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PREFACE

Since the Millennium Summit in 2000, the governments of the world produced a renewed commitment and focus to attain major targets, through the Millennium Development Goals, intended to make the world a better place to live in. Almost a decade later, we see progress in achieving these goals. Some goals are more easily than others. But some goals lack the political drive that it inherently deserves. The issue of maternal and child mortality, or MDG 4 and 5 are a few of those goals that could have been more readily resolved but due to one reason or another, continue to plague nations.

It is with this backdrop that during the 62nd Session of the United Nations General Assembly in New York, the President of the Republic of Indonesia, Susilo Bambang Yudhoyono, together with the Prime Minister of Norway, Jens Stoltenberg and a number of other leaders launched this global call to address MDG4 and 5. Through a group of Sherpa network of Leaders, discussions were made to bring greater application to ensure the 2015 targets for MDG 4 and 5 be attainable. The first meeting of the Sherpa was held in Oslo, Norway in December 2007 and after discussions in Bali, both leaders agreed to host the second meeting of Sherpa in Indonesia in June 2008.

In preparation for this meeting, I have brought together relevant officials of the Indonesian Government and also experts in the field from civil society, NGOs and also international organizations to compile a brief country paper on attaining MDG 4 and 5. Its content, although reflective of Indonesia's situation dares to provide a solution that may be applicable not only to the majority of developing countries, but also specific to the needs of Small Island Developing States (SIDS).

It is my fervent hope that Indonesia may contribute significantly to the global endeavour that ensures MDG 4 and 5 be attained by 2015.

Emil Salim

CHAPTER I THE CURRENT SITUATION ON MDG 4 AND 5 IN INDONESIA

The Millennium Development Goals

Goal 4 Reduce Child Mortality by two-thirds between 1990 and 2015

Indicators: Infant Mortality Rate

Under-5 Mortality Rate

Percent of Children aged 12-23 Months who Received Measles Vaccines

Goal 5 Reduce Maternal Mortality by three-quarters between 1990 and 2015

Indicators: Maternal Mortality Ratio

Delivery by Skilled Health Personnel

Contraceptive Prevalence Rate

Current Profile of Childhood Mortality (MDG 4)

The Level of infant mortality (before the first birth day) in 2007 according to Indonesia Demographic and Health Survey (IDHS) 2007 was 34 per 1000 live births while the under-5 mortality (before the fifth birth days) during the same period of time was 44 per 1000 live births. More than three-fourths of all deaths occurred during the first year of the child's life. In turn, the majority of infant deaths occurred during neonatal period.

The decline in infant and under-5 mortality has slowed down in recent years, as is the case of populations with low mortality rates (*Figure-1*). There is also a high infant and under-5 mortality differential across the provinces. According to IDHS 2007, 26 out of 33 provinces still possess

levels of infant and under-5 mortality above national levels (*Figure-2*). The highest infant and under-5 mortality being in West Sulawesi (74 per 1,000 live births and 96 per 1,000 person under-5).

Figure 1 Trends in Early Childhood Mortality Rates, 1991-2007

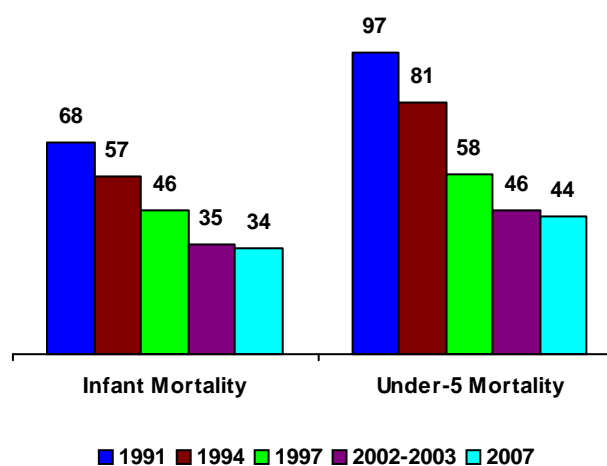
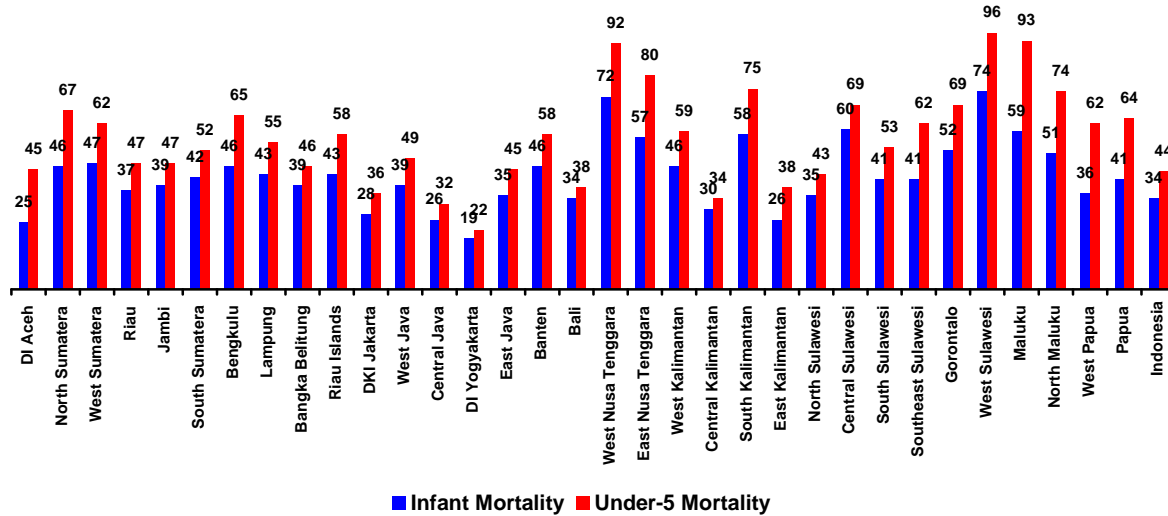


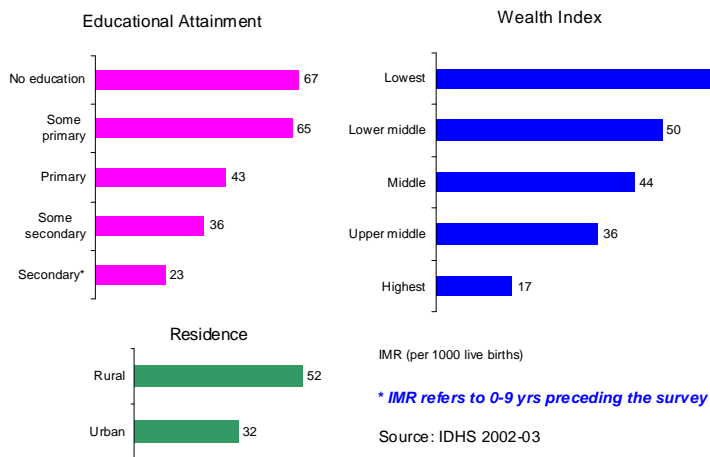
Figure 2 Infant and Under-5 Mortality by Province



A number of socioeconomic, environmental, and biological factors have also influence childhood mortality. Children born to mothers living in urban areas have lower mortality rates compared to those born in rural areas. The lower mortality rates in urban areas may be related to the greater availability of health facilities and better health-seeking practices of urban dwellers.

The educational background of mother also has an inversely relation to childhood mortality levels. In 2002 according to the IDHS 2002-03, the infant mortality rate for children whose mother had no education is almost 3 times higher than infant mortality for children whose mothers received secondary or higher education. Furthermore, there is also an inverse relationship between wealth and mortality rates. The infant mortality of richest households (quintile-5) is almost 4 times lower than the infant mortality of the poorest households (quintile-1); 61 deaths per 1,000 live births compared to 17 deaths per 1,000 live births (*Figure-3*).

Figure-3: Infant Mortality by Socio-Economic Background of the Mother, 2002



Rates for males born are consistently higher than for females. The infant mortality rate for males is 15 percent higher than the rate for females, and the child mortality rate for males is 18 percent higher than for females.

Mother's age, birth interval, and numbers of births can also be correlated to the child survival. According to IDHS 2002-03, the infant mortality for women who gave birth at

age below 20 years is 53 deaths per 1,000 live births. The rate decreases among women who gave birth at age 20-29 years and 30-39 (39 and 46 deaths per 1,000 live births, respectively) and then rises to 50 deaths per 1,000 live births for women who gave birth at age 40-49 years.

The higher rates for younger and older women may be related to biological factors that lead to complications during pregnancy and delivery.

A computation from IDHS 2002-03 discovered other ratios for death of infant is 1.8 times higher when the mother's age is less than 18 years old compared to mothers aged between 19 to 34 years old. Ratio of death of baby with birth interval less than 24 months is 2.02 times higher than baby with birth interval 24 months or more. Ratio of death of babies from mother's age more than 34 and birth order more than 3 are 3.48 times higher than mother aged 19-34 years old and birth orders less than 3.

Childhood mortality is generally lowest for children of mothers who received antenatal care and were assisted by a medical professional at delivery; and highest among women who had neither antenatal care nor assistance at delivery from a trained provider. Women's status has been found to influence infant and child mortality levels through women's ability to control resources and make decisions.

Current Level of Maternal Mortality (MDG 5)

According to IDHS 2007 the level of maternal mortality was 228 per 100 thousand births. As currently the total birth stand around 4.8 million per year, there are 10,914 women who die each year due to pregnancy and delivery issues.

The causes of maternal deaths are similar around the world, including Indonesia. Globally, around 80 per cent of such deaths have direct causes, that is to say, obstetric complications of the pregnant state (pregnancy, delivery and the puerperium), arising from interventions, omissions, incorrect treatment or a chain of events resulting from any of the above.

The most common direct cause of death is obstetric haemorrhage, generally occurring during post-partum followed by puerperal infections often the consequence of poor hygiene during delivery or untreated reproductive tract infections, and hypertensive disorders of pregnancy, particularly eclampsia (convulsions).

Therefore, Indonesian women need not die during childbirth considering the vast majority of maternal deaths are preventable should women have access to - and accustomed to - skilled care during pregnancy, childbirth and the first month after delivery, or to quality family planning services and post-abortion care services.

An in-depth analysis of IDHS data 2002-03 found that women's socio-economic status indicators correlate with receiving maternal health care (antenatal care, postnatal care, and delivery care) from a medical professional. The more educated and wealthy women were, the more they utilized professional health care. Furthermore, the more decisions a woman participates in, the more likely she is to receive maternal health care.

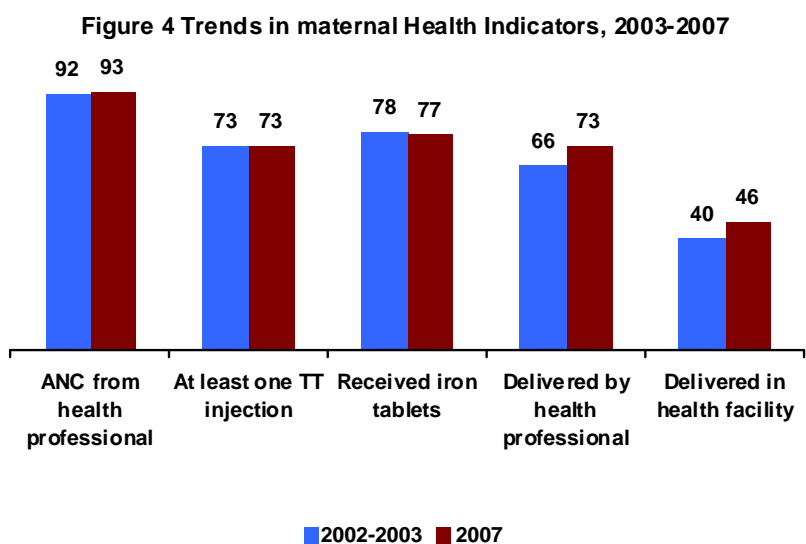
Using the same data, another in depth analysis discovered the close association between complication during pregnancy and delivery with wealth, employment status birth spacing, and abortion of the previous pregnancy. Poor, unemployed women, having a birth spacing less than 24 months, and having experienced abortion in previous pregnancies have a higher risk of complication during pregnancy and delivery.

It is also discovered that low birth weight of babies is an important indicator for maternal health. Overall in Indonesia, 6 percent of babies were reported to weigh less than 2.5 kilograms at birth in 2002-03. The birth weight of babies is related to the characteristics of the mother: babies are more likely to have been weighed and have an average weight (2.5

kilograms or more) if they are born to mothers age 20-34, they are first births, the mother lives in an urban area, and the mothers are educated.

Maternity and Child Care

In 2007, 93 percent of mothers have received the first tri-semester Antenatal Care (ANC) from a medically trained person but only 80.2 percent received at least 4 times ANC. At the same time, 73 percent of mothers received the tetanus toxoid (TT) injections during the pregnancy, 77 percent of mothers reported receiving iron tablets and 46 percent delivered in the health facility. These figures vary according to background characteristics. The age of mothers, birth order, residence and education affect the figures of maternal care (*Table-1*). The level of contraceptive use (CPR) was relatively similar during 2002-2007. In 2002-03 the percentage of contraceptive prevalence rate (CPR) was 60.3 percent while in 2007 was 61.4. The maternal care indicators related to care during pregnancy have not changed much since the 2002-03 IDHS. However, improvement is observed in delivery characteristics (*Figure-4*).



The child care indicators had improved well during the last 5 years. In 2007, 59 percent of children aged 12 to 23 months have received all the recommended vaccinations. This is a notable gain from 51 percent recorded in the 2002-03 IDHS. Nine percent of children had received no vaccinations and the remaining 33 percent of children were partially vaccinated. The vaccination coverage by type of vaccine and background characteristics of children is shown in *Table-2*.

32 percent of infants under age 6 months are being exclusively breastfed and it decrease from 39.5 percent in 2002-03. For 76.9 percent of children with ARI symptoms, advice or treatment was sought from a health provider. About 34.6 percent of diarrhea cases were given solution prepared from packets of oral rehydration salts (ORS).

The problems of maternal mortality and child mortality in Indonesia among others are caused by the following:

The low ratio decrease of maternal mortality and child mortality between 2002-2007 among others are caused by the following:

- The disparity in obtaining continuum of care in health.
- No significant improvement in the scope of services that should be given to infants, babies and children under 5.

- The prevalence of the illness ratio of acute respiratory tract infection (11,2%), fever (31,6%) and diarrhea (13,7%) is quite high.
- There are only 82,67% of the families that have the clean water and family sanitation facilities
- Low educated people has less access to health services such as measles immunization, diarrhea medication (“oralit”) and respiratory tract infection medication
- It is more probable that uneducated people and villagers do not acquire immunization at all.
- The prevalence of nutrient deficiency and under nourished tend to rise.

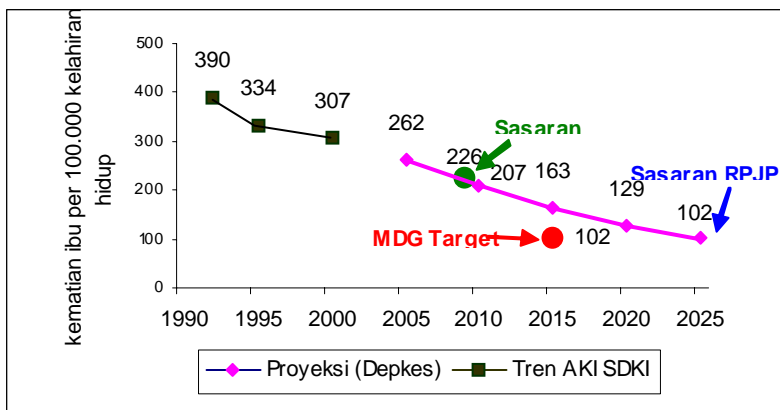
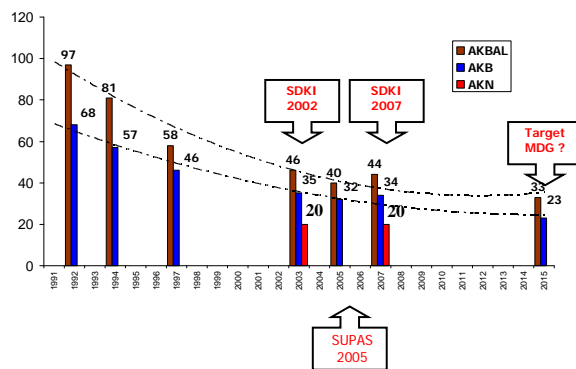
The economic crisis in 1997, governmental reform and radical decentralization from central level to district/municipality level in 2000 somehow contributed to the low improvement of maternity and child care during 1998 to 2003. Through the enactment of rules and regulations including fiscal regulation, formulating *pro-poor* policy and program, delivering norm, standard, guideline, criteria of services to the local government, strengthening technical assistant from central level, the performance has increased in the last couple of years.

Indonesia Targets of MDG4 and MDG5

The MDG4 and 5 targets for Indonesia are shown in figure-5 and figure-6. In addition to the MDG 4, Indonesia set the target for measles immunization is 100 percent, while for MDG 5, target for Contraceptive Prevalence Rate (CPR) is 70 percent, the minimum 4 times ANC services is 95 percent, delivery by skilled health providers is 95 percent. Unfortunately, Indonesia does not have a current data on maternal mortality. The data of maternal mortality in figure-5 for 2007 is derived from extrapolation of the previous trends.

To meet these targets, the Indonesian Government has launched the Maternal, Neonatal, Infant and Under-5 Continuum Health of Care Framework. In the maternal program, the strategy is focused on Maternal, Newborn, Child Survival (MNCS). The focus of the MNCS strategy is to improve the competence of the health system in assuring healthcare provisioning and stabilization aimed to handle the main cause of maternal and newborn baby mortality and illness.

Perkembangan AKB & AKBAL dan target MDG 2015



CHAPTER II STRATEGIC POLICIES IN ATTAINING MDG 4 AND 5

Present policies and strategies to reduce Mortality

In general, the government policies and strategies to reduce the levels of mortality and improve the quality of life amongst the Indonesian population are as follows:

1. Encouraging and empowering the community to live healthily and forge greater cooperation with non government organizations,
2. Improve community access to quality health services through the promotion of health and prevention of diseases. Furthermore, through the implementation of JAMKESMAS programs we aim to increase access of services at the rural level particularly in areas where health facilities distribution remain lacking.
3. Increase surveillance systems, monitoring & information distribution of health facilities,
4. Continue to increase the value of health services.

With regards to effort to reduce child and maternal mortality rates, there has been four policies and strategies formulated through a Continuum Health of Care Framework which consists of:

1. Continuum in the life cycle
2. Continuum in service providing
3. Continuum in cost component
4. Continuum of care in program integration
5. Connection and continuum of care other than the health sector

Current policies and strategies to promote efforts to achieve MDG 4 & 5

To reach the abovementioned aims and targets, four main strategies that are consistent with the Healthy Indonesia Plan 2010 and Grand Strategy of the Ministry of Health) are identified, i.e.:

- Improve the access and the scope of cost-effective quality maternal and newborn baby healthcare, based on evidences and data. Improving access for maternal health is conducted by:
 - Increasing the number and distribution of mid wives in villages, doctors and specialists, with particular emphasis in rural isolated areas.
 - Improving the role of PUSKESMAS.
 - Health-care guarantee for poor and rural communities in far proximity of health facilities.
 - Partnership with traditional delivery assistants (dukun) and mid-wives.
 - Minimizing negative factors that undermine national health effort.

- Build effective partnership through cross program and cross sector cooperation, and other partnerships to conduct advocacy that maximize the allocated resources, and to improve the MPS planning and activity coordination.
 - Enhance the role of communities and
 - Further engage corporate social responsibility and the social role of NGOs
 - Further improve and enhance the role of public and private partnership

- Encourage women, family and community empowerment through knowledge improvement to assure healthy behavior and by using maternal and newborn baby healthcare. Strategies to attain these targets have been through:
 - Continued educating for women and families
 - Garner greater participation and awareness for husbands and male authorities (BCC programs)
 - Greater access for women on health

- Enhance program management through surveillance, monitoring, evaluation and financing system.
 - Strengthen local capacity, particularly at the rural level
 - Sharing roles and responsibility
 - Continue to strengthen monitoring mechanisms health targets
 - Continue to improve human resources of health workers

CHAPTER III EFFORTS TO FINANCE MDGS IN INDONESIA

In effort to implement the above mentioned programs, Indonesia has conducted the following efforts:

As a Member State that signed the Millennium Declaration, the Indonesian government places a strong commitment to ensure the financing of the MDGs. Given the magnitude of financial resources needed to attain these goals, we are cognizant of the importance to balance the fiscal and monetary expenditures to avoid budgetary deficits and negative macro-economic effects. Although government spending on health is still modest, however current data and statistics clearly suggest a steady gradual increase. Many factors have also diminished the strong political attempt to address national health, such high operation cost for health facilities in islands and remote areas, the continued national democratic reform process that also require fiscal support, and the slow adjusting period of decentralization on health system. In this regard, it is pertinent that the government places priority on strategic program for health.

Efforts to mobilise resources for MDG 4 and 5 are closely associated with the Government targets to to reduce the maternal mortality rates, for example the target for 2015 is 75% of maternal mortality levels in 1990. to attain these goals, we optimise the role of local governments in funding, engage business and civil society in the area of funding. And closely involve donor interested in reducing national mortality rates

Regulation strategies has been focused on maximising the outcome of reducing maternal mortality rates by harmonising policies to ensure these goals. Funding for Maternal, Newborn, Child Survival (MNCS) programs has received high priority and the Government is continuing its effort to optimise the output of current government spending, searching alternative funding means to attain these goals and encourage greater ownership at all levels for this important issue.

The government has played an active role in regulating the flows of health funding from the international level to the national level, and also from the national to the local level.

Although nominal values are still modest, given the demographic challenges and the continuously evolving political and social process, Indonesia has seen steady growth on health spending compared to GDP levels. But we are cognizant of the need to do more, and to this end we continue to adjust policies to ensure immediate and short term results.

Financing Strategies

There are basically several known strategies to finance MDGs target, which are as follow:

1. Strengthening financial capacity through synchronizing MDGs target with financial regulations and Government spending

- 1) Strengthening Government's budget allocation for maternal and child health, especially in rural areas.

- 2) Synchronizing more effective and efficient health programs
- 3) Preparing a more comprehensive development plan
- 4) Establishing a Minimum Service Standard (MSS) for financing for health.

2. Empowering civil society, business sectors, and international organizations and NGOs.

Government needs to work together with stakeholders, such as NGOs, private sectors, and local citizens, in order to achieve health development goals of the MDGs. Citizens and NGOs are capable of monitoring government policies, whereas private sectors are more engaged in a more active role such as Corporate Social Responsibility (CSR).

3. Optimising the decentralisation process, empowering local government

The roles of provincial governments are as vital as Central. Local governments are more in tune with local needs and more engaged in realizing local programs for development. Therefore central governments should embrace their local counterparts in order to synchronize efforts for development.

4. Strengthening Cooperation for International Development and Financing

The UN Millennium Project shows that target of MDGs in poor and developing countries are harder to achieve without international assistance. Therefore, international communities are pushing developed countries for their commitment of 0,7 percent of GNI for ODA and debt reductions. In order to achieve the desired development target, there is also a need to establish a more effective and efficient financing system to coordinate country strategies. Communities are also encouraged to formulate a system to reduce debt. Currently, the government allocates 20-25% of their budget for debt payments. This severely restrict our fiscal space and could be better utilised through debt swap programs (Debt for MDGs Swap - DMS)

CHAPTER VI INTERNATIONAL COLLABORATION TO ACHIEVE THE GOALS

The achievement of the MDGs has fallen short of its targets. To get back on track it will require extra efforts. And now it has even become more difficult due to the emerging global issues such as energy, food and environmental crisis which will divert resources away from reaching the MDGs 4 and 5 targets. Developing countries in the pursue of sustainable development with focus on poverty alleviation must also address the MDG 4 and 5 by 2015.

Greater international support in combating malnutrition is particularly needed to ensure that efforts to attain MDG 4 and 5 will not be hampered by structural complexities such as depreciating consumer income affected by effects of climate change, rising oil and food prices.

To attain the targets of MDG 4 and 5, the Indonesian government has identified a number of programs of international cooperation on policy, through four overarching clusters as follows:

POLICY

1. To reduce infant mortality (MDGs 4) through sectoral and intra sectoral policies aim at:
 - a. Improving adequate neonatal care, especially for the poor
 - b. preventing young child malnutrition through improved breastfeeding and complementary feeding practices
 - c. Improving diagnosis, prevention (inoculation) and treatment of childhood illnesses
 - d. Improving quality clinical care for early childhood illness.

2. To reduce maternal mortality (MDGs 5) lies in basically 3 main interventions that address supply and demand side issues:
 - a. Increasing the proportion of births attended by skilled professionals and midwives
 - b. Increasing the proportion of institutional deliveries
 - c. Improving quality clinical care for early childhood illnesses.

Monitoring Mechanism

To establish Red Alert Unit to monitor indicators such as:

1. Maternal Mortality Ratio:
 - a. Proportion of skilled birth attendance
 - b. Proportion of institutional deliveries

2. Infant and Child Mortality
 - a. Neonatal visits
 - b. Measles immunization
 - c. Vitamin A distribution coverage

Financing

1. **Enhance greater mobility of domestic and regional resources** to ensure the adequate of health insurance cost and benefit for the poor to enable them to access health care, with cost reflecting actual cost including transportation cost, stimulated by tax-incentives, fiscal and monetary schemes through among others the use of micro-credit schemes, remittance circulation for health and provide assistance for local financial institutions
2. **Explore innovtative financial mechanism, such as optimising the opportunity for Debt to MDGs Swap programs.** Given the importance of formulating policies to attain the MDGs by 2015, sustainable development needs to be financed that produces co-benefits to reach for MDG 4 and 5;
3. **Encourgare flexibility in utilizing ODA and other international funds such as the G-8 Global Fund that** also address MDGs 4 and 5.
4. **Establish a multilateral funding mechanisme for south-south cooperation** that supports developing countries in developing local and traditional technologies that support attaining MDG 4 and 5
5. **Encourage greater Corporate Social Responsibility of multinational companies** to assist fostering investment in the area of health.
6. **Establish a national social security program** that would encourage the formation of a sustainable health insurance system for the poor;
7. **Optimise the utilization and distribution of information and communication technologies (ICT)** to enhance communication and coordination of the health facilities at the local level. Best practices at the regional level on technology communication should be shared and funded by the international community for easy duplication and application.

CHAPTER V THE WAY FORWARD

The year 2008 has been titled the year to bring the MDGs, including MDG 4 and 5, - back on track. Governments must move out of the *business as usual approach* and solicit innovative ways to ensure that women and children may reap the benefit of attaining the goals by 2015. Institutions can no longer afford to address MDG 4 and 5 merely from a sectoral perspective but must be proactive in enhancing coordination through intra sectoral approach towards sustainable development. Communities must adjust their mindset from taking a passive stance and expecting a solution from local authorities, and instead must encourage all stakeholders to take aggressive ownership on the issue of health.

To this end the Sherpa may suggest to their leaders the need for a reinvigorated national and global movement on the campaign for the welfare of women and children, through MDG 4 and 5. Leaders therefore must use their influence to instigate global desire to attain these objectives, through a innovative cooperation that may produce lasting effects for the health MDGs.

Following the principles of the Global Campaign for Health MDGs, which are to allow countries to set their own priorities, to provide aid without further adding to the countries administrative burdens, to ensure that every resources may be well spent, to assist countries to develop the countries health system and to forge a partnership based on transparency and accountability, our leaders may be in a better position to consolidate cooperation that ensures we work more effectively, better coordinated, enhance every investment opportunity, and ensure that the poorest and weakest may benefit from our health services efforts.

Through this political commitment at the highest level, we commit to providing more for our mother and children and to ensure that our investments bring the highest earnings for a better global health system.

A CALL TO ACTION

In recognition of the challenges of a climatically, politically and economically turbulent century, we can no longer afford to only depend on our natural resources to alleviate poverty, and we must change the winds of our development focus to ensure that our future generations receive the highest quality through the promotion the greater wellbeing of women and children.

In pursuit of our Health MDGs we will focus the need to take greater ownership where:

1. We commit to ensuring all levels of government and partners will urgently address the threat of undernutrition, and to reduce social inequalities by targeting health services for the poorest.
2. We will strive for continued progress in prevention efforts through immunization, distribution of vitamin A supplementation, and the affordable distribution of insecticide-treated mosquito nets.
3. We commit to formulating more accessible multilateral funding mechanisms that address specific needs of the health sector, including greater availability and utilization of ODA, greater accessibility of debt swap regimes and continued trial of innovative financing facilities, such as health insurance systems, in the area of health.
4. In closely monitoring the health MDG targets, we commit to setting up RED ALERT units at the national and regional level to monitor the progress of attaining the targets of MDG 4 and 5. To this end, we encourage inter-governmental organizations to assist in providing resources and access for statistical data for monitoring purposes.
5. We encourage all Governments to commit in establishing national plans that scale up maternal, newborn and child health making basics services available to all; continue to strengthen the health systems by implementing the continuum of care for maternal health, newborn and child health; increase coverage of key interventions and services ensuring these services reach the poor and underserved; focus on the priority period within the continuum of care from pre-pregnancy through 24 month – where this period is crucial for the health of both mother and child; collect timely data on intervention to help guide national programming and prevent bottleneck in services.
6. We invite Parliamentarians to allocate sufficient funding for equitable health services, monitor delivery of health services in their constituencies, empower women to make healthcare decisions themselves and their children, implement legislation that supports women to make their own family planning choices, *adopt the international Code of Marketing of Breast-milk Substitute and ratify the ILO Maternity Protection Convention 183*, and support laws that discourage child marriage and promote socio-economic alternative which enable impoverished families avoid marrying off their young daughters.
7. We call upon donors to ensure adequate, predictable, and long-term flows for maternal, new-born and child health and nutrition, provide appropriate focus on development assistance to the highest burden countries, including in Sub-Saharan

Africa and South Asia, to coordinate donor effort to boost the impact of aid delivery-guided by country priorities, and to invest in better data collection and implementation of research findings.

8. We encourage civil society to monitor local access to essential services, promote political commitment and accountability, to advocate for long term, predictable donor funding and to encourage national government to enhance investment on maternal, newborn and child health services and to provide support to provide services equitable.

ANNEX

Table 1. Maternal care indicators

Percentage of women age 15-49 who had a live birth in the five years preceding the survey who received antenatal care from a **health professional for the most recent birth**, and **for the most recent birth** received at least one tetanus toxoid injection during pregnancy and given iron tablets during pregnancy, and among all live births in the five years before the survey, percentage delivered by a health professional and percentage delivered in a health facility, according to background characteristics, Indonesia 2007

Background characteristic	Percentage with antenatal care from health professional	Percentage given at least one tetanus toxoid injection during pregnancy	Percentage given iron tablets or syrup during pregnancy	Number of women	Percentage delivered by a health professional ¹	Percentage delivered in a health facility	Number of births
Mother's age at birth							
<20	90.8	66.4	74.6	1,385	62.6	35.8	1,716
20-34	94.2	74.7	78.9	10,552	74.8	47.4	12,482
35+	90.1	69.2	71.2	2,106	71.1	46.2	2,306
Mother's age at birth (5 year age groups)							
<20	90.8	66.4	74.6	1,385	62.6	35.8	1,716
20-24	93.9	74.8	78.8	3,796	72.1	43.9	4,573
25-29	94.5	73.6	79.4	3,731	76.0	49.8	4,340
30-34	94.3	75.8	78.4	3,026	76.7	49.1	3,569
35-39	93.0	72.2	74.6	1,572	74.3	48.7	1,745
40-44	82.5	61.0	62.7	466	64.3	39.6	488
45-49	75.1	55.9	51.9	67	40.3	31.7	73
Birth order							
1	95.2	75.1	80.6	4,856	79.6	54.4	5,855
2-3	94.4	75.2	80.0	6,568	73.4	45.6	7,529
4-5	90.4	68.2	68.8	1,860	65.4	34.5	2,207
6+	78.1	52.2	54.9	759	46.2	24.1	913
Residence							
Urban	97.7	77.5	84.0	5,897	87.6	70.3	6,835
Rural	90.1	69.8	72.5	8,145	62.7	28.9	9,669
Education							
No education	62.6	32.1	42.3	457	31.3	15.4	578
Some primary	82.2	55.4	60.6	1,677	44.7	22.0	1,996
Completed primary	92.4	71.1	73.3	4,106	62.3	31.0	4,759
Some secondary	96.4	79.1	81.9	3,543	79.3	48.7	4,132
Secondary +	99.1	81.2	87.9	4,260	94.0	71.2	5,038
Total	93.3	73.0	77.3	14,043	73.0	46.1	16,504
Total ^a	93.7	73.3	77.6	13,643	73.7	46.6	16,056

Note:

^a Excludes 5 provinces which were not included in the 2002-03 IDHS (NAD, Maluku, North Maluku, Papua, and West Papua).

If the respondent mentioned more than one person attending during delivery, only the most qualified is considered in this tabulation.

¹ Doctor, obgyn, nurse, midwife, or village midwife

Table 2. Vaccinations by background characteristics

Percentage of children age 12-23 months who received specific vaccines at any time before the survey (according to a vaccination card or the mother's report), and percentage with a vaccination card seen, by background characteristics, Indonesia 2007

Background characteristic	DPT			Polio				Measles	All basic vaccinations ¹	No vaccinations	Hepatitis B			Percentage with a vaccination card	Number of children	
	BCG	1	2	3	1	2	3				4	1	2			3
Sex																
Male	86.1	84.5	74.7	65.6	88.4	82.0	72.2	54.4	75.1	56.3	8.9	80.5	71.5	59.4	37.9	1,622
Female	84.7	84.3	76.8	67.9	89.2	83.2	74.8	56.7	77.9	61.0	8.2	80.4	72.0	61.2	35.6	1,472
Birth order																
1	89.1	89.0	80.0	72.7	90.5	85.0	77.4	60.2	78.8	63.2	6.0	84.0	75.1	65.8	41.9	1,139
2-3	85.4	84.8	76.8	66.3	89.8	84.2	74.4	55.5	76.8	58.6	8.6	82.3	73.3	59.6	36.8	1,382
4-5	79.2	76.5	68.7	59.8	84.4	76.6	67.6	49.7	72.6	53.3	12.6	71.8	64.9	55.6	30.4	416
6+	75.7	68.7	53.3	44.8	79.8	66.4	51.7	36.3	66.0	39.0	17.1	61.5	51.3	39.1	16.7	158
Residence																
Urban	92.0	91.3	83.6	74.8	94.4	89.5	82.2	64.0	82.0	67.5	4.7	88.8	81.0	70.0	38.1	1,274
Rural	80.8	79.5	70.2	61.0	84.9	77.7	67.3	49.5	72.5	52.3	11.3	74.6	65.2	53.5	35.9	1,820
Education																
No education	58.9	47.8	41.7	28.1	65.3	45.5	32.3	17.8	49.0	18.7	31.7	44.5	38.9	21.1	18.7	68
Some primary	71.1	61.9	52.7	43.5	76.4	68.5	57.5	36.2	63.5	37.3	20.3	60.6	47.5	36.6	23.8	352
Completed primary	80.3	81.3	70.1	59.9	85.7	77.2	65.4	47.1	71.0	52.1	11.3	75.5	64.1	51.5	38.3	898
Some secondary	87.6	87.6	77.9	69.2	90.8	85.0	75.8	62.3	76.0	60.6	6.1	82.4	75.3	65.1	40.8	754
Secondary +	95.0	95.0	89.1	81.2	95.9	92.8	87.1	67.1	87.8	72.8	2.5	92.6	86.3	75.3	38.2	1,022
Total	85.4	84.4	75.7	66.7	88.8	82.6	73.5	55.5	76.4	58.6	8.6	80.5	71.7	60.3	36.8	3,094
Total ^a	85.9	85.0	76.3	67.4	89.4	83.5	74.4	56.1	76.8	59.2	8.0	81.1	72.5	61.1	37.0	3,014

^a Excludes 5 provinces which were not included in the 2002-03 IDHS (NAD, Maluku, North Maluku, Papua, and West Papua).

¹ BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)