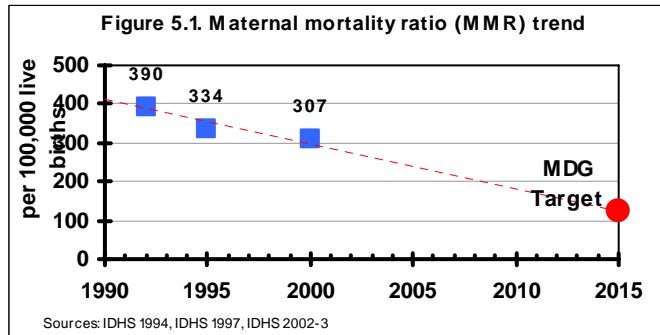


GOAL 5: IMPROVING MATERNAL HEALTH

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Status and trends



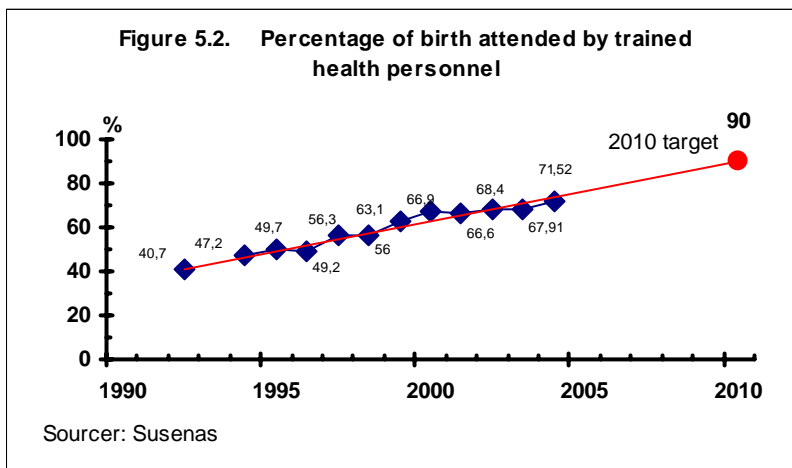
The maternal mortality ratio in Indonesia has dropped to 307 per 100,000 live births (1998-2002). But with 20,000 mothers die each year due to complication during pregnancy and delivery, the MDG's targets will not be achieved unless an intensive effort made to speed up the declining trend.

The disparity of maternal mortality between regions in Indonesia remains high. It also among the highest within ASEAN countries, for example, the life time risk of a mother dying related to childbirth in Indonesia is 1 in 65, compared to 1 in 1,100 in Thailand.

Direct causes. Maternal mortality is mainly caused by hemorrhage, eclampsia, obstructed labor, complication due to abortion, and infections. Hemorrhage contributes to 28 percent to maternal death, eclampsia 13 percent, unsafe abortion 11 percent, and sepsis 10 percent. Modern contraception plays an important role in reducing unwanted pregnancy. In 1997, contraceptive used of married women aged 15-49 was 57.4 percent, and increased to 60.3 percent in 2002-2003 (Indonesia Demographic and Health Survey 2002-2003)

Underlying causes. The risk of maternal mortality is greater due to anemia, chronic energy deficiency, and infectious diseases, such as malaria, tuberculosis, hepatitis, and HIV/AIDS. In 1995, for example, the prevalence of anemia among pregnant women reached 51 percent, and 45 percent among post-partum mothers. In 2002, 17.6 percent of women of reproductive age were suffering from chronic energy deficiency. The levels of socio-economy and education, cultural factors, and access to health facilities, poor transportation, and uneven distribution of trained medical personnel, especially midwives, also indirectly contributed to maternal mortality.

The delivery attended by trained health personnel was increasing, reaching 71.5 percent in 2004. However, the proportion varies among the provinces. The proportion also varies according to the level of income. While 89.2 percent of wealthy women deliver with trained health personnel, only 21.3 percent of poor women do so, highlighting the financial inequalities in accessing health services.



Challenges

Population structure in the future, characterized by higher proportion of reproductive women, will result in increasing demand for health services. Health decentralization has not yet clearly defined the role and responsibility of the central and regional

government. The regions with low financial capability will have difficulties in allocating adequate budget for health programs.

Limited capacity and budget. The latest data shows that the number of village midwives has decreased. Therefore, it will be more difficult for the poor and vulnerable groups to get access in safe delivery. In addition, limited household financial capabilities also make it difficult to get access to basic services. Therefore, innovations in mechanism to address financial constraints at household level are needed in order to guarantee access to services.

Policies and Programs

National priority. As stated in National Development Program (Propenas), reducing the maternal mortality has become the main priority of health development. In order to achieve the purpose, the focus of health development policies will mainly on the improvement of quantity, network, and quality of health centers and the improvement of quality and quantity of health personnel. The policy is expected to make the facilities of medical services closer and accessible to the people. The coverage and the quality of reproductive health services including family planning services shall be improved.

Referring to ‘Healthy Indonesia 2010’, Making Pregnancy Safer campaign has been launched. It focuses on an integrated and systematic planning approach in clinical intervention with the emphasis on partnership. The campaign is done by improving access and coverage of medical services for mothers and new-born babies, developing effective partnership through cross-program and cross-sectoral cooperation, encouraging women and family empowerment, and encouraging people involvement.

In order to improve poor people’s access to health services, the policy is to develop a system of health insurance. The method has been tried since the economy crisis in 1998, through Social Safety Net Program, which offered free services to poor people. In the 2004-2009 National Medium-term Development Plan, the program will be continued and

improved by implementing a system of health insurance with premiums being paid by the government. All poor people can get free medical services at health centers and their network and at third-class hospitals, including services for pregnant women, and delivery, be it normal or difficult delivery. To make people easily access the service, recruitment and deployment of medical staff at hospitals and health centers (especially doctors and midwives) will be done.