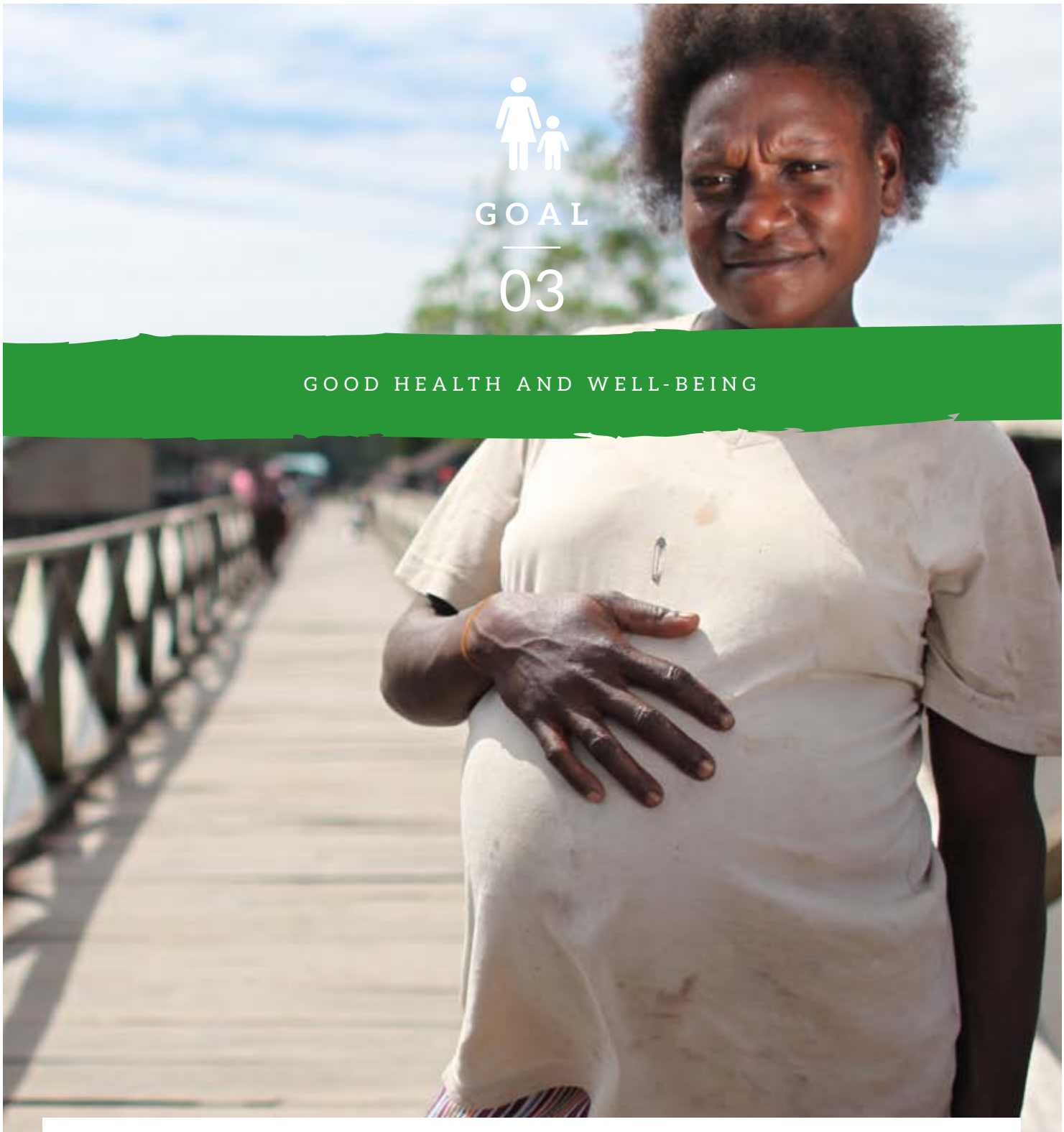


GOAL

03

GOOD HEALTH AND WELL-BEING

9 in 10
births are attended by skilled health personnel

For every 1,000 live births,
40 children
die before their fifth birthday

74%
of infants 12–23 months receive the third dose of the DPT vaccine

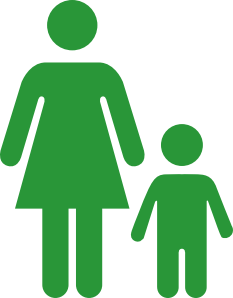


Table 3.A

Priority targets for children	Selected indicators to measure progress	Type of indicator	Baseline value	Data source
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio	Global indicator	305	SUPAS 2015
	Proportion of births attended by skilled health personnel	Global indicator	89%	SUSENAS 2015
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births	Under-five mortality rate (deaths per 1,000 live births)	Global indicator	40	IDHS 2012
	Neonatal mortality rate (deaths per 1,000 live births)	Global indicator	19	IDHS 2012
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Number of new HIV infections per 1,000 uninfected children 0–14 years	Global indicator	0.068	MoH-modelled estimate for 2015
	Tuberculosis incidence per 100,000 people	Global indicator	395	WHO estimate for 2015
	Malaria incidence per 1,000 population	Global indicator	0.85	MoH 2015
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	Proportion of women of reproductive age (age 15–49 years) who have their need for family planning satisfied with modern methods	Global indicator	73%	SUSENAS 2015
	Adolescent birth rate (age 15–19 years) per 1,000 women	Global indicator	40	SUPAS 2015
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Proportion of children 12–23 months who receive all basic vaccinations	National indicator	49%	SUSENAS 2015
	Proportion of children covered by JKN	National indicator	47%	SUSENAS 2015

STATUS OF PRIORITY INDICATORS FOR CHILDREN

MATERNAL AND REPRODUCTIVE HEALTH

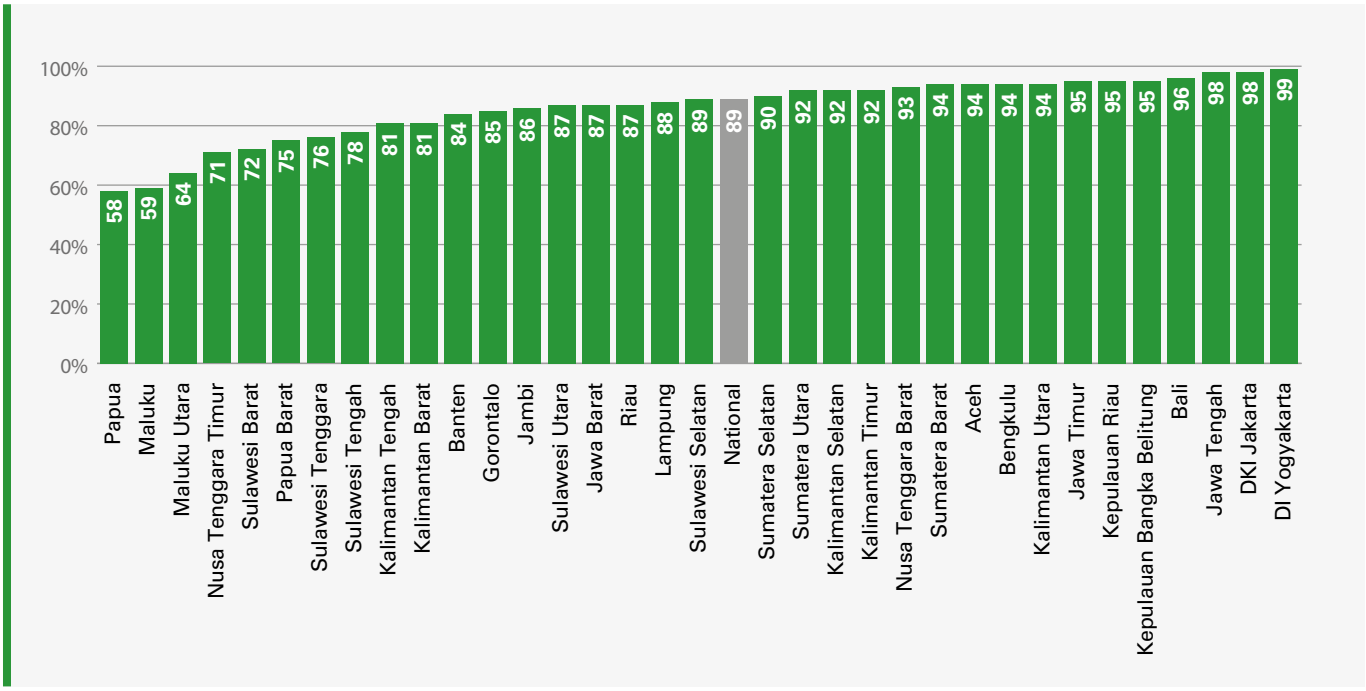
SDG Target 3.1 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births. The indicators to measure progress include the maternal mortality ratio and skilled attendance at birth. Maternal mortality refers to deaths due to complications from pregnancy or childbirth. In 2015, Indonesia's maternal mortality ratio was equal to 305 maternal deaths per 100,000 live births, according to the SUPAS.[4]

Studies indicate that close to eight in 10 maternal deaths (77 per cent) are due to direct obstetric causes, resulting from complications during pregnancy or unsafe delivery practices. The single most critical intervention

Figure 3.A

Skilled birth attendance

Percentage of births attended by skilled health personnel, by province, 2015



Note: The indicator refers to ever-married women who had a live birth in the two years preceding the SUSENAS attended by obstetricians, midwives, nurses or other health professionals.
Source: SUSENAS 2015

for safe motherhood is to ensure that a competent health worker with midwifery skills is present at every birth, and in case of emergency that transport is available to a referral facility for obstetric care. Strengthening primary health care and referral systems, in parallel with enhancing the competency and skills of health personnel to ensure high-quality maternal and newborn services will be essential. Other underlying causes include child marriage and childbearing by adolescent girls.

In Indonesia, 89 per cent of births occurring in the two years preceding the SUSENAS 2015 survey were delivered by skilled personnel (Figure 3.A). Geographic disparities are striking: coverage of skilled attendance ranged from 58 per cent in Papua to 99 per cent in DI Yogyakarta.

SDG Target 3.7 on universal access to sexual and reproductive health-care services is to be monitored by two indicators: the adolescent birth rate and coverage of modern family planning services. Some 10 per cent of adolescent women aged 15–19 years were already mothers or pregnant with their first child, according to the 2012 IDHS. Rural teenagers were more likely than urban teenagers to have started childbearing (13 per cent compared with 6 per cent). By wealth status, the proportion of teenagers who have begun childbearing varies from a high of 17 per cent among those living in households in the lowest wealth quintile to a low of 3 per cent among those in the highest quintile. The 2015 SUPAS recorded an adolescent birth rate of 40 per 1,000 in that age group.

With regard to modern family planning services, nationally in 2015, 73 per cent of ever-married women of reproductive age had their need for family planning with a modern method satisfied, according to SUSENAS. As with other indicators, there was considerable regional variation, with, for example, 83 per cent of ever-married women of reproductive age in Kalimantan Selatan having their family planning needs met, compared with 23 per cent in Papua.

CHILD MORTALITY

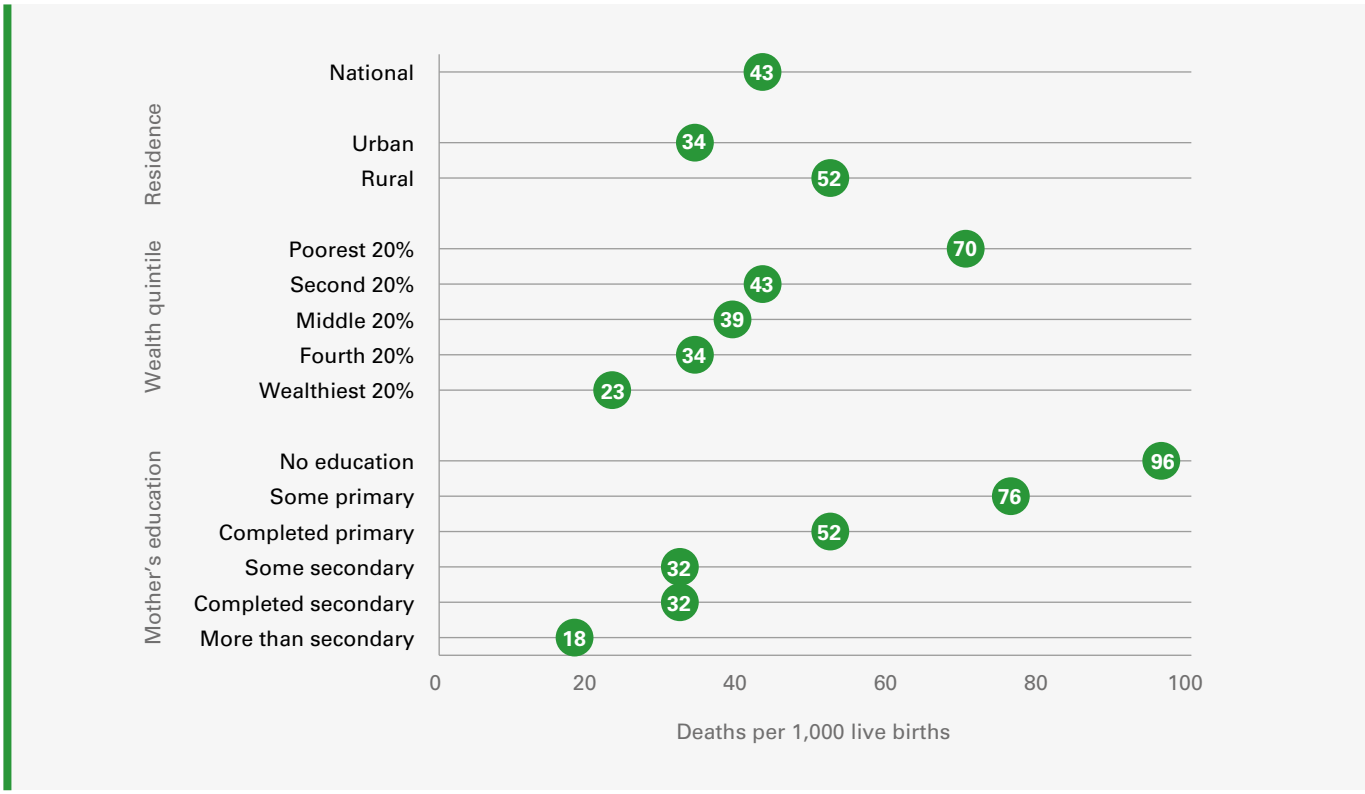
Target 3.2 is about reducing preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births. The 2012 IDHS recorded an under-five mortality rate of 40 deaths per 1,000 live births during the five years preceding the survey (2008–2012). This means that one in 31 children born in Indonesia die before reaching the fifth birthday. Of those deaths, 48 per cent were newborns, with a neonatal mortality rate of 19 per 1,000 live births and little evidence of change over the past two decades.

Disaggregated survey data, only available for a 10-year period, show that children from the poorest households are on average nearly three times as likely to die before the age of 5 as children from the richest households (Figure 3.B). Children under 5 of mothers who lack education are three to five times as likely to die as those whose mothers have secondary or higher education.

Figure 3.B

Children born in the poorest households were three times more likely to die before age 5 than children from the richest households

Under-five mortality rate for the 10-year period preceding the survey, by wealth quintile, 2012



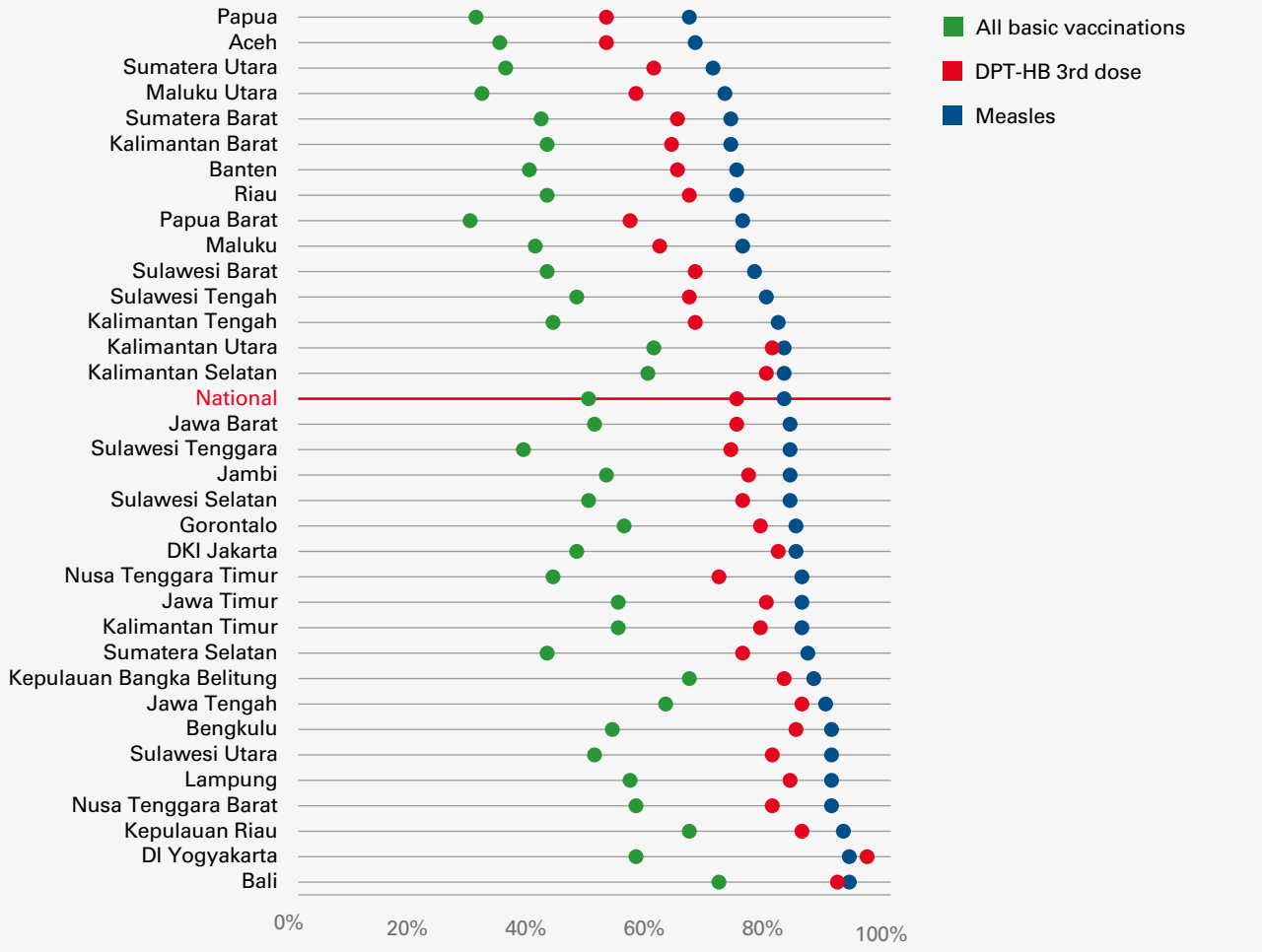
Note: Disaggregated data by the socio-economic characteristics presented in this figure are available only for the 10 years preceding the survey (approximately 2003–2012). The national baseline value for under-five mortality included in Table 3.A refers to the five-year period preceding the survey (2008–2012).

Source: IDHS 2012

Figure 3.C

A child's immunization status is strongly associated with its place of residence

Percentage of children aged 12–23 months who received specific vaccines at any time before the survey, by province, 2015



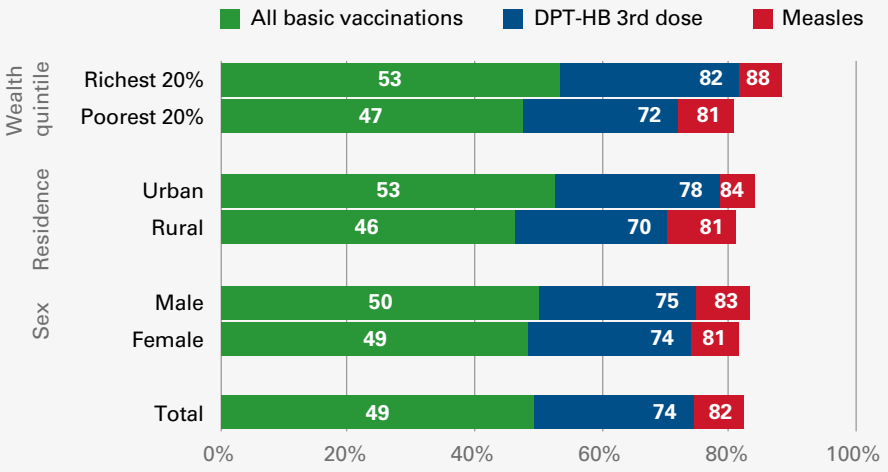
Note: All basic vaccination is measured by coverage of BCG (bacille Calmette-Guérin TB vaccine), Polio4 (four doses of polio vaccine), DPT3 (third dose of DPT vaccine), HepB3 (third dose of hepatitis B vaccine) and MMR (measles, mumps and rubella vaccine).

Source: SUSENAS 2015

Figure 3.D

Children in rural households are least likely to benefit from routine immunization services

Percentage of children aged 12–23 months who received specific vaccines at any time before the survey, by selected characteristics, 2015



Source: SUSENAS 2015

COMMUNICABLE DISEASES

The main target relating to infectious diseases is SDG Target 3.3, which refers to ending the epidemic of acquired immune deficiency syndrome (AIDS), tuberculosis (TB), malaria and neglected tropical diseases, and combating hepatitis, water-borne diseases and other communicable diseases. In 2015, the Ministry of Health recorded 30,935 new cases of human immunodeficiency virus (HIV), although the actual number of new infections is estimated at 72,100 (4,900 among children 0–14 years and 67,200 among people 15 years and above). The HIV incidence among children 0–14 years was 0.068 per 1,000 uninfected children. Among adults of over 15 years, the HIV incidence stood at 0.367 per 1,000 uninfected population.[5] According to the National AIDS Commission, the strategies being employed to contain HIV in Indonesia are by and large appropriate given the stage of the HIV epidemic, but they have not been realizing their full impact due to insufficient scale and programme implementation issues.[6]

TB is a treatable and curable disease, but remains a major global health problem. In 2015, the Ministry of Health detected 331,000 new cases of TB. Close to 9 per cent of new cases were children under 15 years of age. There is, however, significant underreporting: the actual incidence of TB in 2015 was estimated at 1 million or 395 per 100,000 people.[7]

Indonesia is making progress in the fight against malaria, and the share of malaria-free districts has more than doubled over the past five years, to 45 per cent in 2015. According to the 2013 RISKESDAS, the incidence of malaria was 1.9 per cent, or 19 per 1,000 people.

UNIVERSAL HEALTH COVERAGE

The universal health coverage target under Goal 3 aims to ensure that everyone obtains good-quality essential services and the medicines they need, without undue financial hardship due to out-of-pocket payments, as well as vaccines for all. Immunization is a proven public health intervention for controlling and eliminating life-threatening infectious diseases. The percentage of children receiving diphtheria, pertussis and tetanus (DPT) vaccine is often used as an indicator of how well countries are providing routine immunization services. In 2015, national coverage for the third dose of DPT stood at 74 per cent, according to the SUSENAS survey. Protection against measles was somewhat higher, at 82 per cent. Both fall below the targets of 90–95 per cent.

A child's immunization status is strongly associated with her or his place of residence (Figure 3.C). For instance, children living in Maluku or Papua are two times less likely to receive all their basic vaccinations compared with their peers born in Bali or Kepulauan Riau. Disparities by wealth and parental education levels are

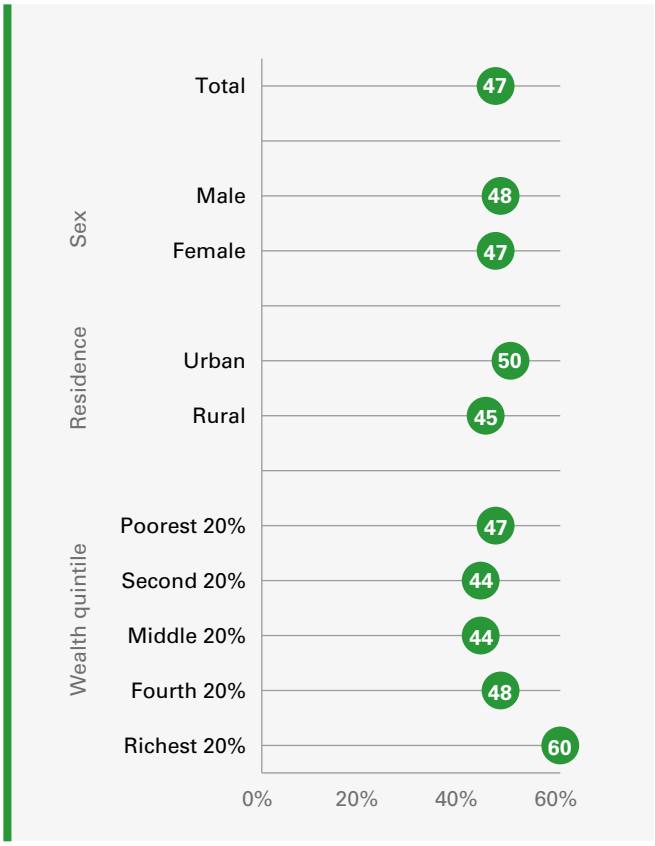
less pronounced (Figure 3.D). Overall, under-coverage is still substantial: only half of children 12–23 months of age received all basic vaccinations.

With the enactment of the National Social Security System Act in 2004 and the Social Security Providers Act in 2011, the Government made a commitment to achieve universal health insurance coverage. The roll-out of JKN – introduced in 2014 – aims to deliver universal health coverage to at least 95 per cent of the population by 2019. However, before the National Social Security System is fully in place, a significant proportion of the population is still without health insurance. In 2015, 47 per cent of children were covered by health insurance programmes (Figure 3.E). Out of those with insurance, 42 per cent reported being covered by the *Jamkesmas* programme (a tax-funded health insurance scheme targeted at the poor); 23 per cent by *Badan Penyelenggara Jaminan Sosial* (a health social insurance administration organization); and another 20 per cent by regional health insurance (*Jamkesda*).

Figure 3.E

Close to half of children were covered by health insurance in 2015

Percentage of children covered by health insurance programmes, by selected background characteristics, 2015



Source: SUSENAS 2015

WHAT CAN BE DONE TO ACCELERATE PROGRESS TOWARDS GOAL 3?

- Accelerate efforts to reduce maternal mortality, including improving knowledge of pregnant women about antenatal care and safe delivery in health facilities; improving the quality of maternal and newborn care services, including competency of human resources, health facilities and hospitals with comprehensive neonatal obstetric emergency services; improving referral systems, particularly in remote areas; the effective introduction of maternal and perinatal death surveillance and response audits; and implementation of regulations which support optimum maternal health services, including the recent Minimum Service Standards.

- Continued investment in reducing child mortality, including the integrated management of newborn and childhood illness at the primary care level; the essential newborn care action plans for high-quality basic and referral services for newborns; and ensuring referral services are available for all sick children.

- Tackle communicable diseases through provider-initiated testing and counselling for HIV among all pregnant women and exposed infants; district-level availability of lifelong antiretrovirals for all those testing HIV-positive; strengthen TB case-finding, screening for multi-drug resistant TB and early initiation of treatment; and improve logistic management systems for key commodities (such as rapid diagnostic testing for HIV, antiretrovirals and TB drugs).