CHILDHOOD DISEASES 13

Acute lower respiratory tract infection, primarily pneumonia, is a common cause of morbidity and death among children under five years of age. Pneumonia is characterized by cough with difficult or rapid breathing and chest indrawing. For severe pneumonia, hospitalization is recommended; otherwise, ambulatory treatment with antibiotics is recommended. Early diagnosis and treatment with antibiotics can prevent many deaths caused by acute lower respiratory infection. In the 2002-2003 Indonesia Demographic and Health Survey (IDHS), identification of acute respiratory infection (ARI) is based on each mother's perception of the respiratory symptoms suffered by her child.

Information about the prevalence of fever in children under five years of age was also recorded in the survey, although the causes of fever were not specified. Various infectious diseases are accompanied by fever. In Indonesia, the most common diseases accompanied with fever are malaria, respiratory and intestinal infections, measles, and typhoid.

The IDHS also recorded the prevalence of diarrhea in children under five as reported by their mothers. Contact with health providers and treatment practices help assess national programs aimed at reducing the impact of diarrhea. The treatment rates with oral rehydration therapy or increased fluids reflect the success of programs that encourage these behaviors.

13.1 PREVALENCE AND TREATMENT OF ACUTE RESPIRATORY INFECTIONS AND FEVER

Table 13.1 indicates that 8 percent of children had symptoms of ARI in the two weeks preceding the survey. The highest prevalence of ARI was found among children age 6-23 months (9 percent). The prevalence of ARI decreases slightly with age to 6 percent for children age 48-59 months. Prevalence of ARI does not vary by the child's sex and residence, and variance by education is also small and not uniform.

Table 13.1 also shows that 26 percent of children had a fever in the two weeks preceding the survey. As in the case of ARI, the highest prevalence of fever was found among children age 6-23 months (35-36 percent). Prevalence of fever follows the same pattern as the prevalence of ARI; it does not vary by the child's sex or residence.

Sixty percent of children who showed symptoms of ARI or fever were taken to a health facility for treatment. This percentage fluctuates by the child's age, with children age 6-23 months being the most likely to be taken for treatment. Treatment-seeking behavior does not vary according to the child's sex. Children in urban areas are more likely to be treated than those in rural areas (64 and 51 percent, respectively). Mother's education makes a difference in the treatment of ARI and/or fever in children. While 69 percent of children whose mothers have completed secondary education were taken for treatment, the corresponding percentage for children of women with no education is 45 percent.

Appendix Table A.13.1 shows the prevalence of ARI and fever by province. Prevalence of ARI is high in Bangka Belitung (20 percent), Banten (17 percent), Gorontalo (14 percent), and West Kalimantan (12 percent). Less than 5 percent of children were reported to have ARI in East Java, DI Yogyakarta, Lampung, Central Kalimantan, and South Sumatera. Provinces with high prevalence of ARI tend to have a high prevalence of fever.

Table 13.1 Prevalence and treatment of acute respiratory infections (ARI) and/or fever

Percentage of children under five years of age who had a cough accompanied by short, rapid breathing (symptoms of ARI), percentage of children who had fever in the two weeks preceding the survey, and percentage of children with symptoms of ARI and/or fever for whom treatment was sought from a health facility or provider, by background characteristics, Indonesia 2002-2003

	Prevalence of ARI and/or fever among children under five			Treatment among children with symptoms of ARI and/or fever	
Background characteristic	Percentage of children with symptoms of ARI	Percentage of children with fever	Number of children	Percentage for whom treatment was sought from a health facility or provider[1]	Number of children
Age in months					
<6	6.3	20.1	1,570	48.1	337
6-11	9.0	35.7	1,373	66.0	508
12-23	9.2	34.5	2,819	63.2	1,016
24-35	8.3	25.5	3,026	55.3	842
36-47	6.5	21.5	3,008	49.9	693
48-59	6.2	20.4	2,714	53.0	591
Sex					
Male	7.7	25.8	7,483	56.9	2,069
Female	7.4	25.9	7,026	56.6	1,918
Residence					
Urban	7.6	25.1	6,830	63.6	1,855
Rural	7.6	26.5	7,680	50.9	2,133
Education					
No education	7.3	21.2	666	45.2	150
Some primary	9.1	29.2	2,102	46.6	653
Completed primary	7.6	26.3	4,865	52.3	1,341
Some secondary	8.0	28.1	2,947	59.7	877
Secondary+	6.3	22.6	3,929	68.9	966
Total	7.6	25.9	14,510	56.8	3,988

[1] Exludes pharmacy, shop, and traditional practitioner

Table 13.2 reports the types of drugs given to children with fever. Since malaria is an important contributory cause of death in infancy and childhood in many developing countries, so-called "presumptive treatment" of fever with antimalarial medication is advocated in many countries where malaria is endemic. Forty-seven percent of children with fever during the two weeks preceding the survey were given acetaminophen or paracetamol, while less than 1 percent of children were given antimalarial drugs. Most of the children (76 percent) were given a drug that was not antimalarial (Table 13.2). Differences by urban-rural residence are insignificant.

Table 13.2 Drugs taken for fever

Percentage of children under five years who were ill with fever during the two weeks preceding the survey, by type of drug taken, according to residence, Indonesia 2002-2003

	Residence		
Result	Urban	Rural	Total
Fansidar	0.3	0.1	0.2
Chloroquine/Nivaquine	0.5	0.5	0.5
Any non-antimalarial drug	77.2	75.7	76.4
Aspirin	2.9	4.6	3.8
Acetaminophen/paracetamol	48.0	46.4	47.1
Ibuprofen	0.6	0.5	0.6
Don't know/missing	16.0	14.6	15.2
No drug	5.2	8.9	7.2
Number of children	1,715	2,036	3,751

13.2 DISPOSAL OF CHILDREN'S STOOLS

The proper disposal of children's feces is extremely important in preventing the spread of disease. If feces are left uncontained, disease may spread by direct contact or through animal contact. Table 13.3 presents information on the disposal of children's stools, by background characteristics, including type of toilet facilities in the household.

Table 13.3 shows that only 21 percent of children under five always use a toilet/latrine, while 31 percent of mothers usually throw the stool into a toilet/latrine. Children in urban areas are more likely than rural children to have their stools contained. Overall, the percentage of urban children who always use a toilet or latrine or whose stools are thrown into a toilet/latrine or are buried is 72 percent, while for rural children it is only 41 percent. Mother's education is related to use of a toilet/latrine; as mother's education increases, so does the percentage of children who use a toilet/latrine or whose stools are thrown into a toilet/latrine.

Table 13.3 Disposal of children's stools

Percent distribution of mothers who are living with their youngest child under five years, by way in which child's fecal matter is disposed of, according to background characteristics and type of toilet facilities in household, Indonesia 2002-2003

	Stools contained			Stools uncontained				Use diapers					
Background characteristic	Child always uses toilet/ latrine	Thrown into toilet/ latrine	Buried in yard	Thrown outside dwelling	Thrown outside yard	Rinsed away	Not disposed of	Dispos-able	Wash-able	Other	Missing	Total	Number of mothers
Residence													
Urban	29.8	40.7	1.1	13.8	3.7	3.6	0.0	0.3	6.4	0.1	0.4	100.0	5,804
Rural	13.9	23.2	4.3	30.0	12.1	5.2	0.4	0.2	10.0	0.3	0.4	100.0	6,598
Education													
No education	5.7	19.7	3.6	37.9	18.3	7.4	0.3	0.0	6.3	0.3	0.6	100.0	564
Some primary	12.6	20.7	4.8	37.1	12.5	4.1	0.4	0.2	6.8	0.3	0.3	100.0	1,780
Completed primary	17.9	27.8	3.3	26.2	9.6	4.4	0.3	0.2	9.8	0.2	0.4	100.0	4,230
Some secondary	20.9	36.6	2.2	19.1	8.0	4.2	0.1	0.2	7.9	0.3	0.4	100.0	2,550
Secondary+	33.5	40.0	1.3	9.5	2.5	4.5	0.1	0.5	7.8	0.0	0.4	100.0	3,278
Toilet facilities													
None	4.1	7.3	3.9	55.7	12.2	5.6	0.1	0.2	10.3	0.4	0.4	100.0	2,338
Pit latrine	16.4	33.3	2.0	23.5	9.7	5.2	0.1	0.0	8.6	0.1	1.1	100.0	1,006
Flush toilet	32.8	43.9	1.5	6.6	2.9	3.8	0.1	0.4	7.7	0.1	0.3	100.0	6,609
Other	8.7	19.7	5.6	33.2	18.0	5.0	0.9	0.1	8.1	0.5	0.3	100.0	2,422
Total	21.3	31.4	2.8	22.4	8.2	4.5	0.2	0.3	8.3	0.2	0.4	100.0	12,402

Note: Total includes 25 cases in which information on type of toilet facility is missing.

Appendix Table A.13.2 shows the variation in the disposal of children's stools by province. Children in DKI Jakarta are the most likely to use a toilet/latrine (45 percent), followed by Bali (30 percent) and North Sulawesi (30 percent). Less than 10 percent of children in North Sumatera, West Nusa Tenggara, East Nusa Tenggara, Central Kalimantan, and Southeast Sulawesi use toilets or latrines. Provinces where stools are most likely thrown into a toilet/latrine are East Kalimantan and DI Yogyakarta (49 and 43 percent, respectively). Unhealthy behaviors such as throwing children's stools outside the dwelling or yard are common in provinces such as West Nusa Tenggara (60 percent) and Bangka Belitung (54 percent).

13.3 PREVALENCE OF DIARRHEA

Diarrhea has been singled out for investigation for two reasons. In many countries, dehydration from watery diarrhea is a major cause of death in infancy and childhood, and the condition is amenable to treatment by oral rehydration therapy. This combination of a high cause-specific mortality rate and the existence of effective treatment makes diarrhea and its treatment a priority concern for health services. Table 13.4 shows the prevalence of diarrhea for children under five years by background characteristics. The reference period is the two weeks preceding the interview. This measure is affected by the reliability of the mother's recall as to when the diarrheal episode occurred. Since the number of cases of diarrhea varies seasonally, the time of year in which the fieldwork was carried out (October 2002 to April 2003) should be taken into account in interpreting the findings.

Table 13.4 shows that 11 percent of children under five had diarrhea in the two weeks preceding the survey. This figure is similar to those found in the 1994 and 1997 IDHS data (9 and 12 percent, respectively). The prevalence of diarrhea is highest among children age 6-11 months. Diarrhea prevalence does not vary by the child's sex and residence. However, mother's education is associated with the prevalence of diarrhea among their children. Children whose mothers have secondary or higher education are least likely to have diarrhea. While the difference is small, children whose source of drinking water is surface water are slightly more likely to have diarrhea than other children.

Table 13.4 Prevalence of diarrhea

Percentage of children under five years with diarrhea in the two weeks preceding the survey, by background characteristics, Indonesia 2002-2003

Background characteristic	Diarrhea in the two weeks preceding the survey	Number of children
Age in months		
<6	8.7	1,570
6-11	19.4	1,373
12-23	14.8	2,819
24-35	12.0	3,026
36-47	7.9	3,008
48-59	6.4	2,714
Sex		
Male	10.8	7,483
Female	11.2	7,026
Residence		
Urban	11.2	6,830
Rural	10.8	7,680
Mother's education		
No education	11.9	666
Some primary	15.5	2,102
Completed primary	11.3	4,865
Some secondary	11.0	2,947
Secondary+	8.1	3,929
Source of drinking water		
Piped	11.8	2,525
Protected well	10.3	5,807
Open well	11.0	2,600
Surface	13.8	2,210
Other/missing	8.0	1,368
Total	11.0	14,510

Appendix Table A.13.3 shows the variation in the prevalence of diarrhea by province. Diarrhea prevalence is highest in South Sulawesi (16 percent) and West Java (15 percent). On the other hand, diarrhea prevalence is lowest in Central Kalimantan (2 percent) and South Sumatera (3 percent).

13.4 KNOWLEDGE OF DIARRHEA CARE

Oral rehydration therapy (ORT), including a solution prepared from ORS packets (prepackaged oral rehydration salts) and increased fluids, has been recommended for treating diarrhea. In Indonesia, ORT is promoted through health education and mass media campaigns. In the IDHS, a mother is classified as knowing about ORT if she reported ever hearing about Oralit, the brand of ORS most commonly used, or ever seeing an ORS packet.

Table 13.5 shows the percentage of mothers who gave birth in the five years preceding the survey and who know about ORS packets. Overall, 92 percent of these mothers know about ORS packets. Knowledge about ORS packets does not vary much by respondent's age and residence. Mother's education is positively associated with knowledge of ORS packets, with 68 percent of mothers with no education knowing about ORS packets, compared with almost all mothers who completed secondary education.

Table 13.5 Knowledge of ORS packets

Percentage of mothers with births in the five years preceding the survey who know about ORS packets for treatment of diarrhea, by background characteristics, Indonesia 2002-2003

Background characteristic	Percentage of mothers who know about ORS packets	Number of mothers
Age		
15-19	85.2	543
20-24	92.1	2,855
25-29	95.1	3,665
30-34	95.2	2,868
35-49	87.9	2,831
Residence		
Urban	95.3	5,970
Rural	90.0	6,791
Education		
No education	68.1	580
Some primary	85.8	1,849
Completed primary	92.4	4,359
Some secondary	95.4	2,614
Secondary+	98.1	3,359
Total	92.4	12,760

ORS = Oral rehydration salts

Appendix Table A.13.4 shows mother's knowledge of ORS packets by province. Mother's knowledge of ORS packets is lowest in Banten (67 percent) and highest in DKI Jakarta and DI Yogyakarta (99 percent).

13.5 DIARRHEA TREATMENT

Table 13.6 provides information on whether medical care and treatment were sought for childhood diarrheal episodes in the two weeks preceding the survey, including the percentage of children receiving various treatments for diarrhea. Particular attention is focused on treatment with ORT, which includes solutions prepared from ORS packets, recommended home fluids, and increased fluids.

Table 13.6 shows that 51 percent of children under five years with diarrhea in the two weeks preceding the survey were taken to a health facility or provider. Treatment of diarrhea varies by the child's age; infants under six months and children three years or older are less likely to be taken to a health facility or provider. Female children and children in urban areas are somewhat more likely to receive care from a health provider than other children.

Table 13.6 Diarrhea treatment

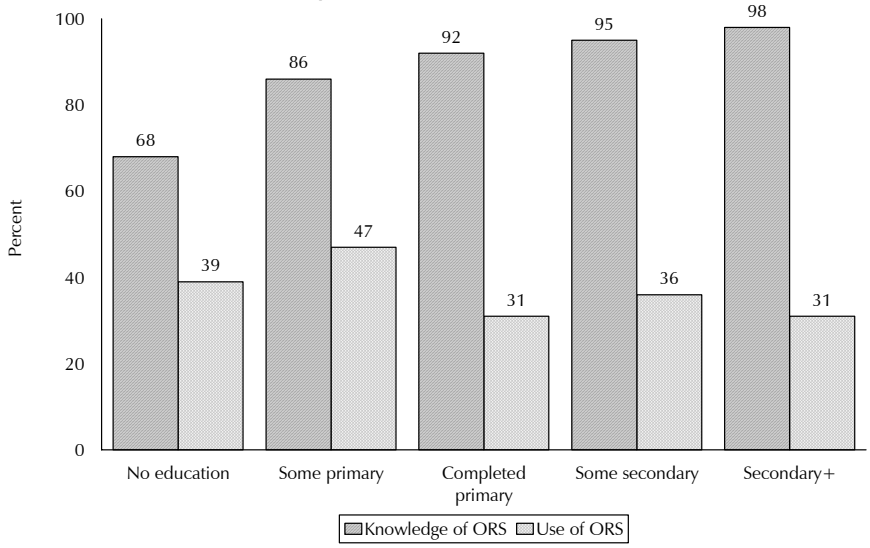
Among children under five years of age who had diarrhea in the two weeks preceding the survey, percentage taken for treatment to a health provider, percentage who received oral rehydration therapy (ORT), and percentage given other treatments, according to background characteristics, Indonesia 2002-2003

		Oral rehydration therapy (ORT)					Other treatments						
Background characteristic	Percentage taken to a health facility or provider[1]	Oral rehydration salts (ORS) packets	Recommended homemade fluids (RHF)	Either ORS or RHF	Increased fluids	ORS, RHF or increased fluids	Pill or syrup	Injection	Intravenous solution	Home remedy/ other	Missing	No treatment	Number of children with diarrhea
Age in months													
<6	24.0	15.3	13.2	26.3	25.3	39.6	30.0	0.6	0.0	17.4	0.0	41.1	137
6-11	60.0	35.5	15.4	45.2	26.3	59.2	59.9	0.7	0.4	8.9	0.0	16.6	267
12-23	59.7	35.4	22.2	51.6	29.1	60.7	60.2	1.2	0.1	10.8	0.0	12.2	417
24-35	55.2	34.7	24.7	45.5	30.3	61.5	64.6	1.1	1.7	13.9	0.0	8.2	364
36-47	39.1	40.4	23.7	51.4	24.7	62.2	51.1	0.9	0.0	11.6	2.8	12.4	237
48-59	43.7	46.6	26.4	65.1	33.4	75.3	66.3	0.0	0.0	15.0	0.0	4.3	175
Sex													
Male	49.0	33.0	24.1	48.0	24.9	56.3	59.9	0.6	0.9	11.1	0.0	15.3	808
Female	52.7	38.0	18.9	48.9	32.0	65.0	55.8	1.1	0.0	13.6	0.8	12.0	788
Residence													
Urban	54.6	35.0	21.8	48.9	29.0	62.5	59.8	0.7	0.9	10.5	0.8	12.6	767
Rural	47.3	35.9	21.3	48.0	27.9	58.9	56.1	1.0	0.0	14.1	0.0	14.7	829
Mother's education													
No education	31.7	39.3	16.4	48.9	34.5	57.4	43.4	0.0	0.0	19.6	0.0	23.9	79
Some primary	50.6	47.0	17.6	55.4	23.0	63.1	51.8	0.7	1.5	9.0	0.0	18.6	326
Completed primary	48.8	30.7	23.5	44.5	27.7	60.0	61.8	1.1	0.0	7.5	1.2	11.9	550
Some secondary	50.1	35.6	20.5	49.4	31.8	60.9	55.8	0.9	0.0	20.5	0.0	12.8	323
Secondary +	60.1	31.0	24.5	47.0	30.2	59.8	63.1	0.8	0.8	14.1	0.0	10.0	318
Total	50.8	35.5	21.6	48.4	28.4	60.6	57.9	0.9	0.5	12.3	0.4	13.7	1,596

Note: ORT includes solution prepared from oral rehydration salt (ORS) packets, recommended homemade fluids (RHF), or increased fluids.
[1] Excludes pharmacy, shop, and traditional practitioner

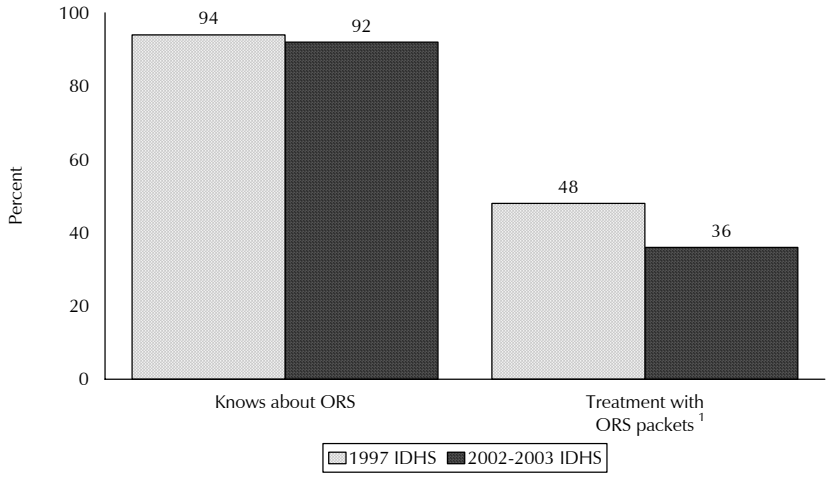
Treatment of children with diarrhea varies by mother's education. Children of mothers with no education are the least likely to be taken to a health facility or provider, while children whose mothers have secondary or higher education are the most likely to receive care from a health professional. However, the association between treating children with diarrhea with ORS and mother's education is less clear (Figure 13.1).

Figure 13.1 **Knowledge and Use of ORS Packets among Mothers Who Gave Birth in the Past Five Years, by Level of Education**



Children who have diarrhea may be given a solution prepared from ORS packets, homemade fluids, other treatments, increased fluids, or a combination of these treatments. Although more than 90 percent of mothers reported that they know about ORS packets, only 36 percent of children with diarrhea were treated with ORS. This percentage is much lower than that in the 1997 IDHS (48 percent) (Figure 13.2). Overall, 22 percent of children with diarrhea were given recommended home fluids (RHF), 48 percent received either ORS or RHF, 58 percent were given some pill or syrup for treatment, and 12 percent were given a home remedy. While the majority of children with diarrhea were given ORS, RHF, or increased fluids, 14 percent of children received no treatment at all.

Figure 13.2 **Trends in Knowledge and Use of ORS Packets for Treatment of Diarrhea by Mothers who Gave Birth in the Past Five Years**



Note: The 2002-2003 IDHS did not include Nanggroe Aceh Darussalam, Maluku, North Maluku, and Papua province. Previous surveys included East Timor.
[1] Children under five who had diarrhea in the two weeks preceding the survey
ORS = Oral rehydration salts

13.6 FEEDING PRACTICES DURING DIARRHEA

The recovery of a child suffering from diarrhea may depend on the feeding practices during and between diarrhea episodes. In particular, consumption of extra fluids is essential. Table 13.7 presents data on feeding practices of children who had diarrhea in the two weeks preceding the survey. The data show that only 28 percent of children with diarrhea were given more fluids than usual, while 47 percent were given the same amount of fluids. It should be noted that 24 percent of children with diarrhea were given less fluid or none at all.

Diarrheal episodes are frequently accompanied by vomiting, which makes feeding difficult because the child may refuse food. Table 13.7 shows that only 10 percent of children were given more food than usual, while 44 percent were given less food or none at all. Overall, results of the 2002-2003 IDHS show that feeding practices of children with diarrhea in Indonesia are not consistent with recommended interventions.

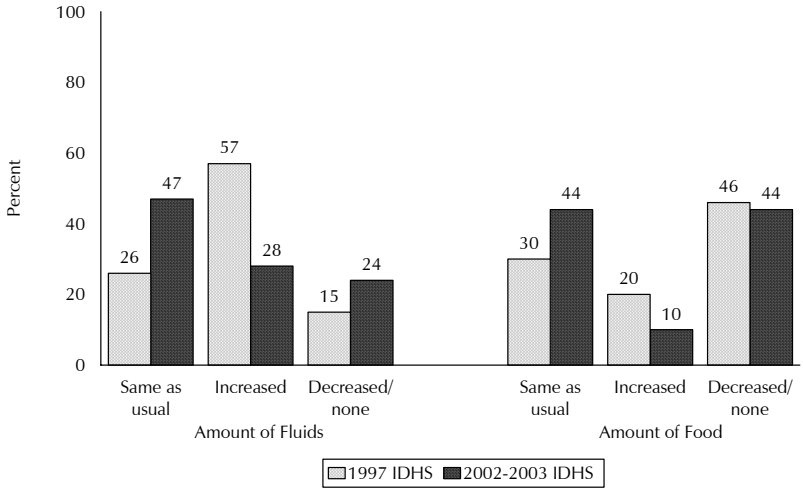
Table 13.7 Feeding practices during diarrhea

Percentage of children under five years who had diarrhea in the two weeks preceding the survey, by amount of fluids and food offered, compared with normal practice, Indonesia 2002-2003

Feeding practices	Percentage
Amount of fluids offered	
Same as usual	46.9
More	28.4
Somewhat less	16.5
Much less	1.2
None	5.9
Don't know/missing	1.1
Total	100.0
Amount of food offered	
Same as usual	44.3
More	9.9
Somewhat less	38.0
Much less	2.8
None	3.4
Never gave food	0.8
Don't know/missing	0.9
Total	100.0
Number of children	1,596

Figure 13.3 compares feeding practices during diarrhea in 1997 and 2002-2003. The figures suggest that appropriate feeding practices have deteriorated. The percentage of children who were given increased fluids and increased foods in 2002-2003 is half of that in 1997. For example, while 57 percent of children with diarrhea were given increased fluids in 1997, the corresponding proportion in 2002-2003 was only 28 percent.

Figure 13.3 **Trends in Feeding Practices among Children Under Five with Diarrhea**



Note: The 2002-2003 IDHS did not include Nanggroe Aceh Darussalam, Maluku, North Maluku, and Papua province. Previous surveys included East Timor.

13.7 CHILDREN'S HEALTH CARE AND WOMEN'S STATUS

The 2002-2003 IDHS investigated the relationship between children's health care and women's status as measured by their ability to influence household decisionmaking, the number of situations in which they believe that a woman is justified in refusing sexual relations with her husband, and the number of circumstances in which she believes that a husband is justified in beating his wife.

Table 13.8 shows little relationship between women's status and children's health care. Although there is a slight positive relationship between women's participation in household decisionmaking and vaccination coverage, the relationship is weaker for treatment of childhood fever and is slightly negative for the likelihood of children's being taken for treatment when they are ill with diarrhea. As for the number of reasons for which women are justified in refusing sex with their husbands, the expected relationship is positive, i.e., the more reasons, the higher the percentage. However, the actual relationship is not linear for any of the three child health variables. Similarly, for the number of reasons for which wife beating is justifiable, the expected negative relationship is found only for the percentage of children with symptoms of ARI or fever who are taken for treatment.

Table 13.8 Children's healthcare by women's status

Percentage of children age 12-23 months who were fully vaccinated and percentages of children under five years who were ill with a fever and/or symptoms of ARI and diarrhea in the two weeks preceding the survey who were taken to a health provider for treatment, by women's status indicators, Indonesia 2002-2003

	Children age 12-23 months fully vaccinated[1]		Children with fever and/or symptoms of ARI taken to a health provider[2]		Children with diarrhea taken to a health provider[2]	
Women's status indicator	Percentage	Number	Percentage	Number	Percentage	Number
Number of decisions in which woman has final say[3]						
0	*	6	*	29	*	15
1-2	41.6	120	50.5	243	57.4	126
3-4	48.3	819	56.6	1,272	49.3	496
5	53.5	1,874	57.4	2,444	50.5	958
Number of reasons to refuse sex with husband						
0	50.4	168	53.3	266	52.8	100
1-2	42.6	273	57.3	431	53.0	194
3-4	52.5	2,378	57.0	3,291	50.4	1,302
Number of reasons wife beating is justified						
0	51.4	1,997	59.5	2,646	50.7	1,051
1-2	52.7	619	54.1	971	53.8	397
3-4	45.4	165	44.1	307	39.6	116
5	(63.4)	38	(43.6)	63	(57.7)	32
Total	51.5	2,819	56.8	3,988	50.8	1,596

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

[1] Those who have received BCG, measles, and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth)

[2] Excludes pharmacy, shop, and traditional practitioner

[3] Either alone or jointly with others

13.8 HAND-WASHING PRACTICES

Many diseases are readily transmitted through contaminated food or from hand to mouth. Hand washing minimizes the transmission of both enteric (fecal) and respiratory pathogens. In the 2002-2003 IDHS, respondents were asked whether they washed their hands before preparing meals for their family.

Table 13.9 shows that 96 percent of women wash their hands before preparing meals. There are almost no differences in the practice by background characteristics or the availability of water.

Table 13.9 Hand-washing practices

Percentage of women who washed their hands before preparing a meal for their family the last time, according to background characteristics, Indonesia 2002-2003

Background characteristic	Washed hands	Did not wash hands	Never prepared meals	Missing	Total	Number of women
Age						
15-19	94.4	2.4	3.2	0.0	100.0	956
20-24	96.0	2.5	1.5	0.0	100.0	3,875
25-29	96.5	2.4	1.0	0.0	100.0	5,375
30-34	95.9	2.3	1.7	0.0	100.0	5,428
35+	95.1	2.4	2.4	0.1	100.0	13,848
Residence						
Urban	96.7	1.6	1.7	0.1	100.0	13,499
Rural	94.7	3.1	2.2	0.0	100.0	15,984
Source of drinking water						
Piped	95.9	2.1	1.9	0.1	100.0	4,987
Protected well	96.4	1.9	1.6	0.0	100.0	12,291
Open well	95.6	2.6	1.7	0.1	100.0	5,150
Surface	92.4	4.1	3.6	0.0	100.0	4,541
Other	96.9	1.6	1.4	0.0	100.0	2,510
Time to get water						
In dwelling/yard/plot	96.4	1.9	1.7	0.1	100.0	22,428
Less than 2 minutes	98.9	1.1	0.0	0.0	100.0	153
2-4 minutes	94.8	2.5	2.7	0.0	100.0	677
5-9 minutes	95.3	3.1	1.6	0.0	100.0	2,152
10+ minutes	91.0	4.9	4.0	0.1	100.0	3,746
Total[1]	95.6	2.4	2.0	0.1	100.0	29,483

[1] Total includes 5 women with missing information on source of drinking water and 327 women with missing information on time to get water.