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NEONATAL CARE MANAGEMENT AT PRIMARY HEALTH CENTERS (PUSKESMAS) WITH HIGH AND LOW COVERAGE OF MANAGED NEONATAL COMPLICATIONS IN CENTRAL BUTON REGENCY

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Abstract

Neonatal Health Services Play A Crucial Role In Reducing The Infant Mortality Rate (IMR), particularly through the effective management of neonatal complications. However, differences in the coverage of managed neonatal complications among puskesmas in Central Buton Regency indicate variations in resource readiness and service management. This study aims to describe and compare neonatal care management at community health centers with high and low coverage of managed neonatal complications in Central Buton Regency. The study design is qualitative descriptive. Data collection was conducted through in-depth interviews and observations of 11 informants, consisting of two community health center directors, two midwife coordinators, two village midwives, one family health staff member at the Health Office, and four mothers with infants aged 1–3 months. Data analysis utilized content *analysis*. The results indicated differences in the readiness of infrastructure and the implementation of management functions between the two community health centers. The community health center with high coverage had relatively more adequate infrastructure, routine planning, direct mobilization of health workers, and supervision through monitoring of midwives' performance. Conversely, the community health center with low coverage had inadequate infrastructure and facilities, irregular planning, indirect mobilization of personnel, and supervision that focused more on reviewing reports without structured corrective actions. At the district level, there were no specific policies, plans, or organizational structures in place for neonatal care. This study concludes that differences in the coverage of managed neonatal complications are related to the readiness of facilities and infrastructure as well as the quality of management functions. Therefore, strengthening neonatal care facilities and infrastructure, developing specific policies and standard operating procedures, and implementing supportive supervision are necessary to improve the quality of neonatal care.
Keywords: Management, Neonatal Care, Community Health Centers, Coverage of Neonatal Complications.

INTRODUCTION

The Infant Mortality Rate (IMR) is one of the key indicators for assessing the level of public health in a region. The 2023–2024 Indonesia Demographic and Health Survey (IDHS) recorded a Neonatal Mortality Rate of 7 per 1,000 live births and an Infant Mortality Rate of 13 per 1,000 live births, down from 15 and 24, respectively (BRIN, 2025). These figures are already below the 2030 SDG target for the Neonatal Mortality Rate—12 per 1,000 live births—and below the targets set in the 2020–2024 National Medium-Term Development Plan (RPJMN), namely a Neonatal Mortality Rate of 10 and an Infant Mortality Rate of 16 per 1,000 live births (Directorate of Public Health and Nutrition, Bappenas, 2025). Nevertheless, neonatal mortality remains a critical issue because, globally, nearly half of all under-five deaths occur within the first 28 days of life (UN IGME, 2025), and national figures do not automatically reflect conditions in every region. Several studies based on the 2017 SDKI data indicate that birth weight, *antenatal care*, maternal age, and multiple births are associated with neonatal and infant mortality (Asiah et al., 2021). To reduce neonatal mortality, the government issued Ministry of Health Regulation No. 53 of 2014 on Essential Neonatal Health Services. These services aim to detect abnormalities in infants as early as possible. They are provided by competent health workers and include care during the first 0–6 hours, as well as a minimum of three neonatal visits between 6 hours and 28 days of age (Indonesian Ministry of Health, 2014). The Health Office of Central Buton Regency ( ) is responsible for implementing the program, while community health centers (puskesmas) serve as the operational providers of neonatal care. As of 2025, Central Buton Regency has 14 community health centers (puskesmas) serving a population of 93,742 (Central Buton Health Profile, 2025). The rates of the first neonatal visit (KN1) and complete neonatal visits (KN lengkap) during 2023–2025 show a downward trend. KN1 decreased from 109.9% (2023) to 109.3% (2024) and 100% (2025), while KN Complete decreased from 107.6% to 105.5% and 97.1% over the same period (Central Buton Health Profile, 2025). This decline highlights the need to evaluate the continuity of neonatal care, particularly to ensure that every newborn receives visits in accordance with standards. This situation serves as the basis for examining factors related to the management of neonatal care in Central Buton Regency, especially in improving the coverage of comprehensive neonatal care.

METHOD

This study is a qualitative descriptive study. Data collection was conducted through *in-depth interviews* and observations. The study was conducted at community health centers (Puskesmas) with the highest and lowest coverage rates for managed neonatal complications. The primary informants were 2 community health center directors, 2 midwife coordinators, and 2 village midwives. Triangulation informants included the head of the family health section and 4 mothers with infants aged 1–3 months. Data analysis was performed using *content analysis*.

RESULTS AND DISCUSSION

1. INPUT

a. Facilities and Infrastructure

The results of the observation revealed differences in neonatal care facilities and equipment between the two community health centers. The high-coverage community health center has a delivery room measuring approximately 20 m². Medications such as antibiotic eye ointment and Vitamin K1 are available in the delivery room cabinet. The equipment is sterile and well-organized, and the midwives also have personal equipment such as stethoscopes and infant thermometers. The only shortcoming at this health center is the lack of a light that also serves as a baby warmer. The low-coverage health center does not yet have adequate facilities and infrastructure. The delivery room is cramped (16 m²) and does not meet the standard of 4 m² of workspace per staff member as stipulated in Ministry of Health Regulation No. 48 of 2016, Article 21. The lighting and infant warmer are not functioning; the resuscitation table is used to store delivery equipment and supplies; and clean water, soap, and dry towels are not available. Vitamin K1 and antibiotic eye ointment were not present in the delivery room because they were still stored in the pharmacy warehouse. At both community health centers, equipment and supplies were provided by the Health Office; however, quantities remained insufficient, and requests for equipment were difficult to fulfill because they were submitted only once a year. Triangulation informants stated that neonatal equipment is still combined with delivery equipment. Facilities and infrastructure are determining factors for the success and smooth operation of a program. Facilities and infrastructure are also crucial for program implementation; a program will not succeed without adequate support from facilities and infrastructure (Azizah N, 2025).

Table 1. Differences in Observation Results Regarding Facilities and Infrastructure for Neonatal Care Management at High- and Low-Coverage Community Health Centers

No	Type of Equipment/Materials	High-Coverage Community Health Center		Low-Coverage Community Health Center	
		Available		Available	
		YES	NO	YES	NO
1.	Newborn Form	√		√	
2.	Partograph	√		√	

3.	Infant Cohort Registry	√		√	
4.	Lights that provide illumination and warmth		√		√
5.	Resuscitation table	√		√	
6.	Clean water	√		√	
7.	Soap	√			√
8.	A dry, warm towel	√			√
9.	Clean gloves	√		√	
10.	Clean cloth	√			√
11.	Stethoscope	√		√	
12.	Clock with a second hand	√		√	
13.	Thermometer	√		√	
14.	Baby scale	√		√	
15.	Baby growth chart	√		√	
16.	Head Circumference Measurer	√		√	
17.	Umbilical cord scissors	√		√	
18.	Umbilical cord thread or plastic clamp	√		√	
19.	2 Kelly clamps or Kocher clamps	√		√	
20.	Vitamin K1	√		√	
21.	Hepatitis B Vaccination	√		√	
22.	Antibiotic eye ointment	√			√

2. PROCESS

a. Planning

Planning for neonatal services at both community health centers involves the community health center director, the coordinating midwife (who is responsible for the Maternal and Child Health [MCH] program), and the village midwife. At the district level, planning involves the Head of the Health Office, the Head of the Family Health Division, and staff from the MCH section. Planning is carried out through meetings or mini-workshops at the community health centers and through monitoring and evaluation (M&E) at the Health Office. At the high-coverage health center, planning is conducted frequently and routinely every month. The established target is for infants aged 0–28 days to be visited at least three times. At the low-

coverage health center, planning is rarely conducted and is not done routinely every month. Planning documents at both health centers are included in the Action Plan (*Plan of Action*), while the District Health Office has not yet developed a specific plan for neonatal care. Regarding procedure development, there have been no efforts to develop Standard Operating Procedures (SOPs) at either of the " " health centers because SOPs are already available, although they are still combined with delivery SOPs. The Health Department has also not pursued this, as it assumes that each health center already has SOPs for accreditation. From a policy perspective, there are no local government policies—whether in the form of written regulations or specific policies—for neonatal care. Triangulation informants from the Family Health Staff stated that policies for the Maternal and Child Health (MCH) program are currently still being drafted. Policies are binding and must be implemented by those subject to them; thus, their absence leaves neonatal care without a strong foundation for implementation.

b. Organization

At both community health centers, working groups have been formed in each village consisting of midwives with civil servant (PNS) status and midwives with government employee under a work contract (PPPK) status, primarily for newborn home visits. The working groups were organized based on the midwives' educational backgrounds and employment statuses. Tasks were divided so that each village midwife has a partner for neonatal home visits. Coordination is conducted by telephone, specifically when the coordinating midwife or the person in charge of maternal and child health (KIA) requests a village midwife to conduct a home visit for a newborn. At the district level, the Health Office has not yet formed a working group or organized specific coordination for neonatal care at community health centers. Effective organization requires an organizational structure with specific division of labor, clear reporting lines, and accountability (Ginter et al., 2002). Coordination via telephone has been helpful in facilitating home visits, but it is not yet supported by a written division of tasks or the supervisory role of the District Health Office; consequently, reporting lines and accountability remain unguaranteed. This situation aligns with findings that enhancing the capabilities of village midwives in conducting neonatal home visits still requires effective supervision (Magfirah et al., 2021). Therefore, community health centers and the Department of Health need to establish written task assignments (e.g., via an official decision letter), standardized neonatal home visit procedures, as well as mechanisms for tiered supervision and reporting.

c. Mobilization

The coordination of neonatal services at the two community health centers differed in form, actors, and frequency. At the community health center with high coverage, the center director and the coordinating midwife jointly provided motivation and guidance through ad hoc meetings and mini-workshops (lokmin)

that discussed the achievement of monthly neonatal targets. These lokmin were routinely held toward the end of the month. After the meetings, the midwives were further encouraged to meet the targets. If problems arise, the health center director immediately convenes a meeting and proposes solutions. At health centers with low coverage, mobilization is carried out only by the health center director and is indirect in nature—that is, through a WhatsApp group toward the end of the month and during lokmin sessions. Motivation and guidance are rarely provided, and new directives emerge only when neonatal issues arise. Midwives stated that they are already aware of their respective duties and therefore work based on their own initiative. The Health Department provides motivation and guidance only during the six-monthly monitoring and evaluation sessions. Triangulation with mothers of infants revealed a gap between the midwives' statements and actual field practices. Some mothers at health centers with low coverage expressed dissatisfaction because midwives with shorter tenure examined their babies in a rushed manner—service was limited to cutting the umbilical cord and swaddling the baby. Lokmin is a mechanism for mobilization and implementation in community health center management s (Indonesian Ministry of Health, 2004, 2016). Differences in the intensity and format of mini-workshops between the two community health centers indicate that this mechanism has not been utilized equally. At the health center with low coverage, the midwives' individual awareness was insufficient to ensure service quality without direct guidance and supervision, as evidenced by the mothers' complaints. In health care, managers play a role in providing guidance, establishing effective communication, resolving conflicts, and creating a work environment that supports quality service [Nurul et al., 2026]. The leadership style of community health center directors has also been reported to be associated with the motivation and performance of health workers (Darmin et al., 2024). Therefore, strengthening routine mini-workshops, two-way communication, and more frequent guidance from the Department of Health—more often than once every six months—has the potential to improve the delivery of neonatal care.

d. Supervision

At health centers with high coverage, supervision is conducted directly by the health center director while on-site, specifically by observing midwives' performance. Coordinator midwives also frequently inquire about neonatal visit targets with village midwives. Additionally, supervision is carried out through monitoring of monthly target reports. At health centers with low coverage, supervision consists only of reviewing monthly reports in the middle and at the end of the month, without direct observation of midwives' performance. Issues identified are discussed at monthly mini-workshops. At the Department of Health level, supervision involves reviewing reports every quarter, which are discussed during monitoring and evaluation sessions held twice a year. Follow-up measures consist of warnings or verbal reprimands issued to community health centers that fail to meet their targets. A similar pattern occurs at the community

health center level, where warnings are issued to village midwives and midwives with PPPK status to ensure they meet targets in the next period. These follow-up actions have not yet become part of a structured problem-solving process. Ideally, supervisors should not only assess but also guide staff during the evaluation process so that they understand the causes of problems and can develop solutions. A collaborative approach to supervision has been reported to boost the confidence of health workers and improve service delivery (Malatji et al., 2022). Supervision that merely reviews reports does not include investigating the reasons for deviations or implementing corrective actions. Findings in Tanzania indicate that the effectiveness of supervision of maternal and newborn care is hampered by unclear supervision policies and limited progress measurement (Nyamhanga et al., 2021). These conditions may be linked to low rates of neonatal complication management at health centers with low coverage.

CONCLUSION

This study concluded that the difference in the coverage of managed neonatal complications between the two community health centers was related to the readiness of facilities and infrastructure and management functions. The community health center with high coverage had nearly complete facilities, routine planning, direct mobilization, and supervision that monitored midwives' performance. The health center with low coverage had inadequate facilities, irregular planning, indirect coordination, and supervision that merely reviewed reports without taking corrective action. At the district level, neonatal services lack specific policies, planning, and organizational structures. Theoretically, these findings enrich the study of public service management by demonstrating that the readiness of infrastructure must be accompanied by sound management to ensure optimal service delivery. This aligns with the service quality framework, which posits that a sound structure increases the likelihood of sound " " processes, and sound processes increase the likelihood of sound outcomes. Practically, these findings serve as a basis for community health centers and health departments to enhance neonatal facilities, develop standard operating procedures (SOPs) and specific policies for neonatal care, and implement supportive supervision that includes direct observation, root cause analysis, and corrective actions (Malatji et al., 2022; Nyamhanga et al., 2021). This study was conducted at two community health centers in a single district using a qualitative design. Consequently, the findings are contextual in nature and are not intended to be statistically generalized. Their application in other settings depends on contextual similarity, a concept known as transferability in qualitative research (Wahyudi, I., & Handiyani, H., 2023). This study also cannot yet demonstrate a cause-and-effect relationship. Further research is recommended using a quantitative or mixed-methods design at a larger number of community health centers, as well as intervention studies to test the effectiveness of strengthening supervision.

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