrated community health care
Prevention and control of communicable and non-communicable diseases	Occupational health
	Oral and dental health
Environmental health	Mental health
Nutrition services	Elderly care program
	Traditional medicine
	Eye health

Antenatal care service (part of MCH program):

a. Weight measurement
b. Blood pressure measurement
c. Uterine fundus height measurement
d. Iron tablets for 90 days during pregnancy
e. Tetanus toxin
f. Hemoglobin evaluation
g. VDRL evaluation
h. Breast management
i. Pregnancy fitness class
j. Discussion for referral preparation
k. Urine protein evaluation
l. Urine reduction evaluation based on indication
m. Iodine capsule for goiter endemic area
n. Anti-malarial drug for malaria endemic area

Community Health Services

Community health services are divided into essential and extended services according to health priority and resources available in each area. Puskesmas is divided into urban, rural, and remote areas, and services provided are adjusted to meet health priorities and existing resources.

Essential Services

a. Health Promotion Services
   - Outreach
     - Health promotion at elementary schools
     - Community empowerment related to health
     - Mental health and drug abuse services
     - Mental health counseling for pregnant and lactating mothers
     - Mental health and drug abuse counseling for at-risk populations (elderly, children, adolescents)
     - Hygiene promotion
     - Oral and dental health promotion throughout the life cycle
     - Promotion of and outreach for childhood immunizations
     - Reproductive health counseling for teens
     - Prevention of HIV/AIDS and sexually transmitted diseases
     - Education and community prevention of diarrhea, typhoid, and hepatitis
     - Education and counseling for feeding infants and children (including breastfeeding, complementary feeding, and promotion of care for malnourished children)
     - Nutrition education and counseling for school-aged children
     - Nutrition education and counseling for malnourished pregnant women
     - General nutrition education and counseling
     - Education and counseling for self-care and rational drug use
   - Community empowerment
     - Engage community leaders to form health cadres or groups
     - Home-based/community-based care networks
     - Community empowerment for community health center provision
     - Rational drug use
   - Training
     - Train health care workers on self-care and home-based care
   - Advocacy
     - Engage community and other sectors

b. Environmental Health Services
   - Food management and water monitoring

c. Maternal and Child Health and Family Planning Services
   - Immunization services
   - School health screening
   - Extension of family planning in accordance with government programs on fertile age groups and community

d. Nutrition Services
   - Early detection
     - Early detection of malnourishment in the community
     - Nutrition surveillance
   - Services
     - Malnutrition management

e. Disease Control and Prevention Services
   - Prevention and treatment of non-communicable diseases
     - Use of community health centers
   - Prevention and control of infectious diseases
     - Filariasis
     - Worms
     - Dengue Fever
     - Malaria
     - Zoonotic diseases
     - HIV/AIDS
     - Sexually transmitted diseases
     - Diseases that can be prevented through immunizations

Extended Services

a. Mental health Services
   - Drug abuse services
     - Substance abuse counseling
     - Mandatory reporting of narcotics abusers
b. Dental Health Services
   - Dental health services for pregnant women, children <5, early childhood, and the elderly
c. Traditional, Complementary, and Alternative Medicine
   - Use of herbal medicines
d. School-based Services
   - Immunization of school children
   - Oral and dental health services
e. Senses Health Services
   - Education and counseling
f. Care of the Elderly
   - Use of community health services
g. Occupational Health and Sports Medicine
   - Early detection

Integrated services on reproductive health in Puskesmas (MOH 2008)

Indicators for essential reproductive health services (PKRE)

1. Number of maternal death during delivery
2. Number of infant death before one year of age
3. Antenatal coverage (target: 95%)
4. Assisted delivery coverage (target: 90 percent)
5. Obstetric complication management (target: 12 percent of delivery)
6. Postpartum service coverage (for mother and newborn) (target: 90 percent)
7. Prevalence of anemia during pregnancy (target: 35 percent)
8. Prevalence of low birth weight (target: 5 percent)
9. Modern contraceptives coverage in fertile couple (target: 70 percent)
10. Contraceptive coverage for men (target: 8 percent)
11. Prevalence of pregnancy with four conditions (too young, too old, too many kids, too close distance between kids (target: 50 percent from 1997 data)
12. Reduction in contraceptive complications (target: all cases are treated)
13. Reduction in contraceptive drop out cases (target: no drop out cases)
14. Prevalence of gonorrhea in high-risk group (target: 10 percent)
15. Prevalence of HIV in high-risk group (target: 1 percent)
16. Prevalence of anemia in teenagers (target: 20 percent)
17. Coverage of reproductive health services for teenagers (target: 85 percent through school and 20 percent outside school)

Minimum Service Standards at Hospitals (MOH Decree 129/2008, complemented by Hospital MSS Guidelines 2012)

No	Type of Service	No	Indicator	Standard
1	Emergency	1	Ability to manage life saving procedure on children and adults	100%
		2	Opening hours	24 hours
		3	Certified emergency care professionals	100%
		4	Disaster rescue time	1 team
		5	Time to treat since patient arrives	≤5 min
		6	Consumer's satisfaction	≥70%
		7	Patient's death in <24 hours	≤2 per 1,000 (move to inpatient after 8 hours)
		8	Patient is stabilized in ≤48 hours (for mental health patient)	100%
		9	Patient is not mandatory for down payment	100%
2	Outpatient	1	Physician providing care at specialized clinic	100% specialists
		2	Services provided	a. Pediatric b. Internal medicine c. Obstetric d. Surgery
		3	Services provided in mental hospital	a. Teenager b. Narcotics, psychotropics, and addictive substances c. Neurotics d. Mental retardation e. Mental organic f. Elderly
		4	Opening hours	Monday to Thursday 08.00–13.00 Friday 08.00–11.00
		5	Waiting time	≤60 minutes
		6	Consumer's satisfaction	≥90%
		7a	TB diagnosis (microscopic)	≥60%
		7b	TB reporting	≥60%

No	Type of Service	No	Indicator	Standard
3	Inpatient	1	Service providers	a. Specialists b. Nurse (D3 minimum)
		2	Physician responsible for inpatient	100%
		3	Services provided	a. Pediatric b. Internal medicine c. Obstetric d. Surgery
		4	Physician visit schedule	Everyday 08.00-14.00
		5	Postsurgical infection	≤1.5%
		6	Nosocomial infection	≤1.5%
		7	No fall causing disability/death	100%
		8	Death >48 hours	≤0.24%
		9	Forced discharge (by patient)	≤5%
		10	Consumer's satisfaction	≥90%
		11a	TB diagnosis (microscopic)	≥60%
		11b	TB reporting	≥60%
		12	Services provided in mental hospital	a. Narcotics, psychotropics, and addictive substances b. Psychotics c. Neurotics d. Mental organic
		13	No suicidal mental patient	100%
		14	Re-admission of mental patient in ≤1 month	100%
		15	Average length of stay for mental patient	≤6 weeks
4	Surgical	1	Waiting time for elective surgery	≤2 days
		2	Death on operation table	≥1 %
		3	No operation error (wrong side)	100%
		4	No operation error (wrong patient)	100%
		5	No operation error (wrong procedure)	100%
		6	No operation error (left tools)	100%
		7	Anesthetic complication (overdose, anesthetic reaction, missed place ETT)	≤6%

No	Type of Service	No	Indicator	Standard
5	Delivery and perinatology	1	Maternal death due to labor	a. Hemorrhage ≤1% b. Pre-eclampsia ≤30% c. Sepsis ≤0.2%
		2	Normal labor service providers	a. Obstetrician b. Trained GP c. Midwife
		3	Complicated labor service providers	Trained CEmONC team
		4	Labor with surgery service providers	a. Obstetrician b. Pediatrician c. Anesthesiologist
		5	Ability to manage low birth weight (1,500-2,500g)	100%
		6	C-section	≤20%
		7a	Percent of FP (vasectomy and tubectomy) by professional (obstetrician, surgeon, urologist, trained GP)	100%
		7b	Percent of permanent FP receiving FP counseling from trained midwife	100%
		8	Consumer's satisfaction	≥80%
6	Intensive care	1	Average of returning patient with similar case in <72 hours	≤3%
		2	Care service providers	a. Anesthesiologist and respective specialist b. 100% nurse (minimum D2) with ICU certification or equal (D4)
7	Radiology	1	Waiting time for CXR result	≤3 hours
		2	Expert	Radiologist
		3	Radiologic error	Photo damage ≤2 %
		4	Consumer's satisfaction	≥80%
8	Clinical pathology lab	1	Waiting time for lab result	≤140 minutes (routine and chemistry blood workup)
		2	Expert	Clinical pathologist
		3	No reading error	100%
		4	Consumer's satisfaction	≥80%
9	Medical rehabilitation	1	Dropped out event for planned medical rehabilitation	≤50%
		2	No error in procedure	100%
		3	Consumer's satisfaction	≥80%

No	Type of Service	No	Indicator	Standard
10	Pharmaceutical	1a	Waiting time for generic/branded drug	≥30 minutes
		1b	Waiting time for prepared drug	≤60 minutes
		2	No error in drug dispensing	100%
		3	Consumer's satisfaction	≥80%
		4	Prescription according to formularium	100%
11	Nutrition	1	Timely feeding schedule	≥90%
		2	Left over food not consumed by patient	≤20%
		3	No error in providing diet	100%
12	Blood transfusion	1	Demand for blood met	100%
		2	Tranfusion reaction	≤0.01%
13	Services for the poor		Poor patient treated	100%
14	Medical records	1	Completed MR after service	100%
		2	Informed consent after thorough information	100%
		3	Availability of medical record for outpatient	≤10 minutes
		4	Availability of medical record for inpatient	≤15 minutes
15	Waste management	1	Standard for liquid waste	a. BOD <30 mg/l b. COD <80 mg/l c. TSS <30mg/l d. pH 6-9
		2	Management of infectious solid waste according to standard	100%
16	Administration management	1	Follow up after board of directors' meeting	100%
		2	Complete acountability report	100%
		3	Timely staff related administration	100%
		4	Timely salary	100%
		5	Employees receiving minimum 20 hours training per year	≥60%
		6	Cost recovery	≥40%
		7	Timely financial report	100%
		8	Time to provide information on patient's inpatient billing	≤2 hours
		9	Timely incentive	100%

No	Type of Service	No	Indicator	Standard
17	Ambulance and hearse transport	1	Service hours	24 hours
		2	Time to provide service	≤230 minutes
		3	Response time when needed	According to local regulation (unspecified)
18	Memorial (cleansing)		Response time	≤2 hours
19	Hospital facility care	1	Response time to handle broken equipment	≤80%
		2	Timely equipment service	100%
		3	Lab and measurement tools are calibrated	100%
20	Laundry	1	No missing linen	100%
		2	Timely available linen for inpatient	100%
21	Infection prevention and control	1	Availability of trained team	75% team member is trained
		2	Availability of personal protective equipments in every unit	60%
		3	Reporting of health care associated infection (nosocomial)	75%
22	Safety	1	Certified security officers	100%
		2	Security system	Available
		3	Monitory by security officers	Every hour
		4	Security system evaluation	Every three months
		5	No lost items	100%
		6	Consumer's satisfaction	≥90%

Services provided by JKN (National Health Insurance) (Presidential Reg 12/2013; BPJS-K 1/2014)

Services are provided by BPJS-contracted facilities. Services provided by facilities contracted elsewhere will only be covered under emergency circumstances.

Primary care level

Primary care level services cover non-specialized services:

a. Administrative services
b. Health promotion and prevention
c. Check-ups, drugs, and medical consultations
d. Non-specialized medical procedures (surgical and non-surgical)
e. Drugs and medical supplies
f. Blood transfusion
g. Diagnostic lab/radiologic service
h. Inpatient service

Referral care level

Referral care services cover outpatient and inpatient services:

a. Administrative services
b. Check-ups, drugs, specialized consultations provided by specialists and sub-specialists
c. Specialized medical procedures (surgical and non-surgical)
d. Drugs and medical supplies
e. Diagnostic lab/radiologic service
f. Medical rehabilitation
g. Blood transfusion
h. Clinical forensics
i. Memorial services (coffin and hearse not included)
j. Non-intensive care inpatient service
k. Intensive care service

Delivery service

Delivery service covers up to third pregnancy.

Ambulance

Ambulatory service is provided to transport patients from one facility to another.

Allocation of capitation transferred to Puskesmas (MOH Reg 19/2014)

A minimum 60 percent is allocated for incentives and maximum 40 percent for operational costs. Operational costs cover:

a. Drugs, medical equipment, and medical supplies
b. Other operational health costs
    i. Individual health services (health promotion, preventive, curative, and rehabilitative services)
    ii. Home visits related to individual health services
    iii. Operational cost for mobile Puskesmas
    iv. Office supplies and printing
    v. Financial administration and information system

ANNEX B. COMPARISON BETWEEN THE EPHS AND THE PRIORITY RMNCH SERVICES

	RMNCH Essential Interventions	Service Included in EPHS	Source and Additional Notes
Adolescence and pre-pregnancy	**Level: Community Primary Referral**		
	Family planning (advice, hormonal and barrier methods)	Yes	Only for people who are engaged and married. Source: *UU 52/2009 Section 21*
	Prevent and manage sexually transmitted infections, HIV	Yes	Source: *Technical Guidelines on BOK by MOH (2015)*
	Folic acid fortification/supplementation to prevent neural tube defects	No	Implicitly excluded
	Level: Primary and Referral		
	Family planning (hormonal, barrier and selected surgical methods)	Yes	Only for people who are engaged and married. Source: *UU 52/2009 Section 21*
	Level: Referral		
	Family planning (surgical methods)	Yes	Only for people who are engaged and married. Source: *UU 52/2009 Section 21*
Pregnancy (antenatal)	**Level: Community Primary Referral**		
	Iron and folic acid supplementation	Yes	Source: *Minimum Service Standards by MOH (2008); Technical guidelines on BOK by MOH (2015); Technical guidelines on MCH by MOH (2015)*
	Tetanus vaccination	Yes	Source: *Minimum Service Standards by MOH (2008); Technical guidelines on BOK by MOH (2015); Technical guidelines on MCH by MOH (2015)*
	Prevention and management of malaria with insecticide treated nets and antimalarial medicines	Yes	Source: *Minimum Service Standards by MOH (2008); Technical guidelines on BOK by MOH (2015); Technical guidelines on MCH by MOH (2015)*
	Prevention and management of sexually transmitted infections and HIV, including with antiretroviral medicines	Yes	Source: *Minimum Service Standards by MOH (2008); Technical guidelines on BOK by MOH (2015); Technical guidelines on MCH by MOH (2015)*
	Calcium supplementation to prevent hypertension (high blood pressure)	Yes	Hypertension management in pregnant women covers more comprehensive approach, not just calcium. Source: *Pocket book of nutritional guideline in*

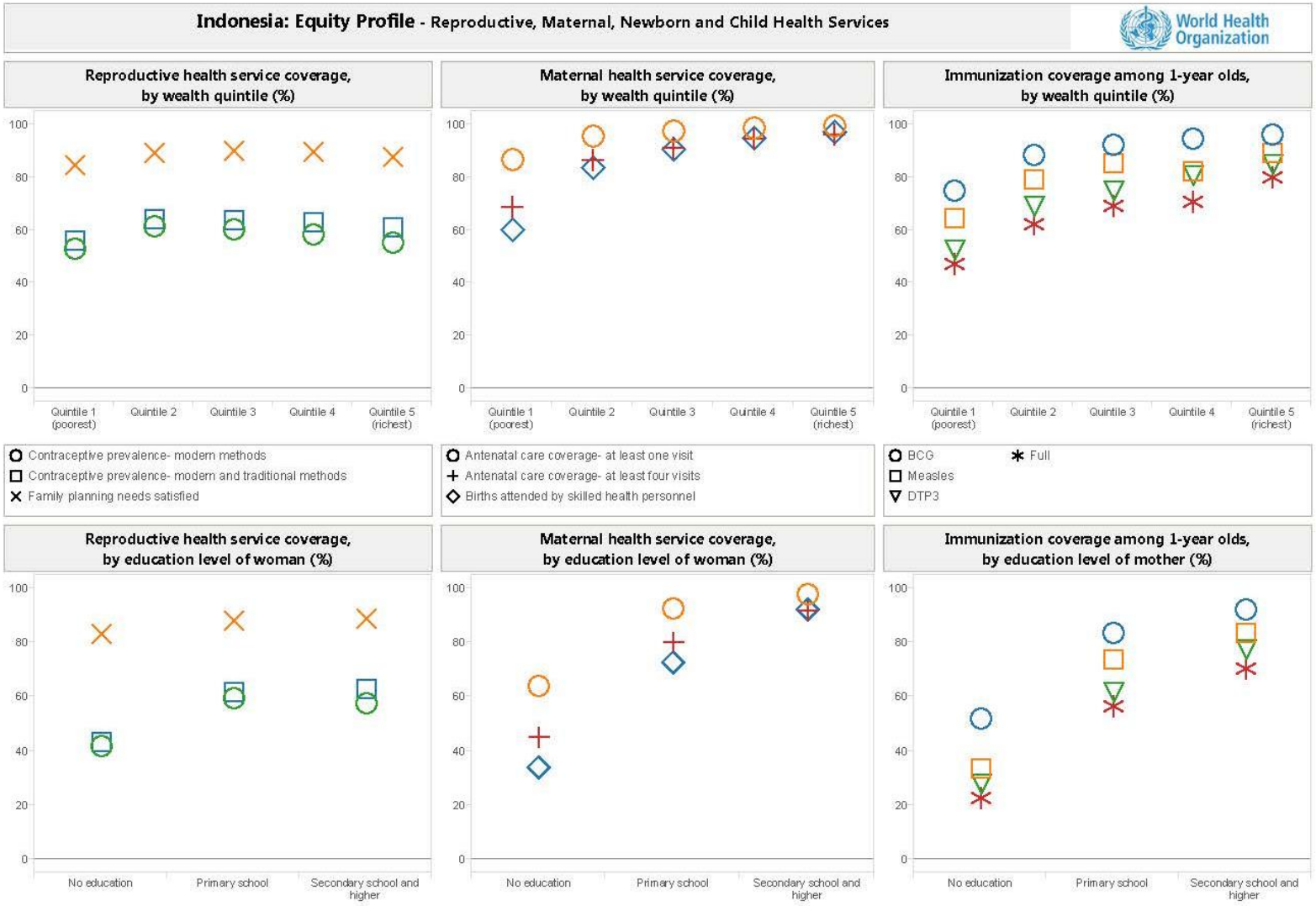
	RMNCH Essential Interventions	Service Included in EPHS	Source and Additional Notes
			Puskemas; BEmONC 2013 guideline
	Interventions for cessation of smoking	Unspecified	This service was not specified in reviewed documents and is not related to other included services and interventions. It is implicitly included. Not smoking inside the house and in public places is one of indicators for health promotion program PHBS (healthy and clean life style) by MOH.
	Level: Primary and Referral		
	Screening for and treatment of syphilis	Yes	Part of 14T ANC program in Puskesmas. IMS (inc syphilis) test is compulsory. Since 2007, MOH has Working Group for HIV/AIDS and IMS. Source: *MOH regulation 51/2013 on PMTCT*
	Low-dose aspirin to prevent pre-eclampsia	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Anti-hypertensive drugs (to treat high blood pressure)	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Magnesium sulphate for eclampsia	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Antibiotics for preterm prelabour rupture of membranes	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Corticosteroids to prevent respiratory distress syndrome in preterm babies	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Safe abortion	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Post abortion care	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Level: Referral		
	Reduce malpresentation at term with External Cephalic Version	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Induction of labour to manage prelabour rupture of membranes at term (initiate labour)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*

	RMNCH Essential Interventions	Service Included in EPHS	Source and Additional Notes
Childbirth	**Level: Community Primary Referral**		
	Prophylactic uterotonics to prevent postpartum haemorrhage (excessive bleeding after birth)	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007)*
	Manage postpartum haemorrhage using uterine massage and uterotonics	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007)*
	Social support during childbirth	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007)*
	Level: Primary and Referral		
	Active management of third stage of labour (to deliver the placenta) to prevent postpartum haemorrhage (*as above plus controlled cord traction)*	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Management of postpartum haemorrhage (as above plus manual removal of placenta)	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Screen and manage HIV (if not already tested)	Yes	HIV test is compulsory to offer, if patient refuses, then health care professional counsels or refers to counseling service or VCT service. Since 2007, MOH has Working Group for HIV/AIDS and IMS. HIV test is covered under JKN and drug is given by government. Source: Minimum Service Standards by MOH (2008); *MOH regulation 51/2013 on PMTCT*
	Level: Referral		
	Caesarean section for maternal/foetal indication (to save the life of the mother/baby)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Prophylactic antibiotic for caesarean section	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Induction of labour for prolonged pregnancy (initiate labour)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Management of postpartum haemorrhage *(as above plus surgical procedures)*	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
Postnatal (Mother)	**Level: Community Primary Referral**		
	Family planning advice and contraceptives	Yes	Source: *Minimum Service Standards by MOH (2008; Technical guidelines on MCH by MOH (2015)*
	Nutrition counselling	Yes	Source: *Minimum Service Standards by MOH (2008; Technical guidelines on MCH by MOH (2015)*
	Level: Primary and Referral		

	RMNCH Essential Interventions	Service Included in EPHS	Source and Additional Notes
	Screen for and initiate or continue antiretroviral therapy for HIV	Yes	HIV test is covered under JKN and drug is given by government. Source: *Technical guidelines on MCH by MOH (2015); Minimum Service Standards by MOH (2008)*
	Treat maternal anaemia	Yes	Source: *Minimum Service Standards by MOH (2008); Technical guidelines on MCH by MOH (2015)*
	Level: Referral		
	Detect and manage postpartum sepsis (serious infections after birth)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
Postnatal (Newborn)	**Level: Community Primary Referral**		
	Immediate thermal care (to keep the baby warm)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Initiation of early breastfeeding (within the first hour)	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Hygienic cord and skin care	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Level: Primary and Referral		
	Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth)	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Kangaroo mother care for preterm (premature) and for less than 2000g babies	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Extra support for feeding small and preterm babies	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Management of newborns with jaundice ("yellow" newborns)	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Initiate prophylactic antiretroviral therapy for babies exposed to HIV	Yes	Source: *Minimum Service Standards by MOH (2008); BEmONC guideline (2007) and CEmONC guideline (2006)*
	Level: Referral		
	Presumptive antibiotic therapy for newborns at risk of bacterial infection	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*
	Case management of neonatal sepsis, meningitis and pneumonia	Yes	Source: *Minimum Service Standards by MOH (2008); CEmONC guideline (2006)*

	RMNCH Essential Interventions	Service Included in EPHS	Source and Additional Notes
Infancy and Childhood	**Level: Community Primary Referral**		
	Exclusive breastfeeding for 6 months	Yes	Source: *MOH regulation 450/MENKES/SK/IV/2004 on exclusive breastfeeding; MOH regulation 75/2014*
	Continued breastfeeding and complementary feeding from 6 months	Yes	Source: *MOH regulation 450/MENKES/SK/IV/2004 on exclusive breastfeeding; Source: MOH regulation 224/MENKES/SK/II/2007 on specification of complementary feeding; MOH regulation 75/2014*
	Prevention and case management of childhood malaria	Yes	Source: *MTBS (Integrated management for the sick under five) 2011; MOH regulation 75/2014*
	Vitamin A supplementation from 6 months of age	Yes	Source: *MTBS (Integrated management for the sick under five) 2011*
	Routine immunization plus *H.influenzae*, meningococcal, pneumococcal and rotavirus vaccines	No	Explicitly excluded. 5 free immunization by government: Hepatitis B, BCG, Polio, DPT-HB-Hib, and measles. Other vaccines are available upon request.
	Management of severe acute malnutrition	Yes	Source: *Minimum Service Standards by MOH (2008); MTBS (Integrated management for the sick under five) 2011*
	Case management of childhood pneumonia	Yes	Source: *Minimum Service Standards by MOH (2008); MTBS (Integrated management for the sick under five) 2011*
	Case management of diarrhoea	Yes	Source: *Minimum Service Standards by MOH (2008); MTBS (Integrated management for the sick under five) 2011*
	Level: Primary and Referral		
	Comprehensive care of children infected with, or exposed to, HIV	Yes	HIV test is covered under JKN and drug is provided by government.
	Level: Referral		
	Case management of meningitis	Yes	
Across the continuum of care	**Level: Community Strategies**		
	Home visits for women and children across the continuum of care	Yes	Source: *Minimum Service Standards by MOH (2008);Technical guidelines on BOK by MOH (2015)*
	Women's groups	Yes	Cadre at the village. Puskesmas and its networks empower these groups to partake in community health services. Source: *Minimum Service Standards by MOH (2008); MOH regulation 75/2014*

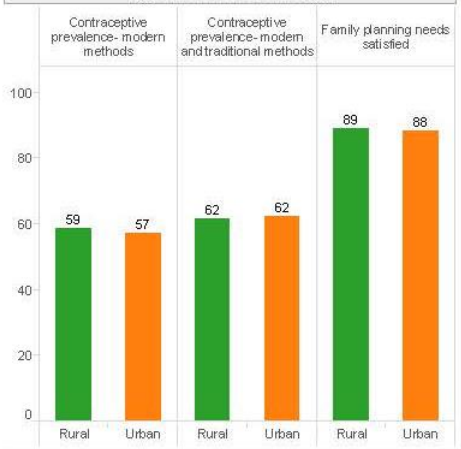
ANNEX C. INDONESIA HEALTH EQUITY PROFILE



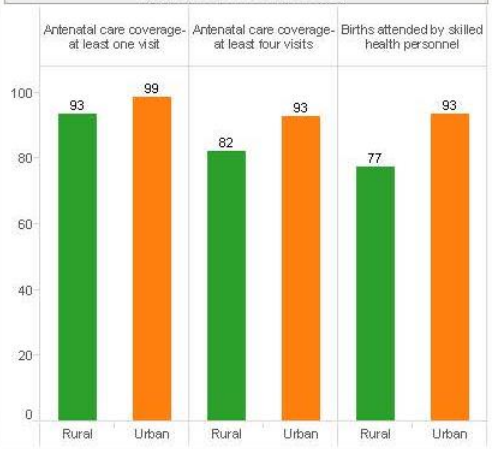
Indonesia: Equity Profile - Reproductive, Maternal, Newborn and Child Health Services

World Health Organization

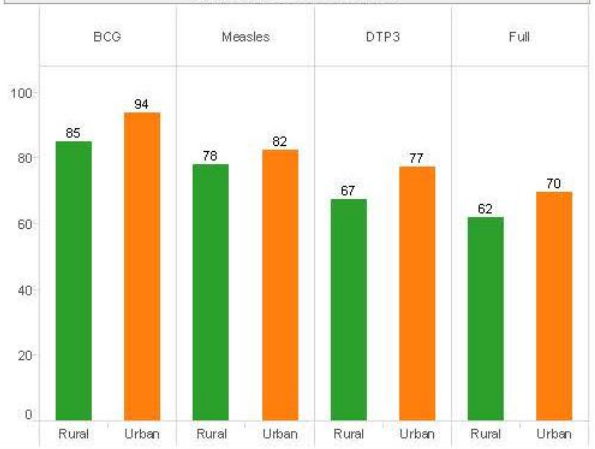
Reproductive health service coverage, by place of residence (%)



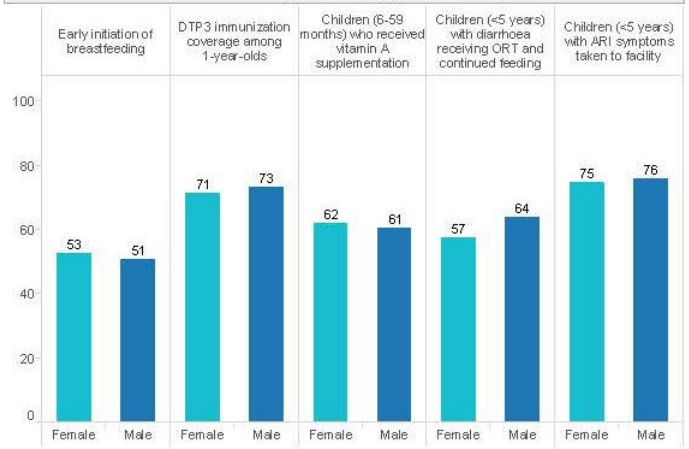
Maternal health service coverage, by place of residence (%)



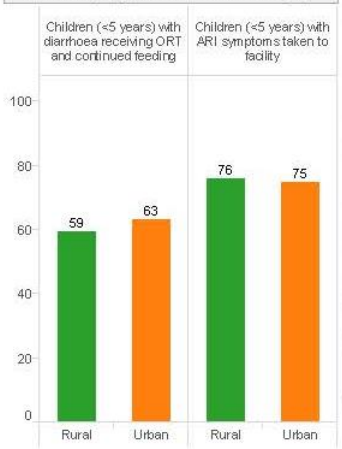
Immunization coverage among 1-year olds, by place of residence (%)



Health service and healthy behaviour coverage, by child sex (%)



Health service coverage among sick children, by place of residence (%)



Health service and healthy behaviour coverage (%)

Contraceptive prevalence- modern methods	58
Contraceptive prevalence- modern and traditional methods	62
Family planning needs satisfied	89
Antenatal care coverage- at least one visit	96
Antenatal care coverage- at least four visits	87
Births attended by skilled health personnel	85
Early initiation of breastfeeding	52
BCG immunization coverage among 1-year-olds	89
Measles immunization coverage among 1-year-olds	80
DTP3 immunization coverage among 1-year-olds	72
Full immunization coverage among 1-year-olds	66
Children (6-59 months) who received vitamin A supplementation	61
Children (<5 yrs) with diarrhoea receiving ORT and continued feeding	61
Children (<5 yrs) with ARI symptoms taken to facility	75

Source: DHS 2012

Antenatal care coverage at least 1 visit, antenatal care coverage at least 4 visits, births attended by skilled health personnel, and early initiation of breastfeeding are based on data from the five years prior to survey.

For more information, please see Global Health Observatory "Health Equity Monitor" page: www.who.int/gho/health_equity/en/index.html

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