Measuring the fulfilment of Human rights in Maternal and Neonatal Health

USING WHO TOOLS

IN 2 CITIES & 2 DISTRICTS IN WEST AND EAST NUSA TENGGARA, INDONESIA

REPORT ON PROVINCIAL & DISTRICT LAWS, REGULATIONS, POLICIES AND STANDARDS OF CARE

November 2008

The Ministry of Health
Provincial Government of West Nusa Tenggara
Provincial Government of East Nusa Tenggara
Supported by: the Indonesian German Development Cooperation Health Sector Support team

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FOREWORD FROM THE HEAD OF THE EAST NUSA TENGGARA PROVINCIAL HEALTH OFFICE

Praise to the Almighty God for His guidance and blessings for the Report Survey on Human Rights for Maternal and Neonatal Reproduction in Timor Tengah Selatan and Kota Kupang is completed.

In early 2007, The Ministry of Health supported by WHO launched The National Report – Using Human Rights for Maternal and Neonatal Health: A tool for strengthening laws, policies, and standards of care. The Federal German and British Government, through GTZ-SISKES, were also supporting the funding for this report. However, this National Report brought up questions demanding further research to apply this method at local level to generate the fulfilment of Human Rights for Maternal and Neonatal Reproduction at Province, District/City level. Responding to the call, a survey at local level was conducted, in which East Nusa Tenggara (NTT) was one of the eligible Provinces.

Since the survey was conducted to test a new tool, not all districts in NTT were included. There are several reasons in choosing Timor Tengah Selatan and Kota Kupang. First, each represents an urban and a rural region. Secondly, they were covered in the MPS (Making Pregnancy Safer) Programme conducted by NTT Provincial Health Office supported by GTZ-SISKES which is funded by DFID-UK (Department for International Development-United Kingdom). Considering the diversity of culture and the width of the area in NTT, these two selected areas cannot completely represent NTT as a whole, however it is expected that the result from these areas can be replicated in other district in NTT for a better mapping on the fulfilment of Human Rights for Maternal and Neonatal Reproduction.

We acknowledged that within the research, every stakeholder involved has done their utmost best, starting from the process of gathering secondary data, conducting respondent interviews, analysing data and eventually producing comprehensive results.

Therefore, in this foreword we intend to state our great appreciation and gratitude. May the Almighty God always give His blessing to all who were involved in this research, and we sincerely hope that the result can facilitate the improvement of Maternal and Children Health Care which leads to the fulfilment of Human Rights for Reproduction Health in Indonesia in general and specifically in NTT.

Kupang, 21 April 2009

Head of Provincial Health Office
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FOREWORD FROM THE HEAD OF THE WEST NUSA TENGGARA PROVINCIAL HEALTH OFFICE

Assalamualaikum warahmatullahi wabarakatuh

Praise and gratitude to God the Al Mighty for His mercy to all of us so we can finished this research report on " Measuring the Fulfillment of Human Rights in Maternal and Neonatal Health ".

Maternal and infant health, especially newborn health and nutrition status among children and pregnant women are still major health issues faced by NTB which need to be address using all available resources.

This report seeing an imbalance on the implementation of laws, policies and its service provision at province and district level related to health service in maternal and newborn health links to the issue of human right fulfillment in general. It was discovered that the access to health service need higher attention with regards to provider skills on provision of the service, limitation of infrastructure especially in remotes area including accessibility to blood bank, financing, gender, communicable disease include STI (and HIV/AIDS), the long amendment process and the need to revise population law and other regulation which make sure the continuum of reproductive health service.

With the results of this report, we hope to open the insight of related stakeholder to improve the overall health service especially for the poor, gender and remote areas. Other sectors could also use this report to developed NTB development strategy and make any decisions on it in order to fulfill the human rights for population in NTB which lead to HDI improvement in the Province of NTB from 32 out of 33 provinces in Indonesia.

There are some shortcoming of the findings and review in this report. Therefore, we are open for additional critics and suggestion for its completion. In this occasion, we want to express our gratitude to all people who gave the effort to finish this report, especially for GTZ who gave its support for the finalization of this report. We also apologize if there was on purpose and inadvertence misunderstanding during preparation, implementation and the finalization of this report.

May God always gives his bless to all of us, Ameen

Wassalamualaikum warahmatullahi wabarakatuh

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FOREWORD FROM GTZ SISKES

In early 2007, the Ministry of Health with WHO support released the National Report - Using Human Rights for Maternal and Neonatal Health: A tool for strengthening laws, policies and standards of care. Siskes/GTZ with German and British Government funding also supported this report. This national report led to an investigation of how the methodology could be adapted to collect data at decentralized levels, which could potentially be used for improvements in human rights at provincial and district levels. This report contains secondary data on how maternal and neonatal health and human rights are represented and protected in national, provincial and district laws, policies, plans and their implementation. It also contains supporting primary data on maternal and neonatal health and human rights collected using a survey conducted in two cities and two rural districts in West Nusa Tenggara and East Nusa Tenggara provinces.

The report was finalized through a long process, starting from the collection of primary and secondary data by the research team, led by local NGOs in West and East Nusa Tenggara provinces. The research design, statistical analysis of primary data, and horizontal and vertical analysis of secondary data, and preparation of the research report was guided by several consultants. Recommendations and strategy formulation to address priority health issues were generated and ratified in workshops attended by stakeholders from related sectors in West and East Nusa Tenggara.

Priority health issues described in this report are:

1) Pregnancy, childbirth and the postpartum period: access to health services
2) Family planning: levels of knowledge about family planning methods; accessibility of family planning for unmarried people; husband authorization to seek services
3) Levels of birth registration
4) STIs and HIV/AIDS: knowledge, education and access to services for prevention and treatment
5) Violence against women
6) Unmet need for safe abortion services
7) Adolescent reproductive health: early marriage and pregnancy, and limited access to sexual and reproductive health education and services
8) This report also identifies vulnerable groups, as well as discrimination and equity issues, related to the fulfilment of human rights in maternal and neonatal health in the community.

The purpose of this research was to analyse health related data, as well as laws, policies, strategies in the context of Indonesia's human rights commitments, in order to measure the fulfilment of human rights related to maternal and neonatal health at the provincial level. The information generated by this research will provide an evidence base that can inform health interventions and promotion, legal and policy development and revision, support human rights advocacy and formulate relevant action plans to overcome barriers identified to the fulfilment of human rights in maternal and neonatal health.

We want to apologize that this final report comes out so late due to issues such as getting agreement on the results and finalising the editing of the report. We hope nevertheless that the results are still valuable, even if there are already some changes at local level. The conclusions and recommendations are the opinion of the researchers and the stakeholders and do not automatically reflect the opinion of GTZ and the Principal Advisor of the SISKES project.

We wish to thank all researchers and stakeholders involved in the research process, data analysis, and the drafting of this report and its recommendations. Special thanks also go to the women who shared their time and experiences through their willing participation in the primary data survey. We sincerely hope that this report will be useful to the many people in both government and NGO sectors working towards the fulfilment of human rights related to maternal and neonate health and the improvement of maternal and infant health in West and East Nusa Tenggara, and throughout Indonesia.

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Mataram, December 2008

CONTENTS

CONTENTS

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ABBREVIATIONS

Indonesian Abbreviation	Indonesian full term	English Abbreviation	Full term
	Kader		Volunteer Health Worker
	Same as English	AIDS	Acquired Immune Deficiency Syndrome
	Pemeriksaan Kehamilan	ANC	Ante Natal Care
	Kesehatan Reproduksi Remaja	ARH	Adolescent Reproductive Health
	Same term as English	ARV	Anti Retro Viral
	Badan Kerjasama Pembangunan Internasional Australia	AusAID	Australian Government Overseas Aid Program
	Deklarasi Beijing dan landasan aksi	BPFA	Beijing Platform For Action
	Sistim Pengawasan Perilaku	BSS	Behaviour Surveillance System
	Unit Transfusi Darah	BTU	Blood Transfusion Unit
	Same term as English	CD	Compact Disc
	Konvensi Penghapusan Segala Bentuk Diskriminasi Terhadap Wanita	CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
	Convenan Internasional Tentang Hak Sosial,Ekonomi dan Budaya	CESC	Covenant on Economic, Social and Cultural Rights
	Algoritma untuk memastikan integritas data dan mengecek kesalahan pada suatu data yang akan ditransmisikan atau disimpan.	CRC	Cyclic Redundancy Check
	Pelayanan Bantuan Kemanusiaan Katolik	CRS	Catholic Relief Services
	Tehnik Kontrasepsi Mutakhir	CTU	Contraceptive Technique Update
	Pelayanan Gereja Dunia Untuk kemanusiaan	CWS	Church World Service
	Departemen Pembangunan Internasional Milik Pemerintah Inggris	DFID	Department for International Development
	Dinas Kesehatan Kabupaten	DHO	District Health Office
	Pemotongan Alat Kelamin Perempuan	FGC	Female Genital Cutting
	Mutilasi Alat Kelamin Perempuan	FGM	Female Genital Mutilation
	Konfrensi Wanita Sedunia ke empat (4)	FWCW	Fourth World Conference on Women
	Pemerintah Indonesia	GOI	Government of Indonesia
	Dokter Umum	GP	General Practitioner
	Kerjasama Tekhnis Pemerintah Jerman	GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)

	Index pembangunan manusia	HDI	Human Development Index
	Same term as English	HIV	Human Immunodeficiency Virus
	Pengembangan Sumber Daya Manusia	HRD	Human Resource Development
	Convenan Internasional Tentang Hak Sipil dan Politik	ICCPR	International Covenant on Civil and Political Rights
	Konfrensi Internasional Tentang Kependudukan dan Pembangunan	ICPD	International Conference on Population and Development
	Identitas	ID	Identity
	Survey Demografis dan kesehatan Indoensia	IDHS	Indonesia Demographic and Health Survey
	Pengguna Obat Suntik	IDU	Injection Drug Users
	Informasi, Pendidikan dan Komunikasi	IEC	Information, Education, and Communication
	Proyek Pencegahan dan Penanggulangan HIV AIDS Indonesia	IHPCP	Indonesia HIV AIDS Prevention and Care Project
	Organisasi Buruh Internasional	ILO	International Labor Office
	Angka Kematian Bayi	IMR	Infant Mortality Rate
	Same as English	INGO	International Non Government Organization
	Yayasan Liver Kanai *Memorial*	KAMELIFO	Kanai Memorial Liver Foundation
	Republik Demokrasi Rakyat Lao	Lao PDR	People's Democratic Republic Lao
	Monitoring Pandemik AIDS	MAP	Monitoring the AIDS Pandemic
	Kantor Komisaris Tinggi PBB untu Hak Asasi Manusia	OHCHR	The Office of the United Nations High Commissioner for Human Rights
	Perawatan Pasca Aborsi	PAC	Post Abortion care
	Program Teknologi Kesehatan Tepat Guna	PATH	Program for Appropriate Technology in Health.
	Dinas Kesehatan Propinsi	PHO	Provincial Health Office
	Pencegahan transmisi ibu ke anak	PMTCT	Prevention of mother-to-child transmission
	Kesehatan Reproduksi	RH	Reproductive Health
	Staff Peneliti	RO	Research Officer
	Paket Statistik untuk Ilmu Sosial	SPSS	Statistical Package for the Social Sciences
	Infeksi menular seksual	STI	Sexually Transmitted Infection
	Same term as English	TB	Tuberculosis
	Dukun Melahirkan	TBA	Traditional birth attendant
	Angka Kesuburan Total	TFR	Total Fertility Rate
	Program Bersama PBB untuk HIV/AIDS	UNAIDS	Joint United Nations Programme on HIV/AIDS

	Badan PBB untuk Program Pembangunan	UNDP	United Nations Development Programme
	Badan PBB untuk Pendidikan, Ilmu Pengetahuan, dan Kebudayaan	UNESCO	United Nations Educational, Scientific and Cultural Organization
	Dana Kependudukan PBB	UNFPA	United Nations Population Fund
	Sidang Khusus Majelis Umum PBB	UNGASS	United Nations General Assembly Special Session
	Dana Anak-Anak PBB	UNICEF	United Nations Children's Fund
	Kekerasan terhadap wanita	VAW	Violence Against Women
	konseling dan Tes Sukarela HIV	VCT	Voluntary Counseling and Testing
	Program Pangan Dunia	WFP	World Food Programme
	Organisasi kesehatan dunia	WHO	World Health Organization
APBD	Anggaran Pendapatan dan Belanja Daerah		Regional Budget of Income and Expenditure
APBN	Anggaran Pendapatan dan Belanja Negara		National Budget of Income and Expenditure
APK	Asuhan Pasca Keguguran	PAC	Post abortion care
APN	Asuhan Persalinan Normal		Normal delivery care
Askeskin	Asuransi Kesehatan untuk Masyarakat Miskin		Community Health insurance for the poor
BAPPEDA	Badan Perencanaan Pembangunan Daerah		Regional Development Planning board
BKBKS	Badan Keluarga Berencana dan Keluarga Sejahtera		Family planning & welfare board at district level
BKKBN	Badan koordinasi keluarga berencana nasional		National Family Planning Coordination Board
BPS	Badan Pusat Statistik		Central Bureau of Statistics
Depkes	Departemen Kesehatan	MOH	Ministry of Health
Dinkes	Dinas Kesehatan		District Health Office
DPD	Dewan Perwakilan Daerah		Board of Regional Representatives
DPR RI	Dewan Perwakilan Rakyat Republik Indoensia		National Parliament
DPRD	Dewan Perwakilan Rakyat Daerah		Local Parliament
FKPP	Forum Komunikasi Pondok Pesantren		Islamic Boarding School Communication Forum
GEMAS	Gerakan Masyarakat		Community Movement
IBI	Ikatan Bidan Indoensia		Indonesia Midwives Association
IDAI	Ikatan Dokter Anak Indonesia		Indonesian Pediatrician Association
IDI	Ikatan Dokter Indonesia		Indonesian Medical Association
KB	Keluarga Berencana	FP	Family Planning
KBKS	Keluarga Berencana dan Keluarga Sejahtera		Family planning and family welfare association

KEK	Kurang Energi Kronik		Chronic Energy Deficiency
KIA	Kesehatan Ibu & Anak	MCH	Maternal & Child Health
KPA	Komisi Penanggulangan AIDS		AIDS Prevention Commission
KPAD	Komisi Penanggulangan HIV/AIDS Daerah		Regional AIDS Prevention Commission
KPKK	Kesehatan Perempuan dan Kesejahteraan Keluarga		Women Health and Family Welfare
LBH	Lembaga Bantuan Hukum		Legal Aid Institute
LSM	Lembaga Swadaya Masyarakat	NGO	Non Governmental Organization
M&E	Monitoring dan evaluasi	M & E	Monitoring & Evaluation
NTB	Nusa Tenggara Barat		West Nusa Tenggara
NTT	Nusa Tenggara Timur		East Nusa Tenggara
NU	Nahdatul Ulama		Islamic Women's NGO
ODHA	Orang Dengan HIV/AIDS	PLWA	Person Living with HIV/AIDS
PBB	Perserikatan Bangsa-Bangsa	UN	United Nations
Perda	Peraturan Daerah		Sub National (Provincial) Regulation
PIKPK	Pusat Informasi Kesehatan dan Perlindungan Keluarga		Health and Family Protection Information Centre
PIKRR	Pusat Informasi Kesehatan Reproduksi Remaja		Adolescent Reproduction Health Information Centre
PJKMM	Program Jaminan Pemeliharaan Kesehatan Masyarakat Miskin		Health Insurance for the Poor Program
PKBI	Perkumpulan Keluarga Berencana Indonesia		Indonesian Family Planning Association
PKK	Pemberdayaan Kesejahteraan Keluarga		Family Welfare Development Organization
POGI	Asosiasi Ahli Obstetri dan Ginekologi Indonesia		Indonesian Obstetrician & Gynaecologist Association
PONED	Pelayanan Obstetri Neonatal Emergensi Dasar	BEONC	Basic Emergency Obstetric and Neonatal Care
PONEK	Pelayanan obstetri neonatal emergensi komprehensif	CEONC	Comprehensive Emergency Obstetric and Newborn Care
Posyandu	Pos Pelayanan Terpadu		integrated maternal and child health service post
PPK	Perkumpulan Panca Karsa		
PT. Askes	Peseroan terbatas Asuransi Kesehatan		GOI Health Insurance scheme for the poor
Puskesmas	Pusat Kesehatan Masyarakat		Community health clinic
RPK	Ruang Pelayanan Khusus		Special Service Shelter
RSUD	Rumah Sakit Umum Daerah		Hospital at District Level

Setda	Sekretaris daerah		Local Government Secretary
SH	Sarjana Hukum		Baccalaureate Degree in Law
SISKES	Sistem Kesehatan		Health System
SKM	Sarjana Kesehatan Masyarakat		Baccalaureate Degree in Public health
Susenas	Survei Sosial-Ekonomi Nasional		National Economic & Social Survey
TTS	Timor Tengah Selatan		South Middle Timor
TTU	Timor Tengah Utara		North Middle Timor
UKS	Usaha Kesehatan Sekolah		School Health Program
YKP	Yayasan Kesehatan Perempuan		Women's Health Foundation
YKSSI	Yayasan Keluarga Sehat Sejahtera Indonesia		Indonesian Healthy Family and Welfare Foundation

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CHAPTER 1

INTRODUCTION

1. INTRODUCTION

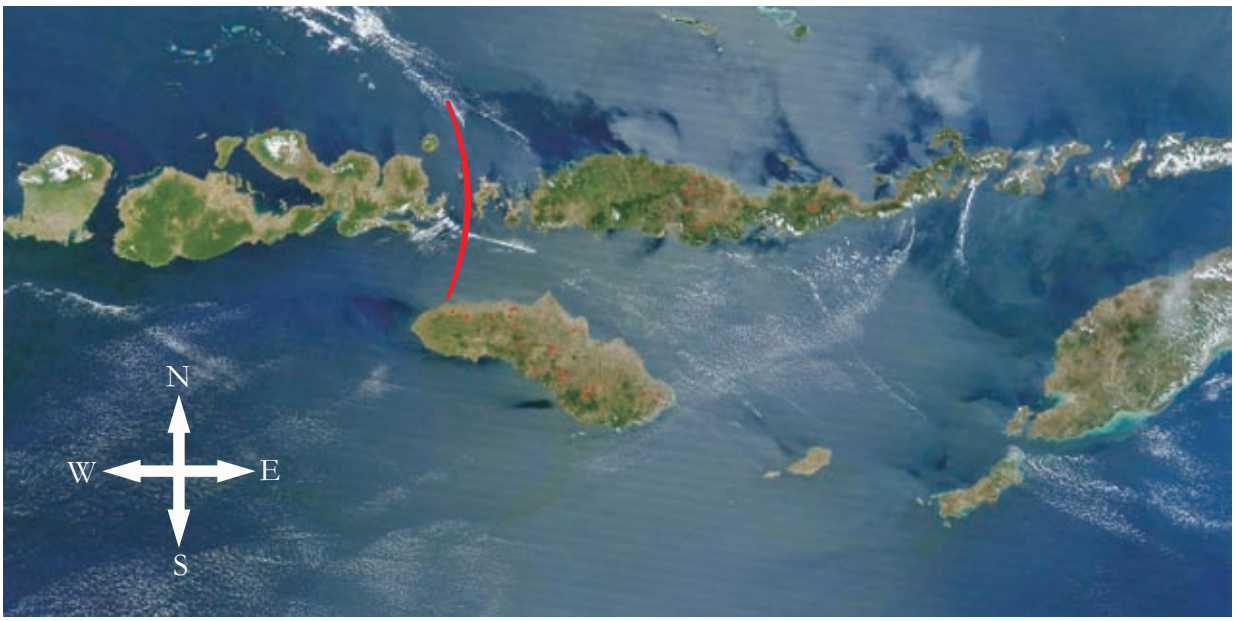
This report summarizes the outcomes of exploratory research on human rights in maternal and neonatal health in two cities and two rural districts of Eastern Indonesia, and considers the research findings in the context of Indonesia's national human rights commitments. The research was conducted in 2007, following completion of a national level enquiry that was conducted from 2005 to 2006. The national enquiry was conducted in partnership between the Ministry of Health, WHO and various other stakeholders. The enquiry was part of a pilot[2] to test the WHO Tool - *Using human rights for maternal and neonatal health: a Tool for strengthening laws, policies and standards of care in three countries; Brazil, Mozambique and Indonesia.* To contribute to the baseline data for the SISKES Health Project in Nusa Tenggara Barat and Timor Provinces the WHO Tool was adapted and primary data collection was also undertaken, to more intensively examine human rights issues related to maternal and neonatal health at provincial and district levels.

Decentralization legislation was passed in Indonesia in 1999, which devolved new powers and responsibilities to provincial and sub-provincial levels. Thus, it is within an environment of adaptation and capacity building for provincial and sub-provincial authorities and services that this research was conducted.

All efforts have been made to include the most recent data available on government efforts at promoting human rights in maternal and neonatal health in Nusa Tenggara Barat (NTB) and Nusa Tenggara Timor (NTT). However, because the pace of progress in addressing maternal and neonatal health issues in these provinces is increasing due to decentralization, it is possible that further improvements have been made in the time between the completion of data collection and the publication of this report.

While Indonesia overall has a HDI (0.697 in 2005), superior to many Southeast Asian neighbors, the two provinces featured in this report are similar in terms of development to Indonesia's poorest neighbors. The HDI in (NTB) is 0.578

Map of West and East Nusa Tenggara Islands



Source: http://visibleearth.nasa.gov/view_rec.php?id=5819

[1] Using Human Rights for Maternal and Neonatal health: *A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis, MOH and WHO Indonesian Office* (2007).
[2] The research was further supported by the Ford Foundation, UNFPA, UNICEF and a grant from the SISKES Program.

(similar to Myanmar) and in NTT it is 0.603 (similar to Lao PDR)[3]. As it is widely recognized that poverty and underdevelopment have an inhibiting effect upon the full realization of human rights, and on the promotion of maternal and child health, these two provinces are ideal locations for exploring how data on human rights and maternal and neonatal health can be adequately collected and utilized by key stakeholders in resource poor settings.

1.1 Geographical, demographic and historical context

The Nusa Tenggara islands are generally resource poor and sparsely populated. In the easternmost islands, the climate is dry and the landscape is hilly. Nusa Tenggara is significantly different from the rest of Indonesia geographically, ethnically and culturally. It begins immediately to the east of the Wallace Line, which marks the edge of the Asian continental shelf. It is to the east of this line that Southeast Asian flora and fauna becomes more scarce and Australasian flora and fauna begins to dominate.

Previously, Nusa Tenggara was referred to as belonging to the Lesser Sunda Islands which included Bali, West Nusa Tenggara and East Nusa Tenggara, and the capital city was Singaraja in Bali. In 1958, the area was divided into three provinces: Bali, West Nusa Tenggara and East Nusa Tenggara. The administrative capital of NTB province is the city of Mataram on Lombok island, and the administrative capital of NTT province is the city of Kupang on Timor island. The populations of these two provinces are similar in size, estimated to be 4.2 million NTB and 4.1 million NTT[4].

NTB has two main islands, Lombok and Sumbawa, and hundreds of small islands. In general, NTB's landscape is fertile and wealthy in minerals, flora and fauna. The majority of the population is Muslim. The local syncretic form of Islam practiced in NTB is significantly influenced by the beliefs of the Sasak ethnic group, who are the indigenous inhabitants of Lombok. The west coast of Lombok also has a significant minority population of Balinese who have resided on the island for some generations.

NTT has a drier climate and the land tends to be less fertile

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East Nusa Tenggara: An elderly lady with tattoos from Betun © SISKES

than the islands of NTB. NTT includes several large islands - Flores, Sumba, Alor, Rote, Sabu, and Timor.

The majority of NTT's population is Christian (Protestant and Catholic). In Flores, the Roman Catholic Church has a very strong presence and plays a significant role in development practices. In many cases, the government considers the role of church when planning policy. However, some ethnic groups living in remote areas of NTT continue to practice indigenous religions, such as the Merapu in Sumba and the Jingitiu in Sabu.

Bahasa Indonesia is used as both the official language and in public daily life. However, in Nusa Tenggara people are most likely to use their own languages and dialects in the domestic sphere. There are 73 local languages still alive in Nusa Tenggara.

Lombok is a densely populated island, and is home to around 75% of NTB's population. On Lombok, village populations can reach up to 6,000 people. Most of the remaining 25% of NTB's

[3] According to the 2007/2008 UNDP Human Development Index rankings, accessed at: http://hdr.undp.org/en/statistics/.
[4] Biro of Statistics (BPS) NTB and NTT.

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West Nusa Tenggara: A family sits on the stairs of their traditional house in the remote mountainous inlands of Sumbawa © SISKES

population live on Sumbawa, which is a much larger island that typically has smaller village populations of around 2,250 people. Very small populations live on lesser islands dotted off the coast of the larger islands in both provinces.

In terms of local land and sea transport, Lombok can be reached by ferry in four hours from Bali. Bima the easternmost city of NTB, can be reached by a combination of road and ferry travel within 12 hours from Mataram via East Lombok or by plane via Mataram or Denpasar.

NTT province has many more populated islands than NTB. These smaller islands have poor accessibility from NTT's provincial capital Kupang. The population in West Timor constitutes less than 50% of the province's total population. In NTT, villages tend to have small populations of less than 1,800 people.

The scattered islands of NTT mean that both road and sea transport can be difficult, and there is a heavy reliance on ferry services. Difficulty in accessing remote communities in NTT is a key difference between the two provinces that needs to be taken into account when considering the research findings and the development of feasible recommendations.

1.2 Goal and objectives of the research

The goal of this research was to collect and analyse data on the fulfilment of human rights in maternal and neonatal health in two cities and two districts in NTB and NTT provinces. The research commenced in early 2007 and was finalized in November 2007.

1.3 Specific Objectives

1) To collect and analyse all relevant secondary data on the fulfilment of human rights in maternal and neonatal health using a revised version of the WHO human rights tool, which we refer to in this report as TOOL A.

2) To produce and analyse primary data using a survey specifically designed to collect information directly from women about how women's and their infants' health at national, provincial and districts levels (in reference to two cities and two districts in NTB and NTT.)

3) To generate a multilevel analysis of the research findings, that allows comparison of efforts in addressing human rights in relation to maternal and neonatal health, and whether they are being addressed (or not).This is referred to as TOOL B.

4) To engage local stakeholders in the design, collection and dissemination of data to strengthen awareness of, and commitment to, promoting human rights in maternal and neonatal health.

5) To provide an evidence base that can be utilized for planning action directed towards the fulfilment of human rights in maternal and neonatal health in NTB and NTT.

6) To produce specific recommendations for the development of programs and interventions relevant to all stakeholders, including: the national, provincial and district governments;

the SISKES program; and NGOs active in the promotion of health and human rights.

7) To produce specific recommendations to limit legal and policy barriers to the recognition of human rights in maternal and neonatal health in NTB and NTT.

8) To identify how human rights may be promoted through improvements in the quality of care offered to women and infants by health services.

9) To test a methodology that can be repeated in the future to assess the impact of activities, and legal or policy reforms, directed at improving human rights in maternal and neonatal health in NTB and NTT.

10)To build the capacity of local NGOs and researchers in conducting human rights research and other health related research.

1.4 Methodology

The research was designed to produce two complimentary data sets, one constituted of secondary data and the other of primary data, using two tools; Tool A and Tool B. Both tools collected data on a number of priority health issues related to human rights in maternal and neonatal health.These issues were previously identified by the Government of Indonesia (GOI) and WHO.

The 7 priority health issues that shaped the study design are [5]:

1) Pregnancy, childbirth and the postpartum period access to health services

2) Family planning: low levels of knowledge about family planning methods; inaccessibility of family planning for unmarried people; husband authorization to seek services

3) Low levels of birth registration

4) STI's and HIV/AIDS: lack of knowledge, education & access to services for prevention and treatment

5) Violence against women

6) Unmet need for safe abortion services

7) Adolescent reproductive health: early marriage and pregnancy, and limited access to sexual and reproductive health education and services

The research also identified vulnerable groups, as well as discrimination and equity issues, related to the fulfilment of human rights in maternal and neonatal health in the community.

1.4.1 TOOL A: Collating relevant policy, legislation, regulations, plans, health statistics and program activities related to human rights in maternal and neonatal health

Background to the WHO Tool

In order to examine and identify legal and regulatory/policy barriers to maternal and neonatal health, WHO together with the Harvard School of Public Health developed a Tool to measure governments' actions towards Maternal and Neonatal Health by using a Human Rights approach.

The Tool aims to create a multi-stakeholder, participatory process that uses a human rights framework to examine the governments' efforts to meet its human rights commitments to maternal and newborn health made through the ratification of international treaties and consensus documents and the elaboration of the national constitution and other laws.

The objectives of the Tool are to assist countries to:

- review and address legal, policy and regulatory barriers to maternal and newborn health;
- engage health sector, as well as non-health sector, actors to help eliminate barriers to maternal and newborn health and;
- review and document government efforts to respect, protect and fulfil rights and progress toward achieving international development goals and targets – including the Millennium Development Goals and targets - related to maternal and newborn health.

The tool consists of both process and an instrument. Following human rights principles, the process is participatory in nature, and must involve many different stakeholders.

[5] Three priority health related issues that were addressed in the national level study have not been included as separate issues in this report. Those issues are: Unequal access to education for girls; female genital mutilation; and privacy, confidentiality and informed consent. The issue of female genital mutilation is addressed in this report under violence against women. The issue of equal access to education for girls is addressed under the section on adolescent reproductive health. The issues of privacy, confidentiality and informed consent are included within discussions of various health topics including women's access to maternal and family planning services, adolescent reproductive health, and STIs and HIV/AIDS.

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East Nusa Tenggara: A young mother at a Posyandu in Belu © SISKES

For this research, TOOL A was a revised version of the WHO Tool: *Using Human Rights in Maternal and Neonatal Health: a tool for strengthening laws, policies and standards of care.* The original WHO tool was field tested in collaboration with the Ministry of Health at the national level from May 2005 to September 2006 and the final report was released in early 2007.

Application of Tool A at provincial and district levels

Tool A was utilized to collect existing secondary data on provincial and district regulations, policies, plans and programs in order to assess the progress of the GOI at decentralized levels in relation to realizing its commitments to various international human rights standards. A summary of Indonesia's human rights commitments is included in Chapter 2.

In addition to mapping the progress of provincial and district authorities in addressing human rights in maternal and neonatal health, Tool A also documented the contributions of local NGOs who are active in promoting human rights and maternal and child health, in NTB and NTT. Thus, the main revisions made to the original WHO field tool were:

a) the explicit focus on collecting provincial and district level information, and;

b) the explicit effort made to document all relevant NGO contributions to promoting human rights in maternal and neonatal health in these two provinces.

Tool A was administered by two Research Officers (ROs), one in each province. The ROs collected data at the provincial level, and also collated available data from four districts including the municipalities of Kota Mataram and Kota Kupang, as well as the districts of Sumbawa Besar and Timor Tenggara Selatan.

The ROs received training in the use of Tool A and ongoing supervision from their Provincial Coordinators, the Project Manager and the Technical Assistants.

Stakeholders played a crucial role in providing access to the relevant data sources for ROs and Tool A could not have been completed to a high standard without their input. While Tool A collected available data at both provincial and district levels, this report focuses on laws, policies and plans as they are articulated and implemented at the provincial level.

However, full details of the information collected by Tool A in all districts included in the research are available to stakeholders who wish to review the completed field tools.

1.4.2 TOOL B – Human rights and maternal and neonatal health survey with married women aged 15 to 49

The primary data survey (Tool B) was conducted in four sites across two provinces. Thus, the sample is a purposive sample and findings cannot be claimed as representative for the two provinces of NTB and NTT. However, the findings highlight women's experience in four districts and provide important information on how provincial and district plans and interventions are functioning at the grass roots level.

Tool B was designed by the first Technical Advisor to compliment Tool A. Statistical analysis of the survey results was

performed by the second Technical Advisor, who was consulted during the survey design to ensure that questions were asked in a manner that would allow sound statistical analysis. Findings from analysis of the Tool B data are referenced in this report as - Primary Data Survey (2007).

The survey was administered as a qualitative interview using standardized questions and took between 45 minutes to 1.5 hours to complete. The methodology was experimental and aimed at collecting in depth information on a range of topics that are often considered private and sensitive, and thus can be difficult to discuss. Tool B was designed using a social dialogue approach in order to put women at ease when discussing their experiences.

The survey was administered using local languages and explored key issues related to maternal and neonatal health. The survey used a format that roughly followed women's reproductive histories, which allowed them the opportunity to answer questions in a logical order and prompted them to share their stories at length if they chose to. The fact that some surveys took up to 1.5 hours is indicative of women's high willingness to discuss their lives and health concerns in depth.

All survey interviewers received extensive training on: how to administer Tool B; accurate data recording; research ethics; the risk management protocol for the study; active listening and good communication skills. All members of the interview team received ongoing supervision from the Provincial Coordinators. A budget for consultation for all team members was made available to ensure that their emotional needs were met if women respondents disclosed traumatic experiences. The WHO ethical and methodological guidelines for researching violence against women were fully incorporated into the research design.

The topics included in the survey are: socio-demographic data; prenatal care during women's most recent pregnancy; birth plans and experiences for the women's most recent birth; postpartum care after the birth of a women's youngest child; breast feeding of the youngest child; birth registration of all children; domestic violence; STIs and HIV & AIDS; and family planning. The questions developed for each topic were based on assessing whether women's and their children's human rights related to these topics were being fulfilled. All questions in the survey were extensively piloted before the survey was administered.

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West Nusa Tenggara: Men and woman together haul in fishing nets on the beaches of Western Lombok © SISKES

All interviewers were married women who spoke both the national language and at least one of the local languages used in the field sites. Interviewers also had experience in community development and outreach work through their involvement in local NGO activities. Women's responses to the survey in all districts were overwhelmingly positive and their willingness to answer questions regarding domestic violence and STIs demonstrates both that the research instrument was culturally appropriate and that the interviewers were highly skilled.

A total of 1004 women were surveyed across the four sites and refusal rates were virtually non-existent, being less than 1%[6].

[6] The only reason given for refusal to participate in the survey was that women with many children, and no assistance with childcare, did not feel they could spare the time to take part in the survey.

The effectiveness of this survey instrument in gaining in depth information on sensitive topics suggests that it was a highly successful experiment and that the survey could easily be adapted for application in wider population-based studies in NTB and NTT, provided that the same levels of training and skills were maintained for survey interviewers in the future.

The sample of women surveyed was spread evenly across NTB and NTT with two sites per province, and approximately 250 women surveyed in each site (504 women in NTB and 500 women in NTT). The urban and rural districts were the same as used for Tool A.

In NTB, the urban survey site was within Kota Mataram and included ten neighbourhoods in Tanjung Karang of the Ampenan Sub-District. These ten neighbourhoods were:
1) North Batu Ringgit 2) South Batu Ringgit 3) Bendege 4) Sembalun 5) Bangsal 6) West Kekalik 7) East Kekalik 8) Kekalik Kijang 9) Grisak and 10) Bagik Kembar.

The rural site for NTB was in the Sumbawa District in the Moyo Hilir Sub-District and included nine hamlets. These nine hamlets were: 1) Moyo Luar 2) Karang Orong 3) Brang Beru 4) Moyo Atas 5) Moyo Bawah 6) Poto 7) Bekat 8) Tengke Atas 9) Tengke Bawah.

In NTT, the urban survey sites were within Kota Kupang and included the following sub-districts: Kelapa Lima (Oesapa Village); Oebobo (Bakunase Village); Maulafa (Belo Village and Maulafa Village); and Alak (Naeoni Village).

The rural sites in NTT were in the Timor Tengah Selatan District and included the following sub-districts: West Amanuban (Tetaf and Nusa Village), South Amanuban (Oebelo Village), and Boking (Miosin Village).

1.4.3 Data Analysis

Tool A data was submitted to the research team by ROs as a draft field tool for each province. ROs, Provincial Coordinators, the Project Manager and Technical Advisors then collaborated to identify gaps in the data and guided the ROs in completing the field tool. Research Officers together with the Provincial Coordinators, Project Manager and Technical Advisors collaborated in a week-long workshop to conduct two levels of data analysis on the completed field tools using the analytical framework developed by WHO when testing the Field Tool at the national level.

Thus, the data collected at provincial and district levels was analyzed a) in the context of Indonesia's human rights commitments b) in relation to the legal and policy barriers that have been identified at the national level c) and also according to how human rights were being addressed in relation to specific maternal and neonatal health issues.

Tool B data was collated, coded and entered on computer in NTB. The statistical analysis of survey data was planned by the Technical Advisors to compliment the Tool A data and to fill in gaps for topics that Tool A did not yield sufficient data for. Statistical analysis was performed using SPSS by Technical Advisor 2. The survey yielded an extremely large body of data, and this report contains only those data which are most relevant to the priority health issues addressed in the report and the recommendations developed by stakeholders. A full set of the raw data generated by the Tool B survey is available to stakeholders in CD format.

In many cases health-related statistics generated by Tool B were very similar to those produced by a household survey conducted with a much larger representative sample in NTB and NTT in 2007.[7] As the findings of this larger household survey are more representative of the wider populations of NTB and NTT, we also refer to these findings in the report where they strengthen our analysis of human rights in maternal and neonatal health. We refer to data from this larger survey as - Household Survey (2007).

1.4.4 Development of recommendations for priority action

Based on the analysis of both primary and secondary data by the research team, a draft report was developed for stakeholder consideration. This draft report considered: the secondary data collected via Tool A; the primary data collected via Tool B and the Household Survey (2007); the national level findings from the MOH and WHO National Report on the Indonesian Field Test.

[7] GTZ-SISKES supported a large household survey in all districts of the NTT and NTB in 2007 covering about 9.000 households: Maternal and child health practices and care-seeking behaviour in NTB and NTT Provinces - Indonesia, 2007: Report of a community survey of 7000 households in 22 districts. *The Center for Health Research - University of Indonesia (2007).*

The findings of the draft report were considered by stakeholders at a workshop in Bali. The multi-sector stakeholders collaborated to identify key issues for action and developed recommendations for priority action on those key issues. This process involved work in smaller break-out groups focused on specific priority health issues, and discussion in the larger group of the recommendations developed for each province. This process was assisted by facilitators with expertise in the areas of human rights and reproductive rights, and the research team also participated to address any questions arising regarding the research process and findings.

A second draft report was produced, which included requests for additional information from stakeholders and the draft recommendations developed by stakeholders. This report was again presented to stakeholders in Jakarta, including both provincial and national level stakeholders. At this second workshop the report findings and recommendations were refined and confirmed.

This final report has taken into account the stakeholders input at both workshops and represents recommendations developed for both provinces. However, because the stakeholders from each province, and from national level, were working side by side at the workshops, many of the recommendations overlap for both provinces. To avoid repetition, recommendations for both provinces are presented in one section for each priority health topic, and those recommendations which apply to only one province are identified as being specific to that province.

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CHAPTER 2

INDONESIA'S HUMAN RIGHTS COMMITMENTS

2. INDONESIA'S HUMAN RIGHTS COMMITMENTS[8]

Of the eight international human rights treaties[9], six have been ratified by Indonesia. They are:

(1) The Convention on the Elimination of All Forms of Discrimination Against Women or CEDAW,

(2) Convention on the Rights of the Child,

(3) International Covenant on Economic, Social and Cultural Rights,

(4) International Covenant on Civil and Political Rights),

(5) International Convention on Torture,

(6) International Convention on Elimination of all forms of Racial Discrimination.

One that has not yet ratified is the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families. All of these treaties call on governments to eliminate discrimination on the grounds of sex (or discrimination of any kind) and some of them specifically condemn discrimination against women in all it's forms[10]. This includes adopting appropriate legislative and other measures, and modifying or abolishing existing laws, regulations, customs and practices which constitute discrimination against women[11].

The rights that are related to reproductive health include: the right to life, survival and development; the right to the highest attainable standard of health; the rights to education and to information, and the right to non-discrimination. Many of these rights are guaranteed in more than one of the treaties[12]. International human rights treaties become legally binding when governments ratify them. This means that governments must then ensure that their national laws, policies and practices do not conflict and are consistent with their obligations under international law and that they respect, protect and fulfil the right to health and other human rights.

When a government ratifies a treaty, it agrees to submit reports on a periodic basis on the compliance of domestic standards and practices with the human rights enshrined in the particular treaties. These reports are reviewed by committees that monitor the application of human rights treaties (one committee per treaty - see chart below). The committee then issues concluding observations and recommendations which should be implemented by the government in question.

The Government of Indonesia has submitted a number of reports, most notably to the Committee on the Rights of the Child and the CEDAW Committee[14], and received recommendations from the Committees.[15] These recommendations are incorporated into the analysis on the following page.

2.1 Key human rights treaties & their monitoring committees

The GOI has also made a commitment to major international consensus documents and development goals that recognize maternal mortality cannot be reduced and reproductive health cannot be improved without the respect

[8] The following summary of human rights commitments is quoted directly from the: *National Report on Using Human Rights for Maternal and Neonatal Health: A Tool for strengthening laws, policies and standards of care.* MOH Indonesia (2007).

[9] The eight international treaties are:*Convention on the Elimination of all forms of Racial Discrimination* (in force 4 January 1969); *the International Covenant on Civil and Political Rights* (in force 23 March 1976); *the International Covenant on Economic, Social and Cultural Rights* (in force 23 March 1976); *the Convention on the Elimination of Discrimination Against Women* (in force 3 September 1981); *the Convention Against Torture* (in force 26 June 1987); *the Convention on the Rights of the Child* (in force 2 September 1990); *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families* (in force 31 October 2003);*Convention on the Rights of Persons with Disability* (adapted in 2006).They are all derived from the Universal Declaration of Human Rights, agreed to in 1948.

[10] *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), the *Convention on the Rights of the Child* article 2(1); *the International Covenant on Economic, Social and Cultural Rights* articles 2 (2), 10, 12; *the International Covenant on Civil and Political Rights, the International Convention on Torture and the International Convention Elimination of all forms of Racial Discrimination* article 1.

[11] CEDAW (Article 2).

[12] Cook RJ, Dickens M and Fathalla MF. *Reproductive health and human rights: integrating medicine, ethics and law.* Oxford: Clarendon Press. 2003.

[13] Committee on Economic, Social and Cultural Rights, General Comment 14; Committee on the Rights of the Child, General Recommendation 3; International Covenant on Civil and Political Rights; ICPD Programme of Action; Beijing Platform for Action paragraph 107.d.

[14] CEDAW/C/IDN/2-3(1997) - CEDAW/C/IDN/4-5 (2005) - CRC/C/3/Add.10 (1992) - CRC/C/3/Add.26(1994) - CRC/C/65/Add.23 (2002).

[15] CEDAW A/43/38 (1988) - CEDAW A/53/38/Rev.1 (1998) - CRC A/49/41 (1994) - CRC A/51/41 (1996) - CRC/C/15/Add.223 (2004).

and protection of reproductive rights, enshrined in international, regional and national laws. These consensus documents include the International Conference on Population and Development, Program of Action, (ICPD Program of Action, 1994), the Platform for Action of the Fourth Conference on Women (Beijing Platform for Action, 1995), the Millennium Development Declaration (2000), United Nations General Assembly Special Session on HIV and AIDS (UNGASS on HIV and AIDS, 2001) and the United Nations General Assembly Special Session on Children (UNGASS on Children, 2002). The various reports submitted by Indonesia in connection with these consensus documents describe the efforts made by the Government to improve reproductive health.

These various reports to the treaty monitoring committees and the United Nations describe how the GOI has made a significant effort over the past years to enact laws related to women's rights, and to amend and revise laws that were not in accordance with the Constitution and did not respect and protect internationally-agreed human rights standards. However, discrepancies in the legal system still exist in connection with women's issues, specifically with maternal and neonatal health. As the CEDAW Committee expressed in its latest Concluding Comments (1998), "the Committee is very concerned at the existence of laws that are not in accordance with the provisions of the Convention. It notes that discrimination against women exists in laws regarding: family and marriage, including polygamy; age for marriage; divorce; economic rights, including health and other benefits in the labour sector; health, including the requirement that the wife obtain her husband's consent with regard to sterilization or abortion, even when her life is in danger[16]."

Human Rights Treaty	Committe
• International Covenants on Civil and Political Rights	• Human Rights Committee
• International Covenant on Economic, Social and Cultural Rights	• Committee on Economic, Social and Cultural Rights
• Convention on the Elimination of All forms of Discrimination against Women (CEDAW)	• Committee on the Elimination of Discrimination against Women (CEDAW Committee)
• Convention on the Rights of the Child	• Committee on the Rights of the Child
• International Convention on the Elimination of All Forms and Racial Discrimination	• Committee on the Elimination of Racial Discrimination
• Convention against Torture and Other Cruel Inhuman or Degrading Treatment	• Committee against Torture
• International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	• Committee on Migrant Workers
• Convention on the Rights of Persons with Disabilities.	• Committee on the Rights of Persons with Disabilities.

The Indonesian Constitution, and several national laws such as the Law No.39 of 1999 on Human Rights, the Law No.23 of 2002 on Child Protection, the Law No. 23 of 2004 on Domestic Violence adopted the principles of international human rights treaties and commitments, setting a clear national and local framework for the protection of all women and children.

The GOI has also elaborated policies, strategies, plans and programs on maternal mortality reduction including the improvement of access to skilled birth attendance, making family planning services available, reducing early marriage, and on improving birth registration. However, as the Indonesian report on progress towards attainment of the Millennium Development Goals (2004) points out, the target for the reduction of maternal mortality is very far from being achieved by Indonesia.

[16] Concluding Comments of CEDAW 1998, CEDAW A/53/38/Rev.1 (1998).

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CHAPTER 3

PRIORITY HEALTH RELATED ISSUES AND GOVERNMENT ACCOUNTABILITY IN THE CONTEXT OF INTERNATIONAL HUMAN RIGHTS LAWS AND STANDARDS

3. PRIORITY HEALTH RELATED ISSUES AND GOVERNMENT ACCOUNTABILITY IN THE CONTEXT OF INTERNATIONAL HUMAN RIGHTS LAWS AND STANDARDS

3.1 Pregnancy, Childbirth and the Postpartum Period: Access to Health Services

3.1.1 Health related considerations

Women's rights to quality maternal health services relate directly to: health, life-survival and development; to decide on the number and spacing of children; the rights to information and education; and the rights to benefits of scientific progress. For women who are disadvantaged in relation to their access to adequate maternal health services their right to non-discrimination is also often unrecognized.

Women who attend antenatal care and who have skilled attendance at delivery and during the postpartum period have a better chance of surviving the unexpected complications of labour and birth than those who do not. Key life-preserving interventions during antenatal care include: the provision of malaria prophylaxis; tetanus toxoid immunization; and the diagnosis and treatment of anaemia and syphilis.

National level

The National Field Test Report identified the following issues of concern in Indonesia regarding maternal health, antenatal care and delivery:

- Maternal mortality is still high in Indonesia at 307 deaths per 100,000 women1 and only around 20 % of community health centres offer basic emergency obstetric and neonatal care (BEONC) and 80 % of public hospitals offer irregular CEONC (Comprehensive Emergency Obstetric and Neonatal Care).
- At the national level, the proportions of women seeking antenatal care and skilled attendance at birth have improved considerably over the last 15 years.
- Women with low or no education are less likely to access antenatal care and delivery in health facilities than more educated women. The National population based Caesarean section rate is very different in rural (1.1%) and urban (6.5%) settings, showing impaired access of rural population to emergency services.
- Malnutrition and anemia in pregnancy remain a serious problem, and provision of iron supplementation is poor.
- Tetanus and malaria continue to contribute significantly to maternal and newborn mortality and morbidity; tetanus immunization remains low and prophylaxis for malaria is not systematically provided.
- High numbers of stillbirths and increased HIV infections in the general population justify systematic screening for syphilis in pregnancy, which is not currently part of the antenatal programme.

With regard to the screening of blood for HIV, the Indonesian Red Cross, which has been assigned by the Government to manage blood products, has 169 Blood Transfusion Units (BTU) (in 440 districts). All of these BTU are supposed to conduct HIV screening routinely (reagents are provided by the Red Cross). Some (41) hospitals have their own BTU, usually integrated in the laboratory unit, but there are no reports on the supply of reagents, workload and performance.

The neonatal mortality rate in Indonesia in 2002-03 was estimated to be 20 per 1000 births with big variations among the provinces. This figure is higher than the rate in neighbouring countries.

Provincial level

Antenatal care

Data from both the Primary Data Survey (2007) and the Household Survey (2007) confirms that the coverage of

antenatal care in both rural and urban areas in NTT and NTB is now very high. Provincial governments in both provinces are committed to ensuring women receive the minimum standard of antenatal care (known as the '5Ts'), which consists of:

1) To measure body weight and height

2) To measure blood pressure

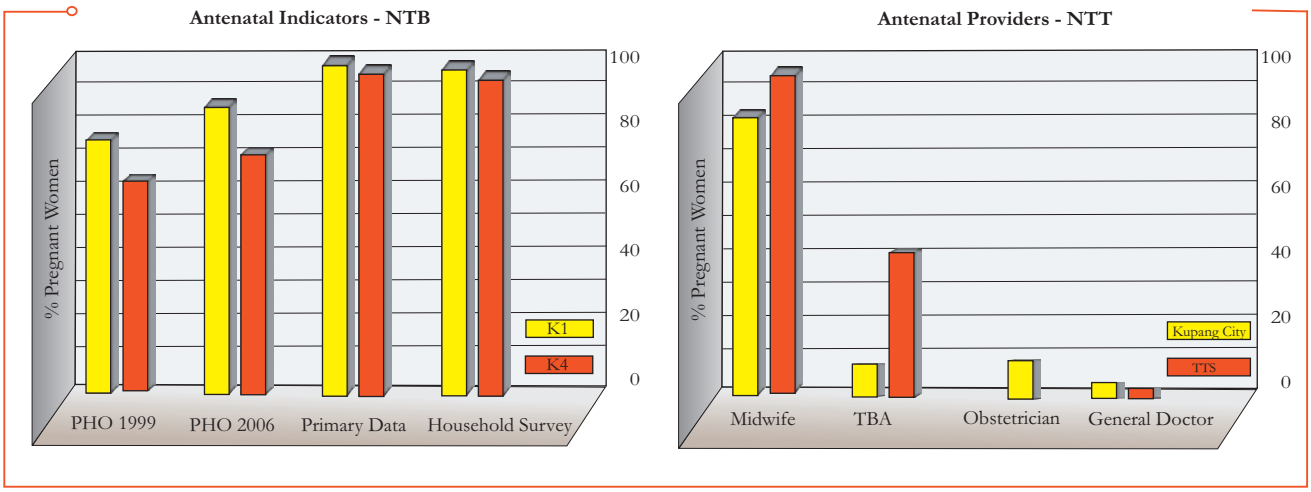
3) To ensure complete Tetanus Toxoid immunization (provided during ANC or by evidence that the pregnant woman has received five doses in her life time)

4) To measure uterine fundus height

5) To distribute iron tablets (minimum 90 tablets) during pregnancy.

The secondary data collected for NTT from PHO showed that K1 and K4 visits in Kupang City reached around 63% in 2005 and K4 visits around 54%. However, according to the Household Survey (2007) the numbers of K1 and K4 visits have increased with 84% of women attending K1 visits and 74% K4 visits in Kupang City. In Kupang City and TTS Districts, the average number of visits by pregnant women to health facilities is six.

Antenatal care in NTB and NTT is provided by midwives, general practitioners, obstetricians and traditional birth attendants (TBAs)[18]. The graph on the right illustrates providers of antenatal care in NTT as indicated by the Primary Data Survey (2007), and confirmed by the Household Survey.



Additionally, primary health services aim to provide a minimum of four antenatal visits (known as K4), including a one visit in both the first and second trimesters and a minimum of two visits in the third trimester.

In NTB, the proportion of pregnant women who had at least one antenatal visit (K1) in the first trimester is considerably high (over 90%) with only a little drop out for the fourth (K4) visit. See the table above. In NTB, the data indicates that women access antenatal care on average seven times during their pregnancy.

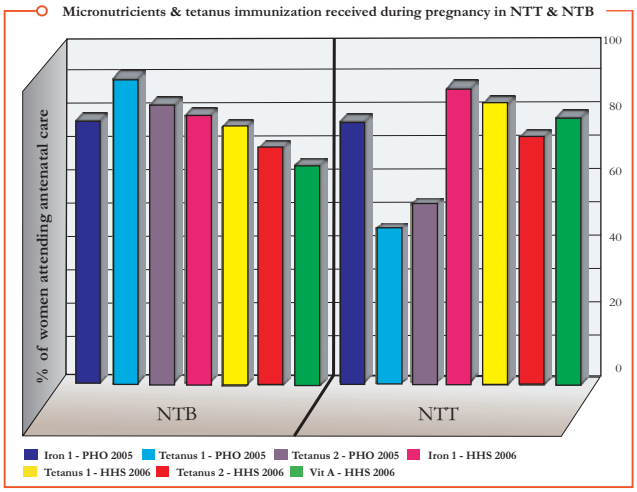
According to the Primary Data Survey 2007 in Tanjung Karang (Mataram) 95% of women visited midwives for antenatal care, 67% visited TBAs and only 1% visited obstetricians.
In Sumbawa, antenatal care by midwives was accessed by 98% of women and TBAs provided care for 80% of women, general practitioners were visited by 1% of women and obstetricians by 4% of women.

Chronic Energy Deficiency (known as Kurang Energi Kronik - KEK) and anaemia in pregnancy remain serious problems despite provision of standard micronutrients to the majority

[18] Household Survey (2007) found that large numbers of women visit TBAs for care (predominantly for massage) in addition to K1 and K4 through the health system.

of pregnant women. The problem of anaemia in pregnancy is well documented in NTB. Dinas Kesehatan NTB conducted a survey on Nutrition Anaemia Among Pregnant Women in 2002 and found 77.01% of women across seven districts to be suffering from anemia.[19] In Kupang City in 2005, 16% of pregnant women were estimated to be suffering from KEK, while in Timor Tengah Selatan 34% of pregnant women were recorded as experiencing KEK.

According to the primary data, iron (FeSO4) supplementation and tetanus vaccination is underestimated in PHO reporting in NTT (See the right column of the graph below). Data from the Household Survey reflecting data predominantly from 2004-2006 (2007) indicates that well over two thirds of women in both provinces received standard micronutrients and tetanus coverage.



Two cases of pregnant women being HIV positive have been recorded in NTB (VCT clinic, 2007) and 1 case in NTT (RS WZ Johannes, 2003). In Sumbawa - NTB, an additional two women have been recorded as being diagnosed with other sexually transmissible infections (DHO Sumbawa, 2004).

Delivery/childbirth services

In NTB delivery attended by skilled personnel has been consistently rising over the past six years, with 77% of the population now giving birth with the assistance of a skilled birth attendant.[20] The trend for skilled birth attendance at delivery appears to have been less positive in NTT with only 45.27% of births in 2005 being attended by skilled personnel.[21]
There is mounting international agreement that ANC should include a birth preparedness plan, defined as taking a series of steps prior to birth to ensure that a pregnant woman is prepared for normal birth and possible complications. Key messages include: care during pregnancy and childbirth, knowing danger signs, identifying a skilled birth attendant, preparing for a clean birth, knowing which health facility to go to in case of an emergency, and planning for complications, including plans for savings and transportation.

Around three quarters of women interviewed in the Primary Data Survey (2007) had planned for their youngest children. The majority of them (90% of all women, with district variations) also had birth plans, including a preferred place of delivery and preferred birth attendants. However, for less women (74%) their actual birth experiences matched their birth plans. About 70% women were satisfied with the attention they received during their last birth.

A high percentage of women in both provinces discussed their pregnancies and birth preference with their husbands. Place of delivery, choice of birth assistant and availability of funds for delivery were by far the most common issues discussed in relation to birth preparedness for women in NTB and NTT. The issues of transport, contingency funds and blood donation received far less discussion in both provinces, which reflects a much lower level of preparedness for emergency versus routine birth experiences.

Postpartum care

Data from both the Household Survey (2007) and the Primary Data Survey (2007) found similar percentages of infants receiving postnatal care in both NTT and NTB. In NTB, 43.3% of neonates received postnatal care within a week, and a total of 50.4% of infants received postnatal contact between 8 to 28 days after birth. The patterns of postpartum visits are reversed in NTT with more neonates receiving postpartum care in the first week 47.1%, and less receiving care between 8 to 28 days after birth.

[19] Dinas Kesehatan NTB (2002). Rapid Survey on Nutrition Anemia among Pregnant Women in NTB.
[20] PHO NTB (2007) and PHO Yearly Report (2006/7).
[21] PHO NTB (2007) and PHO Yearly Report (2006/7).

Of the women interviewed (N=1004) in the Primary Data Survey (2007) 95% said there were no significant differences in postpartum care for male and female babies. The only differences reported by a few women, included circumcision or hair cutting for male babies and ear piercing for female babies, there were no differences in medical care for babies mentioned. Not all of the 1004 women that were interviewed had received postpartum care, but many had multiple providers of care, including: village midwives (50%); traditional birth attendants (28%); health kader (6%); and others (4%) such as their mothers, general practitioners, family and neighbours.

Out of 1004 women surveyed, 353 (or 35%) would like to have received additional information related to postpartum care, with around 90% requesting information about how to care for themselves and children during the postpartum period. Women's enquiries included topics such as: care of their reproductive organs, how to avoid white discharge, how to speed up the recovery process after birth and information about safely resuming their sex life.

Health Indicator: Women with complication treated in BEONC/CEONC

	Province	Kupang	TTS
NTT	2426 cases 2005, NTT PHO) 3% of all woman who delivered	214 cases (2005, NTT PHO) 3% of all woman who delivered	112 cases (2005, NTT PHO) >1% of all woman who delivered

	Province	Sumbawa
NTB	9572 cases (NTB, PHO, 2006)10% of all women who delivered	1339 cases (Sumbawa Hospital, 2005)14% of all women who delivered

Maternal mortality

Recent estimates of maternal mortality in NTB and NTT are both higher than the national average, with NTB reporting 310/100,000[22] and NTT reporting 540/100,000.[23] Two major causes of maternal mortalities during delivery in either national, provincial or district level is hemorrhage (usually immediately following delivery) and eclampsia. Hemorrhage in NTB accounts for 44% of maternal deaths (PHO of NTB) and is similar to the national rate (42%, IDHS 2002/03). In TTS District, maternal mortality caused by hemorrhage is very high at 71% of all reported maternal deaths.

Women with complications treated in BEONC/CEONC facilities in NTB and NTT are generally much less than the international estimates of 15% of all pregnancies. See the table on this page.

Infant mortality

Infant Mortality Rate (IMR) in Indonesia was reported to be 35 deaths per 1000 live births (IDHS, 2002-2003). In NTB, the IMR was reported as 74 deaths per 1,000 live births and Neonatal Mortality Rate as 24 deaths per 1000 live births in 2002 (IDHS, 2002). The number of neonatal deaths (less than 28 days) recorded for 2005 was 689, and for 2006 was 683 (PHO NTB, 2006).

In NTT, the official IMR in 2005 was recorded as 49/1000 live births (BPS NTT, 2005). In 2004, there was a significant difference between the IMR in Kupang City (24/1000 live births) and the IMR in TTS District (53/1000 live births) (BPS NTT, 2005).

The Household Survey (2007) collected data on birth weights from mothers' hand-held records. In NTB an average of 8% of babies were born less than 2.5 kilograms. In NTT there was an average of 11% of babies born with low birth weights. Low birth weight is one of the main causes of infant mortality at provincial and district levels in these provinces. In NTB, low birth weight is estimated to account for 43% of deaths and 36% in Sumbawa District. In NTT, low birth weight is recorded as the cause of infant death for 12% of deaths in TTS District, and for 2% of infant deaths in Kupang city.

The percentage of infant deaths recorded without a specified cause is only 4% at National level. However, 79% of the

[22] Mataram Public Hospital (2006).
[23] Strategic Plan Dinkes Provinsi NTT (2005-2009).

recorded infant deaths have no cause specified in Kupang City, 27% are unspecified in TTS District, and in NTB province 16% of the infants deaths have no cause listed in the Sumbawa District.

3.1.2 Human rights considerations

The National Field Report summarized the relevant human rights treaties related to the provision of maternal health services as follows:

- Article 18 of CEDAW, for instance, calls upon States to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those related to family planning, pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

The Committee on Economic Social and Cultural Rights has issued a General Comment which explains the minimum core obligations of Article 12 on the right to the highest attainable standard of health. It explains that states have core obligations to provide essential primary health care in order to satisfy the right to the highest attainable standard of health, and confirms that ensuring reproductive, maternal (pre-natal as well as post-natal) and child health care are obligations of comparable priority.[24] Treaty monitoring bodies, such as the Committees overseeing CEDAW and the Convention on the Rights of the Child have repeatedly expressed their concern about the high maternal mortality in Indonesia. The Convention on the Rights of the Child, in its latest concluding observations in 2004, acknowledged the improvement in budget allocations to the health-care sector, but remained concerned at the high maternal mortality ratio and the proportion of children born with low birth weight. The Committee recommended that the State ensure universal access to primary health care, especially maternal and child health-care services and facilities, including in rural and conflict-affected areas.[25]

- The Millennium Development Goal 5 cannot be achieved without necessarily strengthening the health system, particularly at the district level, with priority given to strategies for reaching the child health and maternal health services. Maternal mortality strategies should include ways to achieve universal access to reproductive health services and the health workforce strategy should include plans for building a cadre of skilled birth attendants. Poverty-reduction strategies and funding mechanisms should support and promote actions that strengthen equitable access to quality healthcare and do not undermine it.[26]
- The Constitution and several national laws also provide protection for basic human rights related to accessibility and availability of health services, including reproductive health services. (Health Law, Article 4; Law on Child Protection, Article 44; Law on CEDAW Article 12.) . The Law on Human Rights (article 49) specifically enshrines "special rights to which women are entitled arising from their reproductive function are guaranteed and protected by law."

3.1.3 Government effort

National level

Over the past decade the GOI has made significant efforts to increase access to professional assistance during prenatal, delivery and postnatal care. In order to reduce maternal and neonatal mortality and morbidity the MOH launched a national strategic plan on Making Pregnancy safer 2001-2010. The main messages include that every delivery should be assisted by a trained health provider, and every obstetric and neonatal complication should be managed adequately. This plan has become the main instrument for Government planning and project support from the main health partners (donors). To facilitate a comprehensive approach, a strategy for the reduction of neonatal mortality has been developed by the MOH. Both documents include capacity building of obstetric teams in district hospitals and in public health centres for the treatment for the most life threatening complications (BEONC and CEONC training).

A village midwives program was launched in 1993 by MOH starting with a one year training program for 52,000 nurses to become midwives. This program contributed significantly to the improvement of pre and postnatal coverage and services, especially in rural areas.[27] However, since 1994 between 20%

[24] The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) General Comment No. 14. The Committee on Economic, Social and Cultural Rights (2000) Para 44.
[25] CRC/C/15/Add.223/2004
[26] Who's got the power? Transforming health systems for women and children. UN Millennium Project. Task Force on Child Health and Maternal Health (2005).
[27] WHO and Ministry of Health Republic of Indonesia, *Indonesia Reproductive Health Profile* (2003).

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East Nusa Tenggara: Community volunteers help out during Posyandu sessions © SISKES

and 40% of midwives have left the program. The main reasons for this high drop out rate were: the posting of midwives without adequate community involvement; the condition of Polindes (housing and work places) was very poor; emergency drugs and referral mechanisms to emergency services were not provided; and the quality of midwife training was inadequate. Furthermore, the program was designed so that a midwife's contract would only be renewed a maximum of three times and midwifes were then expected to sustain themselves through private practice.

An integrated service post - Posyandu - program was introduced in the context of the safe motherhood program announced in 1988 and has continued as part of the implementation of the Making Pregnancy Safer Strategy.

The aim of the program is to bring services to the community, including family planning, growth monitoring, immunization and nutrition services. It involves community volunteers as service providers, staff from the referral health centre (Puskesmas) and the village midwife. In 1996 a national workshop on accelerating maternal mortality reduction was launched in response to the recommendation of the Mother Friendly Movement.

The movement stressed the importance of a multi-sectoral approach towards the attainment of the reduction of maternal mortality and the improvement of the quality of life for women. MOH aims for universal coverage for basic health services, including maternal health services. However, the cost is a major deterrent for people- especially the poor to use services. Current costs of services include not only payment for services but travel costs and time lost for other productive activities. The result is low utilization of the basic public service especially among the poor.[28]

In response to the economic crisis, the Social Safety Net Program was introduced in 1998 by the Government; one of the five components of the program was free medical and family planning services for the poor at government primary health centres (puskesmas) and hospitals. The program also included free food supplements for pregnant women and for children under three years of age. However, it was found that a substantial percentage (40%) of the health cards issued for the poor were owned by the top three quintiles of the population. It was also noted that whereas 18.8% of the population was identified as poor in January 1998, only 10.6% of Indonesian households reported ownership of a health card.[29]

According to evaluations of the program, two of the main reasons for the relatively weak performance of the Safety Net Program are: local village leaders often did not adhere to the list of eligible households; and health providers receive lump sum grants from the Government to provide services but when the grants ran out they charge for the services again.[30]

In 2005, the government introduced a health insurance scheme for the poor managed by PT Askes as a continuation of government's previous efforts to cover the cost of health financing for the poor. However, barriers are still found related

[28] *The Millennium Development Goals for Health: a review of the indicators.* WHO Indonesia (2003).
[29] Final Report on the Health Referral System in Indonesia. WHO (2005).
[30] Policy brief 5: Social Safety Nets. DFID (2005).

to discrepancies in the numbers of poor families identified by the Central Bureau of Statistics and the local data, lack of awareness raising among the target population about the scheme, and delays in the claim process.

Provincial level

The provincial governments of NTB and NTT have issued substantial legal and policy documents addressing the need to improve maternal and child health, these include:

NTB

- A Decree of Governor of NTB No. 43 2007 on Establishing Reproductive Health Committee of NTB in the Year 2007. Proposed duties of the this committee are: i) to direct and coordinate different policy and intervention strategies on reproductive health and to report on implementation of relevant strategies to the Governor of NTB.
- Regional Government Regulation of NTB No. 3 2003 on the regional strategic plan for NTB for 2003-2008 has incorporated specific strategies to reduce maternal and infant mortality.

NTT

- A Decree of Governor of East NTT No. 103/KEP/HK/2005 on the Mother Friendly Movement Permanent Working Team of NTT with duties to design and implement integrated and sustained services to gradually reduce maternal and neonatal mortality.
- A Decree of the Governor of NTT No. 12 of 2006 on the Establishment of A District Model of Mother Friendly Movement, and an Implementing Team for the Mother Friendly Movement in NTT.
- A mutual agreement was established amongst heads of regencies/municipalities, community leaders and the action team for Family Welfare Education in order to accelerate maternal and neonatal mortality reduction in NTT province.

3.1.4 Non-government effort

NTB

Karina Widiyani

West Nusa Tenggara: An obstetrican trains midwives during a jointly staged GTZ-SISKES and JMPK (National Clinical Training Network at Province Level) Normal Delivery Care Training © SISKES

Over the past decade there has been a clear recognition of the greater need for assistance in addressing women's and their infants' rights to health, indicated by the poor maternal and child health status and high levels of maternal and infant mortality in NTB and NTT. This has led to high levels of cooperation between the government and non-government sectors in these 2 provinces and significant numbers of local NGOs and programs supported by international donors focused on maternal and child health.

Local NGOs:

- PKBI - provides reproductive health education, services and counselling.
- YKSSI - reproductive health education, health promotion and nutrition programs.

- Korporasi Annisa - education on gender, budgeting, nutrition, and provides education for young mothers including school dropouts.
- Fathayat NU - reproductive health promotion and research.
- PIKPK – in cooperation with the Women's Studies Centre of Mataram University provides reproductive health education, training and health services, including family planning counselling for adolescents (Clinic).

International contributors:

GTZ-SISKES NTB in Mataram, Lombok Barat, Sumbawa, Sumbawa Barat and Bima City - making pregnancy safer through activities such as integrated health planning / budgeting and M&E system; health system management, quality control and referral; providing quality services including health promotion; and community participation to access appropriate RH services.

- Burnet Indonesia.
- AusAID.
- Ford Foundation.
- Global Fund.
- Hellen Keller Foundation.
- PATH.
- UNICEF.
- UNFPA.

NTT

Local NGOs:

- PKBI – provides reproductive health education, services and counselling.
- Yayasan Tanpa Batas - provides reproductive health and HIV promotion, services (clinic) and counselling (targeting sexual workers, people with HIV, street children and adolescents).
- Sanggar Suara Perempuan, TTS - provides reproductive health education and health promotion on family planning and nutrition programs for poor women.
- Rumah Perempuan – provides family planning education to village women and health advocacy campaigns.
- Pikul - provides reproductive health education to village women and health advocacy campaigns.
- CWS - provides food supplements for pregnant women and under fives, and assistance with food security.WFP, Kupang, NTT - provides nutrition rehabilitation; food supplement delivery to school-children; and also distributes nutritious foods through Posyandu to children under five, pregnant and breast-feeding women.
- CRS, NTT in TTU and Belu – runs GEMAS for the Enhancing Healthy Children Movement.

International contributors:

- GTZ-SISKES, NTT in Kupang city and district, TTS, TTU, Belu and Rote-Ndao – making pregnancy safer through activities such as: 1) Integrated health planning / budgeting and M&E system; 2) Health systems management, quality control and referral; 3) providing quality services, including health promotion; 4) and community participation to access appropriate RH services.
- Plan International, NTT (in Kupang, TTS) – provides food supplements to children under five and pregnant women and runs advocacy programs for "Enhancing Mother & Child Health".
- UNFPA, NTT (in TTS, Sumba Barat, Kupang, Alor, Manggarai) – provides programmes on reproductive health for mothers and children.
- UNICEF, NTT (Alor, Sikka, West and East Sumba, Kupang City, Ende) – provides programs on maternal health, birth registration and child protection.
- AusAID KPKK (Ende and East Flores) - supports Desa Siaga (Alert Village) and Training for midwives and doctors, runs maternal and perinatal audits, and assists with improving family planning quality.

3.1.5 Discrepancies in laws, policies, strategies and implementation

National level

Barriers in laws and regulations

The Law on Manpower No. 13 of 2003 entitles female workers to rest, starting one and a half months prior to delivery and lasting one and a half months after the birth, which is only a total of 12 weeks maternity leave (Article 82 [1]). This law does not fully apply the principles of the International Labor Office (ILO) convention that requires not less than 14 weeks leave for female employees.[31]

Barriers in policies, strategies, plans & implementation

The National Field Test Report identified key barriers to the promotion of maternal and newborn health in general in Indonesia. The findings of this research confirmed that no systematic auditing of maternal death and other key health indicators related to maternal and neonatal health exist in the provinces of NTB and NTT. This research found that reliable data on the following indicators was not available for NTB/NTT; case fatality for women; case fatality rate for newborns; the percentage of women treated for fistula; the proportion of maternal mortality due to unsafe abortion; and the proportion of obstetric/gynaecological admissions due to unsafe abortion.

- Implementation of the village midwives program has met with only partial success, & long-term sustainability is a problem.
- The system of health cards to enable poor people to access services is only partially reaching those in need.
- National and provincial level data on the availability of essential medicines, equipment and diagnostics for maternal and newborn health is inadequate.
- While there is an immunization program coordinated by the Expanded Program on Immunization and the Maternal and Child Health Care units, no comprehensive national policy, strategy or plan has been developed on addressing congenital syphilis and malaria in pregnancy.

Provincial level

Barriers in laws and regulations

Some employers in NTB demand marriage certificates from women who have a right to maternity leave, although no national level regulation requires it.[32] This practice discriminates against women who are pregnant and have a child out of wedlock. It is contradictory to international human rights treaties that require maternity protection without discrimination of any kind.

Barriers in policies, strategies, plans and implementation

Additional barriers to the successful implementation of MCH strategies in NTB/NTT have been identified in this research, including:[33]

- Inadequate ratio of heath facilities, and trained health providers for the size of the population
- Inadequate infrastructure and operational funds for primary health care services and facilities[34]
- Need for greater investment in human resources at the primary health care level, better training and supervision, and more staff are needed
- Poor knowledge of post natal care and safe delivery among women
- Reluctance of some women to access existing facilities due to fear, negative perceptions of services or previous negative experiences at health services
- Many women still prefer TBAs to medical personnel due to reasons including: cheaper fees, ease of access (TBAs live directly within communities), sharing a common ethnicity and local language, perceived high quality of care from TBAs, less difference in education and social status between poor women and TBAs
- No Government sponsored safe abortion services available

[31] *ILO Convention, C183 on Maternity Protection (2000).*
[32] Evidence presented at a workshop on "Maternity Protection for Female Factory Workers", 16 June (2006). Jakarta.
[33] PHO Annual Report (2004-2006) and Problem Analysis in Renstra Report (2007).
[34] In some districts this results in problems such as: incomplete and damaged midwife kits; not all village birthing huts have beds for pregnancy examinations and/or delivery; poor availability of the standard Mother and Infants Guidebook; and absence of filing cabinets for archiving maternal and child records in village birthing huts.

- Birthing huts do not have direct access to obstetricians or gynaecologists in cases of emergency
- Due to lack of skilled personnel many midwives must work double shifts
- Refresher training for midwives is infrequent and there are no replacement personnel to cover a village while a midwife receives training
- Supplies of essential medicines and health logistics such as intravenous feeding, vaccines, and vitamins are not well-distributed or maintained, particularly in NTT due to the remote nature of many communities
- Access to a blood banks is not available in remote areas

3.1.6 Recommendations for priority actions

National level

Legal and regulatory measures

- The Law on Manpower No. 13 of 2003 harmonized with the ILO Convention, C183 on Maternity Protection, 2000.

Those potentially responsible:

Ministry of Health, Ministry of Manpower, Ministry of Women's Empowerment

Policy, strategy, health system measures

- Existing laws and regulations such as Law No. 7 year 1984 on CEDAW Article 12 should be implemented more proactively. The following should be undertaken with regard to services.
    - Availability of quality maternal health services should be assured. This includes high standard pre-service training for doctors and midwives, recruitment, placement, clear job description and guidance/ supervision of all health personnel, minimum standards for health facilities and accessible referral systems according to local needs and situations.
    - Pregnant women recognized as poor should have comprehensive maternal services free of charge.
    - The TBA-midwife partnership should be strengthened, recognizing the fact that a high percentage of pregnancies are still delivered by TBAs.
    - The referral systems need to be strengthened.
    - The availability of free blood screened for syphilis, HIV and Hepatitis B, coordinated by Red Cross Indonesia should be ensured.
- National data collection:
    - A mechanism for systematically undertaking maternal death audits of the original causes which lead to maternal and perinatal deaths should be put in place.
- The Mother Friendly Movement which was officially launched in 1996 should be revitalized.
- With regard to maternity protection the right to paid pregnancy leave, without having to provide a marriage certificate, should be assured.
- Institutions should guarantee that the time allowance for a woman to breastfeed her baby as recognized in articles 81, 82, and 83 of Law no 13/2003 is implemented to the benefit of the women workers.
- Mechanisms to monitor the implementation of maternity protection in factories and workplaces should be developed.
- Policy and budget allocations for the poor must be evaluated to ensure the control and possible eradication of all communicable and sexual transmitted diseases such as tuberculosis, malaria, STIs (especially HIV), in order to protect women during the pregnancy.

Those potentially responsible

Ministry of Health, Ministry of Women's Empowerment, Central Bureau of Statistics, Ministry of Manpower, Ministry of Social Welfare.

Provincial level

Legal and regulatory measures

Provincial and District level stakeholders reaffirmed the recommendations of the national stakeholders and additionally recommended that local regulations be issued to reinforced National laws on the protection of women's reproductive health.

Those potentially responsible:

Local Parliament, Governor, District Heads, Head of Provincial/District Health Office, Head of Regional Development Planning Board (BAPPEDA), Head of Office of Manpower, Women's Empowerment Bureau, Social and Women's Empowerment Office.

Policies, strategy and health systems measures

- Provincial and District governments need to conduct community socialization on the contents of local regulations, policies and programs aimed at promoting maternal health.
- In both provinces, maternal health should be promoted as a collected responsibility of men and women, and of the whole community.
- NTB, the Desa Siaga programme on preparing for birth should be extended.
- In NTT, the Church should be involved in educating the community on the importance of preparing for birth.
- Referral systems for high risk births, and in the case of obstetric emergencies, need to be strengthened.
- The number of primary health clinics (Puskesmas) with BEONC facilities and hospitals with CEONC facilities needs to be increased.
- Policy should be created to ensure adequate budget allocation for blood facilities and infrastructure.
- Non-smoking policies should be adopted in all maternal health facilities and there should be non-smoking warnings in maternal health facilities.

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West Nusa Tenggara: Female and Male villagers during a Desa Siaga meeting on community preparedness for birth © SISKES

- Programmes need to be developed and implemented to ensure the control and eradication of all communicable diseases effecting pregnant women such as TB, Malaria, STIs, HIV and AIDS.
- The provision of midwifery services needs to be increased in rural and remote areas.
- The TBA-midwife partnership should be strengthened, recognizing the fact that a high percentage of pregnancies are still delivered by TBAs, particularly in rural and remote areas.
- Normal Delivery Management (APN) training for midwives needs to be extended.
- A mechanism for systematically strengthening maternal and perinatal death audits, including those caused by unsafe abortion, should be put in place.

- Programmes should be developed to improve the response to anaemia and KEK/ malnutrition in pregnant women.
- Training programmes should be developed to improve the quality of maternal health care offered in health facilities.
- There is a need to improve the confidentiality of patient information in maternal health services.
- The provision of safe abortion services should be extended to prevent unnecessary maternal deaths.

Those potentially responsible:

Governor, District Heads, Heads of PHO and DHO, Heads of Regional Development Planning Board (BAPPEDA), Head of Manpower and Transmigration office, Women's Empowerment Division of Social Security Bureau.

3.2 Family planning: low levels of knowledge about family planning methods; inaccessibility of family planning for unmarried people; husband authorization to seek services

3.2.1 Health related considerations

National level

Delaying and spacing births through the use of effective contraception has long been recognized as essential for women's reproductive health and for the health of their children. Effective contraceptive use involves the provision of adequate information required to make an informed, voluntary choice of method. This requires service providers to be trained in providing family planning counselling to assist users to make informed and voluntary decisions about their fertility. Contraceptive choice also incorporates the effectiveness of the contraceptive method in preventing unplanned pregnancy, adequate and appropriate equipment, and maintenance of contraceptive supplies. Effective contraception also includes emergency contraception, which has a significant impact in preventing unwanted pregnancies and abortions.[35] Despite the success of the Indonesian family programme in reducing overall fertility drastically since its implementation in the 1970's, women's reproductive rights have yet to be fully protected within the existing program.

Until recently, the GoI's data collection on family planning has focused on key demographic variables such as fertility rates, met and unmet demand and types of contraception used. Consequently, there remains a dearth of important information about client satisfaction, women's decision making processes and to what extent women have a true choice of methods. Data on women's knowledge of family planning has also been largely neglected in national surveys. Consequently, we have little knowledge of whether women adequately understand how different contraceptive methods work or the possible side effects of different methods.

Family Planning Indicator

FP Indicator	National	NTB	NTT
Total Fertility Rate	2.6	4.9	3.49
Met demand for FP		53.5%	52%
Unmet demand for FP	14%	16%	16.7%
% of married women who know about modern contraceptives	96.3%	95.9%	88.2%
% of married men who know about modern contraceptives	98.5%	99.5%	89.5%

Source: Indonesian Demographic Health Survey (2002-2003)

Without access to such information women cannot fully exercise their right to informed consent, because they are not fully informed of all the facts relating to the method of family planning they may be consenting to. In the current era, BKKBN has made a strong commitment to improving the quality of services offered to women and families and has explicitly acknowledged: the importance of client satisfaction; true choice of methods; the availability of counselling; and the rights to privacy and informed consent.

National level data has identified the following issues as needing attention:[36]

- There is a serious lack of data concerning the access of unmarried people, particularly adolescents, to information and services for contraception.

[35] Medical Eligibility Criteria for Contraceptive Use. WHO. Third edition (2004). Available at: http://www.who.int/reproductive-health/publications/mec/index.htm
[36] Data for this section taken from the Indonesia Demographic and Health Survey 2002-2003 and the Indonesia Young Adult Reproductive Health Survey 2002-2003.

- The level of knowledge among young people about contraception is very low.
- The family planning programme makes services available only for married couples.
- Unmet need for contraception nationally is 8.6%.
- The availability of emergency contraception is not widespread. Although it is part of the Government family planning programme, there is as yet no systematic IEC provision and BKKBN does not include emergency contraception in its logistics procurement program.
- According to the Indonesian Demographic Health Survey (2003), 9.6% of women would have preferred their most recent pregnancy at a later time, and for 7.2% percent of women their latest pregnancy was unwanted.
- Less than a quarter of current contraceptive users are informed about side effects and the possibility of changing to other methods. Women who are sterilized are the least likely to be informed about side effects.
- Male participation in family planning is very low, consisting of 0.9% for condoms and 0.4% for male sterilization.

Provincial level

According to official government statistics the provinces of NTB and NTT still have significantly higher rates of fertility that the national average (see table below). NTB and NTT also have lower rates of met demand for modern contraceptives than the national average. While knowledge of modern contraceptives is reasonably high among women and men in both provinces (but lower in NTT), the unmet need for contraceptives remains high and represents an ongoing challenge for provincial and district governments in both provinces. Thus, BKKBN and other partners responsible for family planning in NTB and NTT face the dual task of improving both the coverage and quality of family planning services.

The Primary Data Survey (2007) focused on collecting data not only on contraceptive prevalence and type of methods used, but also collected information on client satisfaction, choice and knowledge. The key findings of the Primary Data Survey (2007) and the Household Survey (2007) at the provincial level include:

- Rates of contraceptive use among women in the survey samples varied significantly between districts. The primary data survey found acceptance rates among women surveyed in Mataram city to be 68.4%, in Sumbawa district to be 78.2%, in Kupang city to be 49.6%, and in TTS District to be 51.3%.
- The percentage of women surveyed who were offered family planning and began using family planning in the postpartum period following their most recent birth was high for all districts surveyed: 94.6% in Mataram city; 95.3% in Sumbawa district; 82.6% in Kupang City and 91.8% in TTS District. This indicates growing success in the provision of family planning services as an integrated aspect of postnatal care in NTB/NTT.
- Despite the free provision of contraception through primary health care services, there is still unmet need for contraception in NTB and NTT. The unmet demand for contraception among the women surveyed was 17% for women in Tanjung Karang Mataram city, 17% for women in Sumbawa, 18% in Kupang City and 8% in TTS District.
- The Primary Data Survey (2007) confirmed that the most popular contraceptive method used by women in both provinces is injectable contraception (in Mataram city 71%, Sumbawa District 88%, Kupang city 56%, and TTS District 88%).
- Choice of contraceptive method is not yet fully available to all women in these provinces. Approximately 25% of the women surveyed reported that they were not using their method of choice. Percentages of women using their method of choice in each district were 67% in Mataram city; 78 % in Sumbawa district; 69% in Kupang City & 82 % in TTS.
- When asked who had made the decision regarding women's current contraceptive method, the majority of women in the primary data Survey (2007) (73%) reported that they

themselves made the decision, a further 22% reported making this decision in consultation with their husbands. In total 95% of current family planning users made their choice of method either independently or in consultation with their husbands. The remaining 5% of current users stated that their midwives or private GPs had made the decision for them. The issue of providers making choices for women should be investigated further, to ensure that providers are enabling women to make their own informed choices and not being overly proscriptive.

- For women not using contraception, husband permission to use family planning is still a barrier to women's realisation of their right to contraception in these provinces. In the Primary data Survey (2007) 4% of the women not currently using contraception reported that their reason for not using family planning was that their husband's had denied them permission to do so.

- Women's satisfaction with their current method of contraception is also lacking in both provinces. The percentages of women reporting that they were not satisfied with their current method were 16% in Mataram city; 12% in Sumbawa district; 10% in Kupang City and 16 % in TTS District.

- Of the 1004 women interviewed in Primary Data Survey (2007) 402 (or 40% of the total sample) were not using any family planning method. The most frequent reasons reported for not using contraception were: a current pregnancy or desire to become pregnant (30% of non-users); women were still breastfeeding (17% of non-users); or women had health concerns related to the side effects of family planning (16% of non-users). The fact that 16% of non-users reported that concern over side effects was their reason for not using family planning suggests a strong need for better information and counseling for women on potential side effects and their management.

- Between 60% (Mataram City) and 35% (Kupang City) of women in the four sites included in the Primary Data Survey (2007) had not had the possible side effects of their current methods explained to them. One third of the women surveyed remained concerned over possible side effects regardless of whether they had or had not previously received information on possible side effects.

- Male participation in family planning in NTB and NTT remains very low. The most recent data available shows 2.8% of men surveyed in NTT had ever used male contraception (BKKBK Province, 2007). Specifically in TTS District, 1.33% of men reported ever having used condoms and 4.45% reported having had a vasectomy.

3.2.2 Human rights considerations[37]

Rights relating to reproductive self determination and free choice of maternity have been developed through interrelated rights, including the right to decide the number and spacing of one's children, the right to privacy and to family life, and the right to marry and found a family. Furthermore, the availability, accessibility (including affordability, and accessibility of information) and quality of reproductive and sexual health services, are recognized not only as a key intervention for improving the health of men, women and children, but also as a human right to the highest attainable standard of health. These rights are enshrined in various human rights treaties and consensus documents ratified and signed by Indonesia.[38] They are also enshrined in the Constitution of Indonesia, and other national laws such as the Law on Human Rights, Law on CEDAW and the Health Law (which is still in amendment process).

Free choice of maternity is increasingly recognized as an attribute of private and family life, in order that individuals may decide whether, when and how often to have children, without control and coercion by the government or third parties. (Governments may propose to influence reproductive choices through incentives, but cannot apply compulsion or coercive means). Treaty monitoring bodies, such as the CEDAW Committee, the Committee on the Rights of the Child and the Human Rights Committee, have shown concern over laws in several countries that require husband's authorization for women to access family planning methods. They have asked particular states to eliminate requirements for parental consent in an effort to make health services, including reproductive health services, more accessible for adolescents, and asked for women's free and informed consent with respect to contraception.[39]

[37] Quoted from "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007): Page 14..
[38] Article 12 CESC. GC 14, CRC, CEDAW, CESC, ICPD 1994, BPFA 1995.
[39] "Bringing Rights to Bear: An analysis of the Work of U.N. Treaty Monitoring Bodies on Reproductive and Sexual Rights." Center for Reproductive Rights and University of Toronto International Programme on Reproductive and Sexual Heath Law (2002).

3.2.3 Government effort

National level

Presidential Decree No. 7 of 2005 regarding the medium term development plan for 2005-2009 and the achievement of "quality of life for all families" by 2015 stimulates all key policies on national family planning. The targets set out in this plan include: a reduction in population growth to 1.14%; reduction of the TFR to 2.2 children per women; reduction of unmet need for contraceptives among eligible couples to 6%; increased male participation to 4.5%; promoting an overall increase in the use of effective and efficient contraceptive devices; and increasing the age of first marriage for women to 21 years. Additional objectives set out in the medium term plan (that are not focused on population control) include: maximizing service delivery and the quality of care of services, particularly for less privileged and vulnerable families, and those in remote areas; advancing IEC on reproductive health for eligible couples; preventing side effects of contraceptive devices and drugs; improving the quality of contraceptive devices and drugs; improving human resources; and ensuring sustained funding of services and programs.

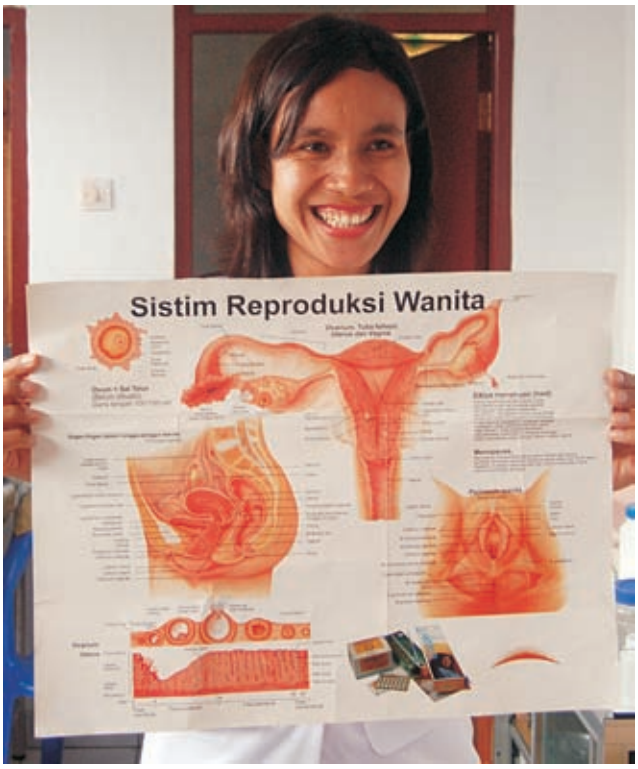
Three of the key policy areas for the National Family Planing programs relate directly to the improvement of women's and child's health and reproductive rights, these are:

1) Encouraging the planning of pregnancy and reducing unwanted pregnancy;

2) Improving the health status of women and children;

3) Improving sexual health and satisfaction.

Activities directed towards improving access to and quality of family planning include: improving quality of the training of family planning providers in midwifery schools (pre service training approach) and in-service training of midwives and other family planning providers; integrating family planning services into the health insurance system for the poor, further encouraging the private sector to provide contraception in remote areas; and starting to promote emergency contraception through training. The MOH in collaboration with POGY has elaborated guidelines on emergency contraception, however they are not yet fully disseminated.



Karsten van der Oord

East Nusa Tenggara: A nurse explains on family planning and reproductive health during consultation hours at a health facility in Kupang © SISKES

Provincial level

In NTB province BKKBN's current regional plan aims to decrease the TFR through: integrated programme management directed at adolescent reproductive health; community empowerment to optimize support for the implementation of an adolescent reproductive health programme; increasing male contraceptive use; promotion of self-reliance in family planning (KB mandiri); and improving the coverage and quality of family planning services.
To date, BKKBN has achieved the regional allocation of funds from the National and Regional Block Grant (APBN/APBD) for the Family Planning Programme; the implementation of IEC programmes; a programme of free condom distribution; and programmes on advocacy, counseling and education for adolescents.

In NTT, BKKBN aims to achieve the goals of its current regional plan through focusing on: the promotion and protection of reproductive rights; improving access to and quality of family planning services; and promoting reproductive health through gender equality and justice. Specific actions outlined in the current NTT plan include: promotion of condom usage among men at community level, religious leaders, NGOs, the army and the police; the provision of family planning field workers with updated IEC materials such as brochures, posters, manuals and visual aids; the publication of a Family Planning Guideline manual for health kader; radio talk shows; and provider training on Contraceptive Technique Update (CTU). To date, CTU training has been completed by 107 midwives and 5 doctors.

3.2.4 Non-government effort

NTB

Local NGOs:

- PKBI - provides reproductive health education and services including counseling.
- YKSSI - provides reproductive health education, health promotion and nutrition programs.
- Fatayat NU - provides reproductive health promotion and conducts research.
- PIKPK - provides reproductive health education and training, and runs a health clinic.

NTT

Local NGOs:

- Rumah Perempuan - provides reproductive health education for village women; health advocacy and IEC campaigns.
- PKBI (Perhimpunan Keluarga Berencana Indonesia) – provides reproductive health services including family planning counseling.
- Yayasan Tanpa Batas (Kupang) - provides reproductive health and HIV promotion, health services and counseling specifically for sexual workers, people with HIV, street children, and adolescents; and also runs a health clinic offering voluntary counseling and testing for STIs.
- Sanggar Suara Perempuan (TTS) - provides reproductive health education and health promotion, nutrition programs for poor and pregnant women.
- Pikul - provides reproductive health education for village women; health advocacy and IEC campaigns.
- CWS - provides food supplements for pregnant women and under fives and assistance for food security.

International contributors:

- UNFPA (Kupang, TTS) - provides IEC, advocacy, training and funding for ARH maternal and neonatal health.

3.2.5 Discrepancies in laws, regulations, policies, strategies, and implementation

National level

Legal and policy barriers[40]

- Inadequate legal protection for unmarried women in relation to reproductive health services (see also 3.1.4) - Indonesian Population Law allows family planning services only for married couples. This means that unmarried women who are not able to get access to contraceptives may be exposed to unintended pregnancy and are likely to seek an induced abortion. As it is mentioned before, because of the restrictive nature of abortion, this is likely to be carried out by an unqualified provider in unsafe conditions, thus presenting a high health risk. This is why the specific provision of the Population Law that allows only married couples to access family planning services, might be contradictory to the Constitution, the Law on Human Rights, the Law on CEDAW and the Health Law all of which call for the provision of adequate health services and facilities to everyone without discrimination.
- Husband authorization for women to have access to reproductive health services is problematic. International

[40] Quoted from the National Field Report: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

human rights treaties and consensus documents ratified/signed by Indonesia recognize individuals' basic human rights related to free choice of maternity. The Population Law number 10/1992 Article 17 requires that "husband and wife must agree on birth regulation and the method that will be used", and the practice of requiring the husband's authorization for a married woman to receive contraception and sterilization is contradictory to the principles of international law and consensus documents ratified and signed by Indonesia.

These treaties, and agreements state that individuals may decide whether, when and how often to have children, without control and coercion by the government or third parties. Although at the International Conference on Population and Development in 1994 Indonesia supported the position that family planning is for couples not for individuals, it did not make reservations to the Beijing Platform for Action or to CEDAW and other Treaties in this regard. The Population Law also contradictory to the Law on Human Rights (Article 49 (3)) which states that "the special rights to which women are entitled arising from their reproductive function are guaranteed and protected by Law."

- There is discrepancy in the Criminal law with regard to family planning information. The Criminal Code forbids the showing in public of materials, contraceptive devices and pictures of the anatomy of women and men, and to provide information on termination of pregnancy. This might be contradictory to the provisions of CEDAW, as well as to the provision of the Law on Population and Family Welfare, that states, "in order to encourage the small, happy and prosperous family norm, the government shall implement improvement in: (a) education, development, and/or services on spacing of births; (b) provision of facilities and infrastructure that are required for pregnancy spacing services; (c) counseling to determine the best age to enter marriage and give birth."[41]

Barriers in policies, strategies, plans & implementation[42]

- The Government initiated steps to develop programs that provide counseling and information on reproductive health for adolescents. However, none of these provide contraception services, but only information and education.
- Current implementation activities related to the provision of family planning give inadequate emphasis to the importance of men's use of contraception (only 1% of contraceptive prevalence nationally).
- Inadequate attention is paid to giving full and accurate information about the different methods of contraception available (especially to women who are sterilized, since nearly 20% are not aware that sterilization is a permanent method).
- For emergency contraception, while there is training for health personnel in some provinces, there are, as yet, no standards or protocols at national or provincial levels for its provision. The Ministry of Health has disseminated guidelines and provided training in emergency contraception, but IEC on emergency contraception is not yet part of the BKKBN policy. Emergency contraception is not included in the national essential medicine list, despite the fact that it is included in the WHO Model List of Essential Medicines.

Provincial level

Barriers in policies, strategies, plans and implementation

- Following decentralization the coordination between BKKBN and DHO/PHO is not well established.
- Women and men often do not receive adequate information on contraceptive side effects and the emergency referral system. Consequently many women have concerns over contraceptive side effects.
- Supply of contraceptives is limited, particularly in rural and remote areas, so that many family planning users do not have a true choice of methods.
- Comprehensive reproductive education is still not implemented in all schools.

41. Law No. 10 of (1992) on Development of Population and Family Welfare, Article 23 Paragraph (1).
42. Quoted from "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

- Reproductive health programs for adolescents are generally limited to socialization and IEC, and do not provide full services, counseling or contraceptives.
- There is continued stigmatization and discrimination of adolescents trying to access family planning information and services, due to moral values and norms.
- The indicators currently used to collect family planning data are different at different government levels (national, provincial, district). This makes it difficult for collaborative and realistic planning across different regions.
- The community still has very low awareness and acceptance of male methods.
- There is low community awareness of emergency contraception and providers at provincial and district levels are not adequately equipped with information about emergency contraception.
- Family planning providers are not skilled enough to provide adequate counseling to family planning acceptors.
- Family planning providers can be over proscriptive when offering contraceptive methods, which prevent women from making and informed choice.
- There is very low awareness in the community of the right to informed consent with regard to accepting family planning methods.

3.2.6 Recommendations for priority actions

National level

Legal and regulatory measures

- The accessibility and affordability of contraceptive services for unmarried people has to be assured through amendment of the Health Law.
- Access to family planning services for unmarried people (as well as married people) should be ensured though the ongoing process amendments to the Population Law.
- Requirement of husband authorization for women to use birth regulation and what type should be eliminated and the Population Law should be amended in this regard.
- The provisions in the revised Criminal Code that "forbids the showing in public of materials, contraceptive devices and pictures of the anatomy of women and men, and to provide information on termination of pregnancy" needs to be eliminated.

Those potentially responsible:

The Ministry of Health, BKKBN, the Ministry of Law and Human Rights, professional associations, Ministry of Manpower.

Policies, strategies, health system measures

- Partnerships between the Government and the private sector should be fostered in order to raise the contraceptive knowledge of and use by unmarried people and adolescents, especially those who live in remote areas.
- Reproductive health services that include family planning should be provided for unmarried people and adolescents.
- The provision of comprehensive information on contraceptives and informed choice for all must be reinforced.
- The Government programme on male participation/ involvement in family planning, which consists of both information and services, must be strengthened.
- At central, provincial, district and service levels, coordination should be improved between BKKBN and MOH in planning and implementing interventions.

Those potentially responsible:

The Ministry of Health, BKKBN, professional associations, NGOs.

Provincial level

Legal and regulatory measures

- There is a need for provincial governments to issue local regulations (perda) to address the specific needs and barriers to providing adequate family planning services, which are determined by local culture, religion, topography and socio-economic conditions.
- Local regulations that explicitly state that women do not require husband authorization to access contraception should be issued.
- Provincial governments should issue local regulations that reinforce recent changes to national legislation with regard to promoting the provision of emergency contraception.

Policies, strategies, health system measures

- The unmet need for contraception in NTB and NTT needs to be addressed through improving access to family planning services, and requires the following actions: widespread socialization on the Askeskin programme for the poor to ensure poverty is not a barrier to contraceptive use; improving the capacity and coordination of the different institutions involved in the provision of family planning services (PHO/DHO, BKKBN/ BKBKS/ KBKS); improvements in the delivery of family planning services in remote and hard to access communities.
- Quality counselling services need to be ensured as an integral aspect of government family planning services in both provinces. This requires: that all providers receive training and supervision to support them in providing accurate information on contraceptive methods and their side effects, to promote client choice of methods, and to guarantee clients are able to give informed consent.
- True choice of methods needs to be guaranteed to clients in both provinces, which requires: the continuous availability of all contraceptive devices and medicines at district and village levels (including male methods); that family planing providers offer clients a choice of contraceptive methods; and that all methods available are free of charge.
- Women's right to choice in relation to family planning needs to be promoted in NTB and NTT by: informing women that they have the right to choose to use contraception and to a choice of methods; informing women and family planning providers that women have the right to practice family planning and to a choice of method without husband authorization; socializing family planning providers (including kader) not to be proscriptive when offering women contraceptives.
- Socialization of the community regarding their right to informed consent in relation to all health consultations, including family planning, is required.
- Male participation in family planning in both provinces needs to be promoted via: socialization to men to ensure they are aware of the benefits and availability of male methods; socialization of family planning providers to routinely offer contraception to men; ensuring the free availability of male methods.
- Provincial and district governments in NTB and NTT should implement the GOIs policy on the provision of emergency contraception, and there should be widespread socialization on the availability of emergency contraception.
- Family planning services in NTB and NTT should be provided for free without discrimination on the grounds of marital status. Family planning providers need to be socialized to provide services, including counseling and contraception to unmarried persons and adolescents.
- In NTT there is a need to increase the availability of comprehensive IEC material (on different types of contraceptive methods, how they work, their benefits and side effects) for fertile couples, religious leaders, community leaders, NGOs and other stakeholders. In particular, Church leaders should be invited to distribute IEC materials on family planning.

Those potentially responsible:

Governor, DPRD (provincial and districts), DPD, District Head, Head of Regional Development and Planning Board

(BAPPEDA), PHO and DHO, Head of BKKBN/ KBKS/ BKBKS, Office of Women's Empowerment, Community Empowerment Body, Department of Religion at Provincial level, religious institutions and leaders, NGOs, private family planning providers.

3.3 Low levels of birth registration

3.3.1 Health related considerations

National level

When infants and children are not officially registered, they are disadvantaged in relation to accessing free health services, commencing formal education and accessing other social benefits. Children who are not registered at birth do not officially exist and thus suffer in multiple ways throughout their life. Low birth registration also inhibits the government's ability to accurately plan for the health and education needs of unregistered children. At the national level, it is estimated that only 54% of children are registered at birth, although birth registration is the responsibility of regional and not the national government. The most common reason given for not registering a birth is the cost, but other reasons include not knowing that the child has to be registered, not knowing where to register, and the registration office being too far away. [43]

Provincial level

In NTB, the available secondary data for the province estimates birth registration for children under five to be 30% for urban areas and 14% in rural areas. In Sumbawa district, birth registration is recorded to be at 42% in urban areas and 25% in rural areas, and in Mataram district birth registration has reached 48%.[44] The Primary Data Survey 2007 indicated lower levels of birth registration than BPS data reports. In Mataram only 17% of the children of women in the survey had been registered and in Sumbawa only 36% of the children of women in the survey had been registered.

In NTT, UNICEF has reported that birth registration reached 46% in 2006, while the Provincial Government reported only 15% birth registration across the province for 2006.[45] The Primary Data Survey (2007) found birth registration in Kupang City to be 35% and 24% in TTS District. Reasons for low levels of birth registration reported by women in the Primary Data Survey (in order of frequency) include: not getting around to registration (belum diurus) (75.6%); the cost of registration being expensive (13.4%); not knowing that the child has to be registered (5%); not knowing where to register a child (1.6%); and for NTT assuming that baptism certificates are equal to birth registration. This is an understandable assumption in NTT because baptism certificates do entitle children to access health care and education, provided by church institutions.

3.3.2 Human rights considerations[46]

The International Convention on the Rights of the Child states that every child has the right to a name and nationality and a right to protection from being deprived of his or her identity. Article 7 of the convention states that "the child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire nationality…"

The legal framework in Indonesia clearly calls for compulsory, free child registration. The Law on Child Protection explicitly states that every child must be given an identity that shall be stated in a birth certificate and it further regulates the requirements for birth registration.[47] This Law (Article 28(3)) states that birth registrations must be free of charge (Article 28(3)). The National Plan of Action on Human Rights and the Law No. 10 of 1992 on Population also states that every person is required to register every birth, in accordance with the provision of prevailing laws and regulations. [48]

Furthermore, Law No. 32 of 2004 on Regional Government states that provincial governments have an obligation to manage demographic and civil registration services.[49] Law No. 23 of 2006 on Population Administration states article 26, *"Citizens who cannot manage to report demographic events by themselves can be helped by implementation institutions or by other persons"*. Furthermore, Law No.27 Article 1 stipulates, *"Every birth must be reported by the citizens to the implementation institution where birth*

43. *"Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis"*, MOH and WHO Indonesian Office, (2007).
44. BPS NTB (2005).
45. Biro Tata Pemerintahan Setda (2006).
46. "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office, (2007) Pp 26.
47. Law No. 23 on Chid Protection Article 27, 28. In accordance with this law, an issuance of birth certificate should based on the declaration of the people who see or assist the birth delivery process. The making and issuance of birth certificate will be the responsible of the government and will be executed in at least in village or sub-district level. The execution will be done at the latest 30 days after filling a form and will be given free of charge.
48. Law No. 10 of 1992, article 28 paragraph (3).
49. Law No. 32 of 2004 on Regional Government article 13.

took place at the latest 60 days after birth": And Article 2 stipulates that "According to report as mentioned in Article 1, *the authorized civil registration personnel take notes on the birth certificate register and issue a birth certificate quotation"*.

In its latest Concluding Observations, the Committee on the Rights of the Child welcomed the provisions contained in Law No. 23 of 2002 on Child Protection, stipulating that a birth certificate shall be issued by the Government, free of charge. However, the committee remained concerned by the low rate of birth registration and by the fact that few concrete measures have been taken to increase it. While noting that the Human Rights Act of 1999 guarantees the right of the child to a nationality, the Committee expressed its concern that in some instances, children born out of wedlock may be denied the right to know their father, and children with a foreign father may be denied Indonesian citizenship. The Committee recommended that the State party amend all national and local laws relating to birth registration and that it implement a comprehensive strategy to achieve 100% birth registration by 2015, including by cooperating with UNICEF and other international agencies.[50] Birth registration is required to protect a child's right to an identity, their right to citizenship, and the rights to health, education and information, and other social services.

In NTB and NTT it is generally considered a husband's role to attend to the administrative needs of his family. This represents a problem for mothers, as not all women are aware of the importance of registering their children and are not able to negotiate their children's access to crucial services if a registration certificate is not produced by their husbands, or if their husbands fail to inform them that the child is registered or where the birth certificate is kept. Thus, the gender preference for fathers alone to attend to the family's administrative needs can also cause discrimination in relation to women's right to information concerning their children.

3.3.3 Government effort

National level

Strategies and plans have been elaborated to include dissemination of the importance of having a birth certificate for all citizens, and encouraging health officers and hospitals (district public hospitals, private hospitals, maternity clinics and midwives) to collaborate in providing the Letter of Birth Identification. The Ministry of Internal Affairs also issued a policy on Implementation of Follow-Up Job Training for Civil Registration, which consists of civil registration operational procedures (No 893.3/1558/POUD).

In some districts local government, in recognizing the problem of not having birth certificates, ran "mass birth certificate" programmes through schools, providing birth certificates free of charge to children who did not have the certificate, without requiring parents' marriage certificates. However, it was not a nationwide program.[51]

UNICEF has also collaborated with the GOI at provincial and national levels and other actors to implement a birth registration programme in 16 districts across 5 provinces. The programme consists of: establishing a memorandum of understanding between related sectors involved in the birth and registration services at district level; legal reform to obtain local government regulations on free birth registration; and simplification of the procedures at the Civil Registration Office with the aim of bringing the service nearer to the village level; capacity building of the civil registrars and other stakeholders including community based organizations; and campaigns to increase public awareness to report births.

Provincial level

NTB

The Government of NTB has a policy that promotes birth registration through supervision, facility and infrastructure enhancement, demographic database establishment, public service improvement and a clearing programme for free birth certificates. The NTB Government has a free of charge birth registration policy that is promoted through: coordination between population registration offices and civil registration offices; supervision and socialization of civil registration officers; and budget allocation for free birth registration. The Government of Mataram City has issued a Mayor's Regulation (No. 13/PERT/2007) on the assurance of a free birth certificate if processed within 60 days of birth. The Government of

[50] CRC/C/15/Add.223/2004.
[51] Sampanag birth registration programme.

Sumbawa District has also issued 2 local regulations:

- Local Regulation No.13 of 2003 on Population and Civil registration, article 17, states that: every birth from permanent and temporary residents should be reported to the Village Head within 60 days after birth; as proof of birth, a birth note from the health care provider who attended the birth should be attached to the certificate.
- Local Regulation No. 21 of 2005, states that: every child registered within 60 days after birth should receive a birth certificate free of charge; registration of dispensation births (for children born before 1985) will be charged 8,000 rupiah; registration of special births (those born after 1986) will be charged 10,000 rupiah.

NTT

In NTT different districts have policies promoting free birth registration, although the time limits vary. These policies include: Kupang City Mayor's Decree (No. 9 of 2006) on Free of Charge Birth Certificates for those between 0-18 years old; TTS District Head's Decree (No. 5 of 2007) on retribution and compensation for ID Cards and Civil Registration Certificates which is free of charge for those 0-18 years old.

East Flores and Sikka districts guarantee free birth certificates until the age of 18; Belu & East Sumba districts ensure a free certificate until 17 years old, in Rote-Ndao district birth registration is free until 16 years old. However, in the districts of West Sumba, and Ngada free certificates are only guaranteed for infants up to 60 days old.

With the aim of achieving free birth registration in all districts within NTT the Secretary of Provincial Government Management Bureau (Biro Tata Pemerintahan Setda) of NTT Province cooperates with UNICEF to provide:

- Advocacy to District Heads on the free cost and simplification of procedures of birth registration.
- Training on birth registration for civil registration officers, midwives, and RT/RW (household units) administrators to simplify the procedure of birth registration.
- Community socialization on the importance of birth registration of children and their rights to free registration.

3.3.4 Non-government effort

Due to District Governments' lack of sufficient resources to dedicate to increasing birth registration in more remote areas of NTB and NTT, INGO and international organizations support is particularly salient in improving the current situation. Their working in tandem with provincial governments include UNICEF (NTT/NTB) and Plan International (NTT). Local NGOs working at both the provincial and district levels include the Child Protection Foundation (Lembaga Perlindungan Anak) (NTB/NTT), and the Annisa Foundation and Gagas Foundation (NTB) (supported by UNICEF and UNESCO). These NGO efforts are directed at funding the free birth registration policy and delivering education campaigns about birth registration. The largest INGO player in addressing low birth registration is UNICEF who have been active in NTB since 1985 and in NTT since 1990, and have a current plan of action in NTB/NTT from 2006 to 2010.

3.3.5 Discrepancies in laws, regulations, policies, strategies and implementation

National level

Barriers in laws and regulations

- There is lack of application of free birth registration law to local regulations. Although the Child Protection Law and the National Plan of Action on Human Rights both call for birth registration of every child free of charge, local regulations (perda) that were issued mainly before the enactment of the Child Protection Law still require fees for birth registration.
- There is discrepancy between the Child Protection law and the Law on Marriage with regard to birth registration. Local government regulations on civil registration of a child require a marriage certificate for the registration, and issue different birth certificates for children born in wedlock and out of wedlock. Such provisions are contradictory to the Constitution, the Child Protection Law and the Provisions

of the Law on Human Rights, all of which call for non-discrimination.

Barriers in policies, strategies, plans and implementation

- The Birth Registration Programme is only implemented in some parts of the country, in 16 out of 430 districts and in 5 out of 33 provinces.
- In 2004, Presidential Decree (No 40) was issued on the National Plan of Action of Human Rights 2004–2009. Among the actions mentioned is the application of norms and standards of human rights instruments "to enhance the rights of the child to obtain a birth certificate". The same action was stated in the previous Plan of Action of Human Rights. However, despite this initiative, there is still no comprehensive national effort to address the needs of low-income children living in remote, isolated and/or rural areas and whose mothers have low educational and socio-economic status. Clarity is also needed on which government sector is responsible for the implementation of the law and the national plan of action.

Provincial level

Barriers in laws and regulations

In NTB, the legal requirement of a parents marriage certificate in order to register a child's birth means that children born of parents whose marriage is unregistered (ie. couples married under religious law and not registered in civil court) cannot legally apply for a birth certificate.

- In NTT, the registration of both birth parents is a legal requirement that prevents children born out of wedlock and those without official adoption papers from being registered.

Barriers in policies, strategies, plans and implementation

- There is a lack of integration of regional plans for promoting free birth registration with other relevant provincial and district strategic plans in NTT and NTB.
- Different districts in NTB and NTT have different levels of commitment, human resources and funds necessary to carry out national and provincial plans on birth registration. The limited speed of decentralization has not been adequately considered with regard to the readiness and capacity of each district in the region to successfully implement provincial programmes for increasing birth registration.
- In both provinces, there is currently an over reliance on international funds and donors to achieve government targets and districts outside the area-coverage of INGO programmes are more handicapped in their ability to implement provincial plans on birth registration.
- IEC campaign messages on birth registration in NTT have failed to reach remote areas due to transport and weather problems, and a shortage of campaign materials. Campaign evaluations also noted a mismatch between campaign methods and materials and the culture and physical conditions of remote areas.
- Due to differences in the cost of birth registration at different times (before or after 30 days, or before or after 60 days) and for different categories of birth (general, special and dispensation) there is a lack of confidence within the community in the governments' promotion of birth registration as a free service.

3.3.6 Recommendations for Priority Actions

National level

Legal and regulatory measures

- Local government regulations on civil registration should be revised according to international human rights principles and should not be discriminatory or stigmatize children born out of wedlock.
- All local regulations must ensure that birth registration is issued free of charge, and be implemented and enforced in order to make registration accessible for all, including the poor.

Those potentially responsible:

The Ministry of Law and Human Rights; the Ministry of Internal Affairs, Ministry of Women's Empowerment.

Policies, strategy and health system measures

- In order to assure that every newborn child receives a birth certificate, local governments and health providers should coordinate by clarifying roles and responsibilities. Coordination should be from the village level up, with a clear designation of who will sign the certificate and who will be responsible for keeping the documentation.
- Those who are responsible for birth registration (mother, father, doctor, midwife, traditional birth attendant) should be informed, educated and empowered to be able to do so. Mothers in particular need to be informed of the importance of birth registration.
- The Birth Registration Programme should be implemented countrywide, with special attention given to children from low-income families, those living in remote, isolated and/or rural areas, and whose mothers have low educational and socio-economic status.

Those potentially responsible:

The Ministry on Law and Human Rights, the Ministry of Health, the Ministry of Internal Affairs, BKKBN, local governments.

Provincial level

Legal and regulatory measures

- Socialization of Law No.23/ 2006 on Population Administration to ensure parents understand that birth registration should be completed within 60 days of birth.
- Socialization for authorities and parents to ensure that the policy of assisting those who have difficulty in registering births are given assistance to do so.
- NTB and NTT need to issue regulations related to free birth registration for children currently excluded, such as adopted children, children born out of wedlock and children whose parents do not have marriage certificates.

Anila Bierwirth

West Nusa Tenggara: Young adults both male and female sit together for gender and reproductive health talks. © SISKES

Those potentially responsible:

Governor, District Head, Local Parliament (DPRD) and Civil Registration Institution.

Policy, strategy and health system measures

- All districts in NTT and NTB should implement free birth registration programme.
- Coordination between Provincial / District Health Offices and the Demographic Office regarding the mechanisms for birth registration needs to be improved. This should involve Hospitals, Community Health Clinics (Puskesmas), Birthing Clinics, Midwives, Churches, Sub-districts and Village administrative offices.

- The community needs to receive culturally appropriate socialization regarding the benefits of birth registration, the cost (free), and the procedure of birth registration.
- Existing birth registration interventions needs to be improved by setting time specific goals for ensuring the registration of the 70% of unregistered births in NTB and the 60-85% of unregistered births in NTT.
- In NTT civil registration officers need to be pro-active in coordinating with the church to improve birth registration procedures.
- In NTT the civil registration office should involve schools in surveying and issuing birth certificates for students who have no birth certificate.

Those potentially responsible:

Provincial and Local Parliament (DPRD), Governor, District Head, Head of Demographic Office and the Civil Registration Institution, Hospital Directors, Private Clinics, Heads of Public Health Clinics, Midwives, Church Principals, Sub-District Heads, Village Heads, Department of Education.

3.4 STIs and HIV/AIDS: Lack of Knowledge, Education and Access to Services for Prevention and Treatment

3.4.1 Health related considerations

National level

Common STIs such as chlamydia, gonorrhoea, trichomoniasis, genital ulcer disease and herpes, are responsible for serious health complications for women during pregnancy, as well as for the health of newborns. They also increase the risk of the HIV transmission. The prevalence of STIs in Indonesia is not adequately documented at the national level. The National Field Test Report noted that data from surveillance among vulnerable groups such as sex workers show that cases of syphilis and gonorrhoea are high. While the reported prevalence of HIV is still considered low compared to nations with well established epidemics, the 2001 MAP Report described Indonesia's epidemic as 'explosive' noting that HIV/AIDS cases jumped 60% from 2000 to 2001[52]. As of December 2003, UNAIDS estimated that 110,000 Indonesians were living with HIV/AIDS, and the current estimate for 2007 is 170,000 people living with HIV/AIDS. By 31 December 2003, the cumulative number of AIDS cases and deaths were 1371 and 479, respectively.

The UNAIDS estimates of the cumulative number of AIDS deaths for 2007 is now at 5500. Lack of adequate access to anti-retroviral drugs for HIV + Indonesians has been a key factor credited with the escalating number of AIDS deaths in recent years[53]. Since the end of 2002, cases of AIDS have increased considerably. In some areas in key populations at higher risk the prevalence already reaches 5%. Consequently, Indonesia has recently been included in the group of countries considered to have concentrated epidemics (National Strategy on response to HIV and AIDS 2007-2010).

HIV/AIDS data collection to date has relied on the National Behaviour Surveillance System Surveys (BSS), which has focused on risk groups such as commercial sex workers, sailors and seaport labourers, truck drivers and factory workers. The 2000 survey also included university students as a target group. While the BSS has been conducted yearly since 1996, it has only sampled populations in large cities such as Jakarta, Surabaya and Manado. This focus on high-risk groups and very large cities has meant that regional Indonesian cities and rural populations, such as those of NTB and NTT have been excluded from data collection. Thus, the limited focus of STI/HIV surveillance is highly problematic because it undermines attempts at lobbying and planning for early prevention in provinces such as NTT and NTB.[54]

According to the Indonesian Young Adult Reproductive Health Survey (2003), which did not include young adults from NTT/NTB, knowledge about STIs other than HIV/AIDS among Indonesian young adults is very limited. Two out of three women and six out of ten men have no knowledge of symptoms of STIs. The same survey indicates that less than 40 % of respondents can name one way to avoid HIV/AIDS and only 10% of respondents name correctly two ways to avoid HIV/AIDS.

[52] MAP (Monitoring The AIDS Pandemic) (2001). The Status and Trends of the HIV/AIDS/STI Epidemics in Asia and the Pacific. Melbourne: MAP Network.
[53] UNAIDS Indonesia Country profile (2006). Accessed at: http://www.unaids.org/en/Regions_Countries/Countries/indonesia.asp
[54] (Bennett 2005: 138).

Provincial level

Provincial data on HIV/AIDS in NTB and NTT has only recently begun to be collected. The total number of HIV positive people reported in 2007 for NTB is 91 people (61 men and 30 women). Reported AIDS cases up to 2007 are 47 people, and to date 32 people have died of AIDS related causes in NTB (KPA, NTB). In NTB one case of mother to child transmission has been recorded, and two cases of HIV positive women being pregnant have been documented (VCT clinic, 2007).

According to KPAD the total number of HIV positive people reported in NTT is 231, consisting of 126 HIV positive and 105 AIDS cases (2007). Reported AIDS related deaths for NTT were 73 people in 2006.[55] The total cases of HIV / AIDS documented in Kupang City are 85, consisting of 56 HIV infections and 29 AIDS cases, with 20 AIDS related deaths recorded. In TTS District, 5 people with AIDS have died. The NGO Yayasan Tanpa Batas has also reported HIV positive pregnant women and 2 children under the age of ten who are HIV positive (2006).

100% of blood is now screened for HIV in both NTB and NTT. Moreover, there is a definite positive trend in the number of people undertaking HIV tests in NTB, with the total number of people recorded as testing for HIV each year steadily rising. The Global Fund reports a total of 584 people tested in 2005, a total of 3577 people tested in 2006, and up until May 2007 a total of 1998 people have been tested this year. Parallel data on the number of people testing for HIV is not currently available for NTT.

A total of 6 institutions (including NGOs) are now active in providing HIV and AIDS related services in NTB, and HIV testing is available at 3 of these institutions (see Appendix 2 for details of services offered by institution). In NTT, there are 5 key institutions providing HIV and AIDS related services and all 5 offer HIV testing (again see Appendix for details of services by institution).

Indonesia's National Demographic Health Survey (2002-2003) reported that only 38.7% of men and 18.9% of women have access to HIV/AIDS prevention information in NTB, and only 33.4% of men and 18% of women have access to such information in NTT. This data indicates an alarming deficiency in the knowledge of the adult populations of NTB/NTT regarding HIV/AIDS. The Household Survey (2007) also produced HIV related data and found that almost two-thirds of NTT respondents and half of NTB respondents had heard of HIV and AIDS. However, it is crucial not to equate ever having heard of HIV/AIDS with having adequate knowledge of HIV/AIDS to avoid infection.

The Primary Data Survey (2007) included ten questions to assess women's knowledge of HIV/AIDS and methods of protecting themselves from HIV infection. More than one third of the women interviewed were not able to give a single correct answer to the HIV knowledge test. More than half could give only 3 or less correct answers (out of 10 questions), and only 22.2% were able to answer 7 (out of 10) questions correctly. These figures indicate that an alarming proportion of the women surveyed had no or very poor knowledge of HIV or how to protect themselves from HIV infection.

3.4.2 Human rights considerations

Women's right to adequate STI/HIV knowledge, prevention and treatment is in itself a fundamental right, but one that also embodies women's basic rights: to health; the right to life, survival and development; the right to benefits of scientific progress; the right to privacy; the right to information and education; and the right to non-discrimination. Being HIV+ also impacts on women's right to marry and found a family due the difficulty in finding a partner and the risks involved in having children when HIV positive.

It has been recognized that in many parts of the world women and adolescent girls lack adequate access to information and services necessary to ensure their sexual health and to prevent, detect and treat sexually transmitted infections, including HIV / AIDS. Governments agree that the protection of human rights remains critical to a successful response to STIs, including HIV / AIDS. Furthermore, governments agree to strengthen or enforce appropriate legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV/AIDS and members of vulnerable groups.

[55] Yaysan Tanpa Batas (2006).

They further agree that since globally women and girls are disproportionately affected by HIV / AIDS, they ought to develop and accelerate the implementation of national strategies that increase people's abilities to protect themselves from HIV infection. It has been accepted that governments must implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including sexual and reproductive health and through education that promotes prevention, and gender equality within a culturally and gender sensitive framework.

It has been agreed that governments will accelerate the implementation of national strategies for women's empowerment, promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerabilities to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls.[56]

3.4.3 Government Effort

National level

At national level, a Presidential Decree established the Indonesia National AIDS Commission in 1994. The Commission promotes the National AIDS Strategy, a collaborative effort by government, non-governmental organizations, the private sector, and the community. This strategy promotes a healthy lifestyle, safer sex through the use of condoms, safe injections, and supports people living with HIV/AIDS. Similar programmes have been designed and committees have been created at the provincial and district levels to respond to the new reality of HIV / AIDS in locally appropriate ways (Ministry of Health 2001, cited in IDHS 2002-2003).

East Java Province is the only province that has yet responded to the need for a formal law to address HIV / AIDS by enacting local government regulation No.5 of 2002 on Prevention and Management of HIV and AIDS.

The Ministry of Health has also established an Integration Program on HIV/AIDS management for pregnant women. This program includes a general policy on HIV mother to child transmission developed in accordance with the national policies on maternal and child health, and HIV/AIDS management in Indonesia. Services for prevention of mother to child transmission are to be incorporated into maternal and child health care services, as well as family planning services at every level of health care.

Every woman who visits a maternal and child health and family planning service at every level of the health system will receive information on the prevention of mother to child transmission. As part of the implementation of this policy guidelines have also been produced on the prevention of mother-to-child transmission, which provide psychological, social support and treatment for HIV positive mothers and their children.

Provincial level

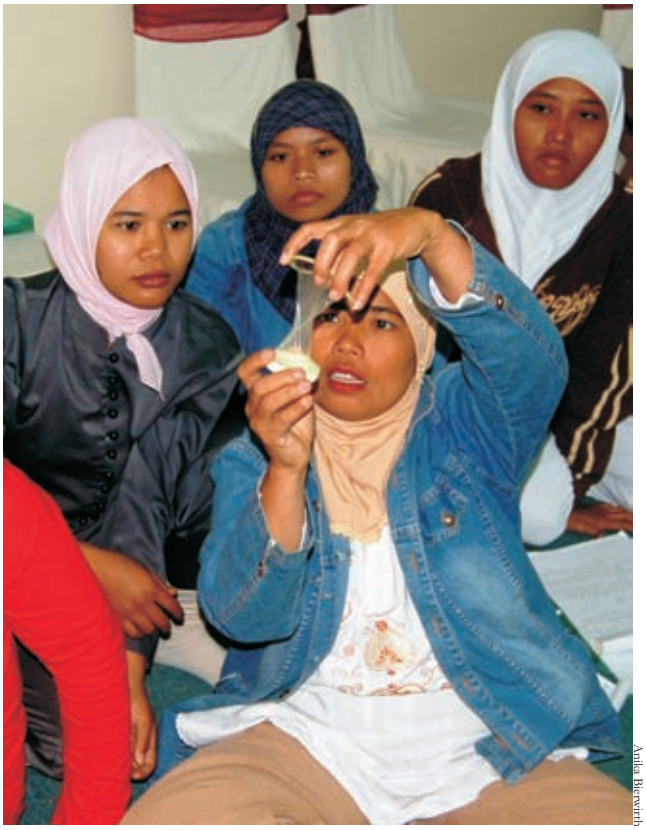
NTB

NTB has established 2 decrees to address HIV / AIDS, the Decree of the Governor of NTB No.12A of 2007 on Establishment of NTB HIV/AIDS Response Commission and Governor Decree No.43/2007 on Establishment of Reproductive Health Commission to provide health care for sexual and reproductive health.

In NTB the following programs, run under the maternal and child heath strategy, operate to address HIV/AIDS:

- BKKBN and PKBI provide counselling, training and reproductive health services
- Prevention of HIV-AIDS through program called PMTCT (prevention of mother to child transmission)
- The PMTCT program is implemented in Mataram Public Hospital, which is the referral hospital treating people living with HIV/AIDS.
- HIV treatment using Anti Retro Viral drugs (ARV) during pregnancy, normal delivery and breast feeding substitution
- Pregnant mothers who are HIV positive are encouraged to have caesarean sections.

[56] Resolution adopted by the General Assembly. S-26/2. Declaration of Commitment on HIV/AIDS. Follow up of this declaration is available at: http://www.unaids.org/en/AIDSreview2006/AIDSReview2006/default.asp



Anika Biersmith

West Nusa Tenggara: Sub-village family planning volunteers inspect a female condom © SISKES

NTT

The NTT Government has issued a decree to address HIV / AIDS, the Governor's Decree No.271/KEP/HK/2003 on "The Establishment of AIDS Prevention Commission". This decree has been replicated in some districts such as TTS District, which has issued the Head of District Decree No.22/KEP/HK/2005 on Establishment of HIV / AIDS Response Commission. Kupang City has also issued Mayor's Decree No.113/Kep/HK/2005 on the Establishment of HIV / AIDS Response Commission.

The Provincial Health Office of NTT has developed a PMTCT programme. In NTT, 5 VCT programmes are currently provided in 4 hospitals in Kupang City. This includes WZ. Yohanes Hospital, Bhayangkara Hospital, Wirasakti Hospital, TC Hillers Hospital in Maumere and the VCT Clinic at Yayasan Tanpa Batas.

3.4.4 Non-government effort

NTB

Local NGOs:

- KAMELIFO/Kanai Memorial Liver Foundation (NTB) - Conducts research, health promotion, and community socialization related to HIV/AIDS and Hepatitis.
- PIKPK (Mataram, NTB) in cooperation with the Women's Studies Center at Mataram University - Conducts research, health socialization, training, and services related to reproductive health.
- Fatayat NU - conducts research, socialization, and training related to reproductive health.
- PKBI – Provides HIV/AIDS prevention, intensive assistance for ODHAs and IDUs, runs an STI/HIV and VCT service, provides condom distribution, counselling and promotion of adolescent reproductive health.

NTT

Local NGOs:

- PKBI with financial support from IHPCP (Kota Kupang dan Kupang Timur) - Targets HIV/AIDS prevention, intensive assistance for ODHAs and IDUs, runs a STI and HIV/AIDS and VCT service, provides condom distribution, counselling for and promotion of adolescent reproductive health.
- Yayasan Tanpa Batas (Kupang, NTT) - Provides IEC on HIV/AIDS for vulnerable groups and communities, assistance to HIV + people, VCT especially for sexual workers and clients, and community socialization on HIV/AIDS.
- Flobamora Support (Kupang, Sikka and Belu district) – Provides outreach and assistance for people with HIV/AIDS.
- Yayasan Bina Mandiri - Promotes healthy circumcision (in relation to sifon), sexual health training for sifon providers

(dukun sunat), students and youth, healthy circumcision training and supplies of circumcision kits, IMS referral to public health centers, and medical circumcision services for youth, and distribution of condoms to construction workers.

Discrepancies in laws, regulations, policies, strategies and implementation

National level[57]

Barriers in laws and regulations

There is a lack of a legal and regulatory framework on the prevention of HIV/AIDS and on access to health services for positive people. Given the extreme way in which people with HIV are stigmatised and discriminated against, there is need for a strong policy and implementation mechanisms that ensure people are not stigmatised, especially within health services.

Barriers in policies, strategies, plans & implementation

Because of the rapidly increasing prevalence of HIV in Indonesia, implementation of strategies and actions geared to both the prevention of HIV/AIDS (especially through public information campaigns), as well as the diagnosis and treatment, require further measures to be taken.

Information and integrated reproductive health programmes and services related to sexually transmitted infections are apparently very inadequate and in need of further resources and training (both pre-service and in-service) for health personnel. There is concern that the National AIDS Commission solely is not an effective enough mechanism to combat the epidemic.

Provincial level

Barriers in laws and regulations

- In NTT, the regional perda responsible for regulating (Ranperda) the provincial response to HIV / AIDS is still in the process of legalization.
- It is still unclear whether the provincial regulations for NTB and NTT include stipulations to protect people living with HIV/AIDS from stigmatization and discrimination in accessing health care services.
- A regulation related to a set budget allocation for HIV / AIDS prevention activities and support for people living with HIV is still lacking in NTB and NTT.

Barriers in policies, strategies, plans and implementation

- While commissions for the prevention of HIV/AIDS have been established in both provinces, coordination of actual services and interventions is lacking. These committees need to dramatically increase their capacity to coordinate actual services and interventions in the relevant sectors.
- Lack of reliable data on STI/HIV prevalence, sexual networking, and experiences of positive people.
- Lack of local research capacity, both in terms of research skills and institutional resources.
- Lack of trained Indonesian personnel working in STI/HIV prevention leading to an over reliance on expatriate experts.
- Continued resistance to active condom promotion.
- Limited focus on at risk groups, despite the fact that the whole population is at risk. The continued focus on at risk groups also perpetuates the stigma associated with STIs and HIV.
- Over reliance on external donors.
- Heavy reliance on NGOs to date in both provinces has meant IEC campaigns have been adhoc and sporadic, and as a result are not spread through different communities evenly.
- Continued resistance to providing comprehensive sex and reproductive education to youth and adults, despite strong demand in many sectors of society.
- Limited collaboration efforts between relevant implementing partners.
- Lack of funding at the community level.
- Limited quality and cultural fit of many IEC materials.

[57] Quoted from *"Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis"*, MOH and WHO Indonesian Office (2007).

- Not all districts have the facilities or trained personnel for STI and HIV testing or treatment.
- Lack of specific methodologies and programs designed to overcome the stigma and taboos associated with discussing STIs and HIV in Indonesia.
- Community Health Insurance programs (Askeskin) and (PJKMM) are not accessed by HIV positive people.
- Hospital capacity to adequately provide special care for people living with HIV is still lacking in both provinces.

3.4.5 Recommendations for priority actions

National[58]

Legal and regulatory measures

- The protection of the rights of HIV positive people must be specifically included in the ongoing process of the amendment of the Health Law.
- Mechanisms should be developed to control and make sure that every HIV positive person has access to health care and services without any discrimination on the basis of their HIV status. A decree should be issued to formalize the decision.
- HIV positive people must not be discriminated against in the workplace. A special decree should be issued to deal with this issue.

Those potentially responsible:

The Ministry of Health, the Ministry of Manpower, the Ministry of Law and Human Rights, professional associations, local and district health offices.

- **Policies, strategy, health system measures**
- A policy should be developed to record national data on STIs, not only HIV/AIDS.
- Every primary health clinic (Puskesmas) must be able to provide comprehensive and affordable reproductive health services, which include screening and treatment for STIs and HIV/AIDS.
- The role and responsibility of the National AIDS Commission must be revised and strengthened in order to be more effective in health promotion and education efforts in the community for the prevention of HIV/AIDS. In this effort, the National AIDS Commission should develop networks with local NGOs, donor partners and other community groups.

Karsten van der Oord

East Nusa Tenggara: A health promotion poster warning for HIV in Kupang local language© SISKES

Those potentially responsible:

The Ministry of Health, the Ministry of Social Welfare, National AIDS Commission, NGOs.

Provincial level

Legal and regulatory measures

- Protection of the rights of people living with HIV/AIDS should be guaranteed by provincial regulations.
- A provincial body should be established in both NTB and NTT that is dedicated to ensuring that people living with HIV/AIDS have access to appropriate health services, and do not experience discrimination in relation to health and social welfare services.
- Provincial regulations ensuring that HIV positive people

[58] Quoted from *"Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis"*, MOH and WHO Indonesian Office (2007).

receive all necessary medical treatment free of charge should be issued.

- A policy should be developed on comprehensive data collection of information on STIs and HIV/AIDS from provincial and district health providers, VCT clinics and hospitals.

Those potentially responsible:

The Govenors of NTB and NTT, Provincial KPA of NTB and NTT, Provincial and District Offices of Health, Office of Manpower and Transmigration, Office of Law and Human Rights, Professional Organizations of health providers.

Policies, strategies and health system measures

- In both provinces PHO should allocate adequate funds to capacity building for Puskesmas health personnel and equipment, to ensure that every primary health clinic is equipped to provide comprehensive reproductive health care including testing for and treatment of STIs including HIV/AIDS.
- The AIDS Response Commission (KPAD) in both provinces should strengthen their capacity, broaden their roles in HIV prevention, and build more operational partnerships with NGOs, professional organizations and other partners (donors).
- Community Health Insurance programs (Askeskin/ PJKMM) should include free treatment for people living with HIV.
- Every district hospital should have the facilities for HIV/AIDS testing, counselling and treatment.
- The education curriculum for health personnel should be revised to include information and counselling skills to address STIs and HIV/AIDS.
- Refresher training should be provided to those health personnel who gained their qualifications before STIs and HIV/AIDS were a part of the standard curriculum.
- Culturally appropriate visual aids and IEC materials should be issued to all health personnel required to offer STI and HIV/AIDS counseling.
- Campaigns designed to promote condom use should be conducted throughout the community. In both provinces such campaigns need to be designed to address cultural and religious resistance to condom use.
- The whole community, including women, men and adolescents, should be empowered with accurate knowledge for the prevention of HIV transmission.
- The provision of STI and HIV/AIDS education and prevention materials should continue to be integrated into existing maternal health services.
- STI and HIV/AIDS education and prevention materials should be integrated into comprehensive reproductive/sex education for adolescents.
- Outreach programmes should be developed to educate and assist high-risk groups.
- High-risk groups should be offered voluntary STI and HIV testing free of charge.
- An accurate data collection mechanism should be developed to collect all relevant data on STIs, HIV and AIDS from provincial and district health providers, VCT clinics and hospitals.
- In-depth research should be conducted on HIV prevalence, patterns of transmission and sexual networking, the needs of HIV positive people, and cultural practices that increase the risk of HIV transmission such as sifon and vaginal drying.

Those potentially responsible:

Governors, Local Parliament, District Heads (Bupati/ Walikota), Provincial/District Health Offices, Social Welfare Offices, Regional Development Planning Boards (BAPPEDA), Regional AIDS Prevention Commissions, Provincial /District Hospital Directors, NGOs, Professional Organizations, Support Groups for People Living with HIV.

3.5 Violence Against Women

3.5.1 Health related considerations

National level

The key health issues stemming from the forms of VAW that we have focused on in this report - domestic violence, rape and unwanted sex in marriage and FGC - all represent multiple violations of women's human rights. Such crimes negate women's right to health, their right to liberty, security of the person and freedom from inhumane and degrading treatment, their right to non-discrimination, and also ignore women's marital rights as enshrined in non-sexist religious teachings of both Islam and Christianity.

In Indonesia there is no systematic nationwide collection of data on violence against women. Subsequently, reliable population based data on the prevalence of different forms of violence experienced by women cannot be provided to policy makers and programme planners. Reports from women's crisis centres, police stations and health facilities and some other institutions (court, physiological services, etc.) indicate that violence against women is increasing. Data collected in the National Field Test – Using Human Rights for Maternal and Neonatal Health, indicate that 72 % of women reporting violence are married and that the perpetrator is nearly always their husband.[59] This is confirmed by additional data showing that for the majority (80%) of women reporting to crisis centres, the perpetrators are husbands, former husbands, boyfriends, relatives or parents. Of the women reporting, 4.5 % were under 18 years old.[60]

Reliable regional estimates of the prevalence of various types of domestic violence have been produced by a number of studies in East Java. Andajani-Sutjahjo (2003) reported that 29.3% of women interviewed had experienced violence perpetrated by their partners, while Hakimi et al. (2001)[62] reported very similar findings of 27% of women ever experiencing partner violence. Andajani-Sutjahjo (2003)[61] also found that 31.5% of women reported having unwanted sex within marriage over the past 12 months and that 6.5% of women had experienced marital violence during pregnancy.

While such studies only measure prevalence in selected provinces and districts they provide critical insight to the prevalence of domestic violence against women at the local level, which due to decentralization should enable provincial and district planners to respond appropriately.

Provincial level

In the provinces of NTB and NTT the secondary data on VAW collected using TOOL A is represented in real numbers and not as a percentage of the population, and is thus likely to significantly underestimate the prevalence of VAW because it relies on the restricted sub-sample of women who have actually reported violence. In 2006, the number of women reporting to health centres in NTB with evidence of violence was 9440, 58% of these women were migrant workers.[63] Female migrant workers are a particularly vulnerable sector of society that pose specific challenges in terms of providing protection and services, because their experiences of violence typically occur overseas where their ability to access health and legal services is highly constrained by their migrant worker status.[64] In NTT, the total number of reported cases of violence against women between 2003 and 2006 was 1,037.[65]

The Primary Data survey produced reliable data on the prevalence of domestic violence among our sample of 1004 married women in four districts of NTB/NTT. While this data is not representative of the entire population of these provinces, it does highlight general trends in the prevalence of VAW in the region and is derived from the largest sample and the most systematic survey of VAW so far conducted in Eastern Indonesia. An average of 50.3% of women across all 4 districts surveyed reported having been physically or emotionally abused by their partners.

A concerning percentage of women also reported having been physically injured by their partner during pregnancy. In Tanjung Karang Mataram 9.2% of women reported violence during pregnancy and in Sumbawa 2.4% of women reported violence

[59] National Commission on Violence Against Women. *Annual Report on Violence Against Women*, (2004/2005).
[60] Mitra Perempuan, Statistic on Domestic Violence, Fact sheet (2005).
[61] Andajani-Sutjahjo, S. (2003). *Motherhood and women's emotional wellbeing in Indonesia.* Unpublished PhD Thesis, The University of Melbourne; Melbourne.
[62] Hakimi, M., Nur Hayati, E., Marlinawati, V. U., Winkvist, A., & Ellsberg, M. C. (2001). Membisu demi Harmoni: Kekerasan terhadap Istri dan Kesehatan Perempuan di Jawa Tengah, Indonesia Yogyakarta: LpkGm-FK-UGM (Indonesia), Rifka Annisa Women's Crisis Centre (Indonesia), Umea University (Sweden), Women's Health Exchange (USA).
[63] Office of Women's Empowerment NTB (2006).
[64] Two NGOs that work specifically with and collect data on migrant workers in NTB are PPK (Perkumpulan Panca Karsa) and Solidaritas Perempuan.
[65] Women and Children's Profile NTT (2006).

while pregnant. In NTT, violence during pregnancy was recorded for 4.4% of women in Kupang city and 2.4% of women in Timor Tenggara Selatan. Out of all women who were surveyed were reported being afraid of their husbands or others (n=328), 57.6% had no safe place to go when violence occurred or when their lives were in danger. This finding clearly highlights the desperate need to increase the numbers of women's shelters and the availability of free short-term accommodation to women experiencing domestic violence in NTB and NTT. Currently, there are only two integrated women's crisis centre's operating in these provinces, one in Mataram and one in Kupang.

The number of recorded cases of rape outside of marriage for NTB between 2004 and 2006 was 94[66], and in NTT 291 cases were reported over the same time period[67]. Regardless of the zero tolerance policy on violence against women, marital rape and sexual assault within marriage are still not recognized as crimes within Indonesian national law. Women who experience sexual violence in marriage also typically go without social or family support due to the embarrassment they feel over their violation and a lack of knowledge or access to appropriate counselling and other support services. A total of 57.4% of women in the Primary Data Survey sample reported having unwanted sex in the past year. This finding has serious implications for women's vulnerability to STIs including HIV/AIDS. Unwanted sex in marriage violates women's rights to freedom from sexual violence, as well as their right to control their fertility in some cases.

In eastern Indonesia it is most accurate to refer to FGC (female genital circumcision), rather than FGM (female genital mutilation), as the dangerous practices of clitoradectomy and infibulation are not religiously or culturally sanctioned and are not a traditional practice among local peoples. The forms of female circumcision traditionally practiced in NTB are most accurately described as "symbolic" and do not involve excision of flesh. Most commonly in Lombok, girl babies are symbolically circumcised soon after birth and midwives produce only a drop of blood via a pin prick or minute nick to the clitoris with a razor blade.[68] Adolescent and adult women interviewed about their experiences of circumcision in Lombok have confirmed a lack of any negative health consequences resulting from circumcision and a lack of interference with sexual function or pleasure as a result of circumcision.[69]

Less is known about women's experiences of FGC in Sumbawa, where the practice has not yet been researched. However, anecdotal and health services data confirms that girls are often circumcised later in Sumbawa at age four or five, or in some districts at puberty. There are also celebrations attached to female circumcision in Sumbawa that do not occur for girls in Lombok. Virtually no substantiated data exists on the practice of female circumcision in NTT, largely due to the dominance of Christianity in this province resulting in the assumption that the practice is not prevalent. Despite the knowledge provided by anecdotal evidence and qualitative research, too much remains unknown about the exact and changing practices of female circumcision in NTB and NTT, more widespread research is required in order to develop location specific responses.[70]

Male circumcision is practiced in both NTB and NTT, where it is associated with significant negative health risks for men and boys. In NTB male circumcision generally occurs between the ages of seven and ten, but may occur earlier if it is cheaper for a boy to be circumcised along with older cousins. For the rural poor in NTB circumcision of boys is often not sanitary, is practiced by non-medical practitioners and boys are not given antibiotics to reduce the risk of infection. Subsequently, painful infections among young boys who have recently been circumcised are not rare. In NTT, circumcision for men is practiced in early adulthood and is strongly associated with sexual maturity and is often referred to as sifon. In some areas unprotected sex, with multiple partners, following circumcision is practiced by young men as a sexual right of passage. Thus, male circumcision in NTT poses significant problems in terms of the risk of contracting STIs including HIV, and subsequently the cultural acceptance of this risky practice puts these men's female partners at risk.[71] In terms of addressing reproductive rights, it is clear that male circumcision in NTB and NTT requires further research and attention to reduce the negative health consequences for men and their partners.

[66] Regional Police Department NTB (2007).
[67] Women and Children's Profile NTT (2007).
[68] Bennett, L.R. (2005) Women, Islam and Modernity: Single Women, Sexuality and Reproductive Health in Contemporary Indonesia. Routledge: London. Pp 55.
[69] Bennett Ibid.
[70] M. ET.AL (2003) *"Female circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights."* Population Council, funded by USAID.
[71] For existing research on the health risks associated with sifon in Eastern Indonesia see Hull, T. and Budiharsana, M. (2001) Male circumcision and penis enhancement in Southeast Asia: matters of pain and pleasure. *Reproductive Health Matters* 9 (18):60–67, and Hull, T. (2006) Engaging and Serving Men in the Indonesian Reproductive Health programme: Issues and Obstacles, Paper presented at the Population Association of America: New York

3.5.2 Human rights considerations

The National Field Test Report highlighted the latest Concluding Observation to Indonesia by the CEDAW Committee, which expressed serious concern about the lack of systematic collection of sex disaggregated data and the lack of documentation on the extent, forms and prevalence of violence against women in Indonesia. The Committee urged the government to collect, as a matter of priority, data on the extent, causes and consequences of the problem of violence against women in Indonesia. We believe the TOOL B survey makes an important contribution to the development of a culturally appropriate methodology for measuring VAW in the Indonesian population, as well as demonstrating the feasibility of a larger sample size for this research, which has not previously been attempted in Indonesia. The Committee also emphasized the need for gender sensitization of authorities, including judiciary, law enforcement officers, lawyers, social workers, health professionals or others who are directly involved in combating violence against women.[72]

3.5.3 Government effort

National level

The GOIs commitment to the elimination of violence against women has been increasing since 2005 with a number of key steps being taken at central policy and legal levels. However, the degree to which these government initiatives and directives have been taken up at all or successfully implemented is extremely varied across the archipelago. Key steps taken at the national level include the adoption of a "Zero Tolerance Policy" prohibiting all forms of violence against women, which was legislated for in 2005. In addition, the medium term development plan for 2005-2009 specifically targeted the prevention of violence against women and improvements in women's status and health. There have also been several important presidential decrees addressing VAW, including Presidential instruction No9. of 2000 on Gender Mainstreaming, which resulted in a new source of funds to address VAW as well as a multi-sectoral approach to the problem of gender discrimination. Presidential decree No 181 of 1998, which established the National Commission of Anti-Violence Against Women has also played a significant role in raising public awareness of the importance of combating VAW. The National Actions Plan of the Ministry of Women's Empowerment 2001-2004 was also critical in supporting the establishment of Indonesia's first state funded integrated women's crisis centres, although the population coverage of such centres remains extremely low and in the majority of outer provinces and non-metropolitan areas still no crisis centres exist.

The National government has recently made significant efforts towards eliminating FGC. NGOs and professional associations such as the Indonesian Midwives Association (IBI), the Indonesian Medical Association (IDI) and the Indonesian Pediatrics Association (IDAI) initiated a workshop where all studies regarding FGC were presented. Based on the conclusion of the workshop it was decided to develop advocacy materials in order to eliminate FGM/C.

As a result of various workshops, the Ministry of Health issued a circular letter signed by Director General of Community Health (dated April, 2006), which was based on an agreement that female circumcision has no particular benefit for the health of women. In addition, it could endanger the health of the girl child and therefore it was agreed that female circumcision should not be carried out by medical personnel.

It was also agreed that all chairpersons of all professional organizations should disseminate this information to their members to ensure that all practices related to FGM/C be stopped.[73] The standards for midwifery service adopted by the MOH from the WHO standards on Midwifery Practice for Safe Motherhood[74] clearly state that midwives should avoid harmful traditional practices and support good practices. Subsequently, DEPKES issued a policy in 2006 forbidding health personnel from performing FGM, and midwives who have previously been the most common providers for FGC in NTB / NTT appear to be aware of this new policy.

Provincial level

Provincial governments in NTB and NTT have been referring to National laws and regulations regarding VAW for the past decade, and have also been active at both provincial and district level in law reform directed at preventing and redressing crimes against women.

[72] CEDAW A/53/38/Rev.1 (1998).
[73] Circular for Health Personnel on Prevention and Prohibition on Medicalization of Female Circumcision, Ministry of Health, Director General of Community Health, 20 April (2006)
[74] Standards for Midwifery practice for Safe Motherhood, World Health Organization, Regional Office for South–East Asia, New Delhi, Regional Publication, SEARO, NO. 38 (2001).

- In NTB, four key provincial decrees/regulations have been introduced since 2000: Provincial Government regulation of NTB (Perda) No 9. of 2000 on the Establishment of Women's Empowerment Section; Instruction of the Government of NTB No 2. of 2001 on Involvement of Gender in Development in NTB Province; Decree of the Government of NTB No 7. of 2006 on the Establishment of a Committee for Children's and Women's Protection and Action in NTB Province; and NTB Provincial Police Decision No. POL: SKE/153/VII/11/2004 on establishing counselling services for women victims of violence.

- Recent provincial decrees/regulations in NTT include: Provincial Regulation of The Governor of NNT No. 12 of 1998 On Enhancing Protection and Welfare of Women and Children in NTT Province; Stipulation of the Head of the Indonesian Republic Police Number SKEP/730/X/2003 on the Establishment of Integrated Service Center at Bayangkara Police Hospital; Decree of Governor of NTT No 36. of 2001 On the Establishment of the Evaluation and Working Team to Revise Provincial Regulation No. 12 of 1998 on Enhancing Protection and Women's and Child's welfare; Decree of Governor of NTT No 221/KEP/HK/2006 On Procedural Standards for the Establishment of a Coordinated Team of Integrated Services to Manage Victims of Violence against Women and Children in NTT; Decree of Governor of NTT No 75/KEP/HK/2004 on The Establishment of a Management and Expert Board for a Child Protection Institution in NTT over the period of 2004-2006; Decree of Governor of NTT No 23/KEP/HK/2003 on the Establishment of a Steering Committee, Technical Team and Working Group for Implementing Women's Empowerment in Development; Stipulation of the Governor of NTT No 173/KEP/HK/2004 on the Establishment of a Working Unit on the National Action Plan on Women and Child Trafficking; Decree of the Director of W.Z. Johannes-Kupang Provincial Hospital No 01/ RSUD/KEP/III/2006 on the Establishment of an Integrated Women's and Children's Integrated Service Center.

Plans and strategies

At the provincial level in both NTB and NTT, the problem of VAW has gained increased attention in recent years. However, the nature of activities and interventions has not yet reached an adequate level of engagement with key service providers so that health, advocacy, legal and police systems are fully competent in responding to VAW. In NTT, significant progress has been made in establishing relevant working groups to address VAW, such as: The Coordinating Team for Integrated Services to manage Victims of Violence Against Women and Children in NTT; The Working group for Implementing Women's Empowerment in Development; The Working Unit of the National Action Plan on Women and Child Trafficking; and the Expert Board for Child Protection in NTT. The Women's Empowerment Section of Local Government in NTT has also directed its efforts towards: improving women's quality of life and protection from VAW; improvements in child welfare and protection; the institutionalization of gender mainstreaming and child protection; and the integration of policies related to child protection and women's quality of life. The concrete service outcomes that have resulted from these combined efforts in NTT in recent years include one operational integrated Women's and Children's Services Centre in Kota Kupang and several women's desks at provincial and district police stations.

In NTB, there has been a clear Provincial Government reliance on women's groups to address VAW through an explicit policy to increase the capacity of women's organizations in supporting regional development. The support offered by the regional government to NGOs has been directed towards: strengthening women's empowerment; promoting women's entrepreneurial ship; improving the role of NGOs in protecting women; improving the role of NGOs in family and health education; improving women's participation in public decision making and politics; strengthening community involvement in achieving gender equality; coordination of an integrated team to manage cases of violence against women and children; leading stakeholders in addressing the problem of child sexual trafficking; establishing ongoing programmes on law enforcement and advocacy regarding VAW.

While the women's groups in NTB have been extremely active and have targeted their programmes at both urban and rural populations, their efforts are limited by their small organizational structures and limited funding.

Greater parallel government action is also needed at both provincial and district levels. NTB now has one integrated Women's and Children's Services/Crisis Centre in Mataram

3.5.4 Non-government effort

Numerous local NGOs are active in addressing violence against women in NTT and NTB, these include:

NTB

Local NGOs:

- PKBI (Perhimpunan Keluarga Berencana Indonesia) - provides education, health services, and counseling for victims of violence.
- YKSSI (Yayasan Keluarga Sehat Sejahtera Indonesia) - provides socialization on domestic violence, counseling, and referrals for victims of violence.
- Korporasi Annisa - offers socialization on domestic violence, counseling, referrals for victims of violence and income generation programmes.
- LBH APIK - offers legal aid for victims of violence, and carries out research and documentation on VAW.
- Bina Cempe Foundation, Dompu - offers socialization on VAW and counseling, referrals for victims of violence and income generating programmes.
- PPK (Perkumpulan Panca Karsa) – provides assistance to female migrant workers who have experienced violence.
- Solidaritas Perempuan – also provides assistance to female migrant workers who have experienced violence.

NTT

Local NGOs:

- PKBI (Perhimpunan Keluarga Berencana Indonesia) - provides parallel services to NTB (see above).
- Yayasan Tanpa Batas - provides health service clinics for women victims of VAW.
- Sanggar Suara Perempuan, TTS - offers socialization on VAW, counseling, and referrals for victims of violence.
- Rumah Perempuan offers socialization and counseling, referrals and income generating programmes.
- LBH Yustisia - provides Legal aid for victims of violence and carries out research and documentation on VAW.

3.5.5 Discrepancies in laws, policies, strategies and implementation

National level

Legal and policy barriers

There are discrepancies between the Law on Domestic Violence and the Criminal Code with regard to sexual violence in marriage. The National Government has made significant efforts to provide legal protection for women by adopting a law on Domestic Violence.[75] However, while the Domestic Violence Law encompasses all forms of violence against women irrespective of marital status, Articles 285 and 286 of the Criminal Code still do not recognize sexual violence within marriage.

In Indonesia, while both the Criminal Code and the Domestic Violence Law recognize rape as a serious crime, the Health Law and regulations do not allow women to deal with the possible consequences of rape - such as unwanted pregnancy and services free of charge for the victims of violence. The lack of legal regulation on provision of safe abortion services for women, who are victims of rape or incest, can result in serious harm to the physical and mental health of the victim. For this reason, the Health Law should be amended to allow access to safe abortion services.

Lack of widespread human rights and gender sensitivity training for those working in the judicial system, including judges, results in a highly discriminatory environment for those

[75] Law no. 23 of (2004) on Domestic Violence.

women who seek legal recourse due to their experiences of violence. In particular, women seeking to initiate divorce on the basis of domestic violence or marital rape are often unsuccessful and believe the judicial system does not offer adequate protection of their rights.[76]

Moreover, lack of legal literacy and the inflated cost of legal representation further disadvantages women in accessing legal services and gaining redress for, or freedom from, violence.

Provincial level

Legal and policy barriers

Not all national laws and regulations relevant to the protection of women and children from violence are ratified at provincial and district levels.

- Women's access to courts in the case of domestic violence is highly constrained. The judicial system needs to be reformed to become more supportive of women bringing cases of partner abuse to court.
- Women who do not have marriage certificates are constrained in their ability to access court processes and to access those processes free of charge. All legal services that are supposed to be free for the poor should be offered free of charge to women regardless of whether they have a marriage certificate or not.

Barriers to implementation of plans and strategies

The barriers to the successful implementation of programmes and strategies aimed at addressing VAW include:

- Lack of human resources (skilled gender analysts and planners) especially at the district level.
- Lack of trained counselors in both metropolitan and rural areas, and across all relevant service sectors.
- Inadequate funding for all programmes related to VAW including the running costs of shelters.
- Lack of true inter-sectoral collaboration despite the "zero tolerance" policy being widely endorsed by different government departments.
- Hit and run programmes and donor driven programmes causing programme-dependency.
- Programmes are often not developed on the basis of adequate evidence or evaluated to measure their impact.
- Lack of appropriate VAW counseling skills among health personnel who come into contact with women living with violence through their routine work.
- Lack of appropriate skills and training among the police force.
- Lack of appropriate skills and training within the judiciary system.
- Lack of any operational screening programmes for VAW among GPs and midwives.
- Inflated cost of legal representation makes it difficult for poor women to access.
- Long standing community silence regarding domestic violence based on the attitude that it is a private family matter, and a lack of awareness that domestic violence is a crime.
- The stigma women victims of violence experience when their problems become public, particularly in the case of sexual violence.
- Lack of short and medium term accommodation services for women wishing to leave violent relationships.
- Lack of any programmes or services for men aimed at preventing violence.
- Lack of awareness of women in the community of available services, and of the fact that those services should be free.

3.5.6 Recommendations for priority actions

National Level

Based on the findings of this research the stakeholders have

[76] Idrus, N. (2003) "To Take Each Other": Bugis Practices of Gender, Sexuality and Marriage. PhD Thesis. Australian National University: Canberra, Chapter 6.

ratified the recommended priority actions outlined in the national Field Report, these include:

Legal and regulatory measures

- The Criminal Code and the Law on Domestic Violence should be harmonized and immediate action should be taken to ensure that the revised Criminal Code takes into account the existing Law on Domestic Violence with regard to marital rape.
- The ongoing process of amendment of the Health Law no 23/92 should be accelerated to ensure the provision of safe abortion services in cases of rape and incest.
- A decree should be issued regarding services free of charge for victim/survivors of violence, including free treatment of physical and psychological injury.

Those potentially responsible:

The Ministry of Law and Human Rights; the Ministry of Health; the Ministry of Women's Empowerment; the Ministry of Social Affairs; the Head of Police, National Policy Department, and the Judiciary system.

Policies, strategies, health system measures

- National and provincial data on violence against women should be systematically collected.
- The law on domestic violence and its implementation should be socialized to all, with special attention to law enforcers.
- Measures should be put in place to ensure that violence against women cases are properly recorded and monitored in all health facilities.
- All health personnel should receive in–service training on violence against women and be able to record violence against women cases. Pre service training curricula should also incorporate the topic.
- Measures should be taken to ensure that the cause of death of every woman suspected to be a victim of violence is appropriately documented.
- Socialization of existing policy on Zero Tolerance on violence against women should be reinforced all levels of bureaucracy.

Those potentially responsible:

The Ministry of Health; the Ministry of Women; Head of Police; Ministry of Social Affairs; Head of Police; Head of Policy Department.

Provincial level

Legal and regulatory measures

- Widespread community socialization of Law No.23/2003 on the Elimination of Domestic Violence is needed. This should include men and women, health and social welfare providers and law enforcers.
- Provincial decrees should be issued to ensure free services for victim/survivors of violence, including free treatment of physical and psychological injury.
- Provincial decrees should be issued stating that women have the right to initiate divorce on the grounds of domestic violence. Special economic assistance should be made available to women to cover legal costs when they apply for divorce on the grounds of domestic violence.

Policies, strategies, health system measures

Data on Violence Against Women at provincial and district levels should be systematically collected. This should involve coordination of reporting between the health services, the police, the courts and women's shelters.

- In NTB, the protection of women experiencing violence should be extended by integrating a referral system for victims of violence into the existing "Alert Village program" (Desa Siaga).
- The number of Special Service Shelters (RPK) dedicated to assisting women who experience violence should be increased.
- A program for short term financial assistance for women

seeking to leave violent relationships should be established to assist women and their children in finding a safe place to live.

- Community empowerment programs, especially directed at women, should be conducted to disseminate information about the illegality of domestic violence, and the availability of shelters and other services. Religious leaders should be active in these community empowerment programs.
- Training on the detection of violence against women and children should be conducted for health and social welfare professionals.
- Health and social welfare professionals should undergo intensive training to provide them with appropriate counseling skills to support women experiencing violence.
- Outreach workers should be trained to provide counseling, information and referral to support services for women living with violence within their communities, as most women are still reluctant to access services outside of their immediate community or village.
- Prevention and treatment programs should be developed for men who perpetrate violence against their partners and children. In particular, men who have been convicted of violent crimes against their wives and children should not be released from prison without receiving treatment to support them to avoid re-offending.
- In depth research should be conducted on female circumcision.
- In depth research should be conducted on male circumcision, and in NTT the sexual practices related to sifon should be investigated.
- In depth research into human trafficking should be conducted, and sex segregated data on human trafficking should be recorded.

Those potentially responsible:

Governor's office of NTB/NTT, District Heads, Local Parliament (DPRD), Regional Development Planning Board (BAPPEDA), Women Empowerment Bureau, Provincial/ District Health Office, Hospitals (general/district), Social and Welfare Office, Police Dept, Legal Bureau, Office of Manpower and Transmigration, National Family Planning Coordination Board (BKKBN), NGOs, Religious/Culture leaders and Community leaders.

3.6 Unmet need for safe abortion services

3.6.1 Health-related Considerations

National level

A substantial proportion of unwanted pregnancies end in induced abortion, whether or not it is legal and whether or not it is safe.[77] Evidence over the past 20 years indicates that increased access to contraception, non restrictive legal frameworks on abortion, and appropriate guidelines and training for practitioners can significantly reduce rates of recourse to induced abortion, including unsafe abortion, and rates of abortion-related maternal mortality and morbidity.[78] It has been recognized in connection with the achievement of Millennium Development Goal 5, that complications of unsafe abortion are the one category of fatal obstetric complications that could be almost totally prevented through the provision of appropriate services. The world community has repeatedly agreed that where abortion is legal, it should be provided safely and, in all cases, complications of unsafe abortion should be treated promptly through high-quality health services.

In Indonesia, abortion is under reported due to the restrictive nature of the law but the most recent estimates put the figure at around two million (both induced and spontaneous). This figure is deemed to be an underestimate. This indicates that there is a high unmet need for safe abortion services. Data from the national household health survey in 2001 indicated that complications of (unsafe) abortion contribute to 5% of maternal deaths.[79] However, other estimates suggest that unsafe abortion may be responsible for up to 13-30% of maternal deaths[80] and the Directorate General of Community

[77] World Health Organization. Unsafe abortion: global and regional estimates of mortality and morbidity. Geneva (2005).
[78] Who's got the power? Transforming health systems for women and children. UN Millennium Project. Task Force on Child Health and Maternal Health.2005. Abortion Law, Policy and Practice in Transition. Reproductive Health Matters (2004); 12 (24 Supplement):1-8.
[79] Utomo B. At al. Incidence an social/psychological aspects of abortion in Indonesia. A community survey in ten major cities and six districts, year (2000). Centre for Health research University of Indonesia, Jakarta 001.
[80] NGO Forum on BPFA). +10, Jakarta (2005).

Health has estimated that up to 50% maternal deaths result from unsafe abortion.[81] Data from 2001 indicates that 24% of abortions are performed by traditional birth attendants (ranging from 15% in cities to 84% in rural areas).[82]

Provincial level

There are no official government statistics on the incidence of abortion in NTB and NTT. However, the most comprehensive study of abortion in Indonesia to date, led by the Women's Health Foundation in Jakarta (2004) included a sample of 1446 women clients seeking medical induced abortion at reproductive health clinics in 9 Indonesian cities.[83] Mataram in NTB was one of the cities included in this sample. Out of the study sample 12% of women clients were unmarried, 86% were married and 1% were divorced, making it clear that unmarried women also need and seek access to abortion services.

This study found that 67% of all women surveyed had attempted non-medical forms of induced abortion themselves before seeking medical assistance at clinics, a finding that clearly indicates that unsafe non-medical abortion practices are still extremely common in Indonesia. When asked the reasons why women's unwanted pregnancy occurred, 61 % of the sample answered that it was due to contraceptive failure and 38% answered that it was due to unprotected intercourse. However, in Mataram the percentage of women reporting unprotected sex, as the reason for their unwanted pregnancy (74%), was much higher than in any other city. The fact that women in Mataram appeared to be taking greater risks in relation to unprotected sex should be investigated further. In this study, 58% of clients cited psychological, social or economic reasons for seeking abortion, a finding that highlights the urgency of reforming Indonesia's abortion law to allow legal abortion on grounds other than medical alone.

In this research, 22% of women also reported that they found the cost of medical abortion too high, considering that the sample was derived from urban women who had the financial resources to access clinics, the actual percentage of women in the overall population who would find the cost of abortion a serious barrier to access is likely to be much higher.[84]

Post-procedure interviews with women clients in the study described above, found that 76% of women felt relieved and/or satisfied following their medical procedures and pre/post abortion counselling, a further 6% of women still expressed some regret or distress following their abortions and 18% of women chose not to discuss their feelings. This finding indicates the importance of pre and post abortion counselling in ensuring the best possible outcomes for women seeking medical abortion. Another key finding of the nine city study was that if safe abortion is not made available to women at a reasonable cost, it greatly increases the likelihood that they will attempt unsafe abortion methods.

The SISKES House Hold Survey (2007) also produced relevant statistical data on abortion practices in NTB and NTT. Among the women surveyed with children under five, there was evidence of abortion in the obstetric history of 12.2% of the NTB sample and 10.5% of the NTT sample.[85] These findings suggest a very high demand for safe abortion in these two provinces.

Qualitative research on abortion conducted in Mataram – NTB (200%) revealed that a wide range of popular unsafe methods of induced abortion are being used by both married and unmarried women.[86] These methods include menstrual regulation with jamu (herbal medicines), massage, insertion of sharp objects in the cervix per vagina, consumption of pharmacy medications contra-indicated during pregnancy, overdosing on the contraceptive pill, eating food understood to be contra-indicated during pregnancy, excessive consumption of alcohol and/or mixed with other drugs, and jumping from heights in the attempt to dislodge a foetus. Unmarried women in particular were found to use more dangerous methods of non-medical induced abortion and to be more likely to attempt abortion multiple times if initially unsuccessful.

[81] Kompas newspaper (2003).
[82] .Utomo B. Et al. Incidence an social/psychological aspects of abortion in Indonesia. A community survey in ten major cities and six districts, year (2000). Centre for Health research University of Indonesia, Jakarta 001.
[83] Widyantoro, N and Lestari, H (2004). Laporan Penelitian Pengentian Kehamilan Tak Diinginkan Yang Aman Berbasis Konseling: Penelitian di 9 Kota Besar. Jakarta: YaysanKesehatan Perempuan.
[84] The cost of abortion reported in the study ranged from 600,000 rupiah to 2,000,000 rupiah. The majority of clients surveyed stated that they believed the cost of medical abortion should not exceed 500,000 rupiah.
[85] In NTB 9 districts were sampled and district prevalence ranged from 18.3% to 4.6%. In NTT 13 districts were sampled first with the remaining districts being covered later and prevalence ranged from 25.9% to 5.1%.
[86] Bennett, L. R. (2001) Ibid.

Married women more often relied upon massage and jamu, and were less likely to consume poisonous substances or attempt physical interventions other than massage. The tendency of unmarried women to take greater risks in relation to induced abortion relates both to the stigma attached to premarital pregnancy – leading to women's reluctance to access safe abortion services, as well as the preference of abortion providers for offering such services to married women on the grounds of contraceptive failure and their reluctance to offer the same services to single women.

3.6.2 Human Rights Considerations[87]

Various human rights treaty monitoring bodies have expressed their concern over illegal and unsafe abortion in the context of the right to life, the right to health and the right to privacy all of which are enshrined in various human rights treaties. The Human Rights Committee characterized high rates of maternal mortality caused by unsafe abortion as a violation of women's rights to health and life and recommended that necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the treaties.[88]

The Committees have explicitly asked States to review and change legislation criminalizing abortion, and countries agreed that governments and other relevant actors should review and revise laws, regulations, and practices that jeopardize women's health including those related to abortion.[89]

Furthermore, as abortion is legal in almost every country for at least one reason, and in three-fifths of all countries to preserve the physical and mental health of the woman, the international community agreed that "health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible".[90]

3.6.3 Government Effort

National level

The Making Pregnancy Safer Strategy, which has been guiding the Government's action on maternal mortality since 2001, recognizes unsafe abortion as one of the main causes of maternal mortality, and one of the key messages of the strategy is that every woman should have access to prevention of unwanted pregnancy and management for complications of unsafe abortion. (National strategic plan on making pregnancy safer in Indonesia, 2001-2010. Jakarta, 2001). Implementation activities are targeting mainly prevention of pregnancy through family planning, and provision of post abortion care. They do not address the problem of unsafe abortion contributing to maternal mortality and the unmet need for safe abortion services. Following the survey conducted in 2003[91], NGOs together with POGI (Indonesian Obstetrics and Gynaecology Association) and hospitals/clinics in nine big cities started to develop service delivery standards for safe abortion services for cases allowed by law (Article 15 of the Health law).

Provincial level

NTB

Safe abortion services available in NTB are based on national legislation in cases where it is medically indicated for the woman. Provincial government effort has been limited to providing medical services to women who have miscarried to avoid morbidity such as infection and excessive bleeding, and to prevent maternal death. This programme is known as "Post Abortion Care" (APK/ Asuhan Pasca Keguguran). During the year 2006, Mataram General Hospital performed PAC services for 34% of the 563 women who presented for post abortion / miscarriage services.

As a follow-up to the survey conducted by the Women's Health Foundation in 2003, a standard of care for abortion services has been developed for cases allowed according to Article 15 of Health Law No.23/1992. Mataram General Hospital is one of the hospitals that has applied the standards of safe abortion care through the training of doctors and counsellors.

NTT

In NTT, training on PAC has been conducted with 29 midwives and 29 doctors (Health service of WZ Johannes Hospital, 2003-2007). However, this training has not included all midwives and doctors in NTT. WZ Johannes Hospital,

[87] Quoted from the National Field Report: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).
[88] United Nations, Human Rights Committee. Concluding Observations on Peru:11/18/96. UN Doc. ICCPR/C/79/Add.72 at para. 15.19.22.
[89] Beijing Platform for Action, para 96.
[90] ICPD+5 paragraph 63iii.
[91] Widyantoro, N and Lestari, H (2004). Laporan Penelitian Pengentian Kehamilan Tak Diinginkan Yang Aman Berbasis Konseling: Penelitian di 9 Kota Besar. Jakarta: Yaysan Kesehatan Perempuan.[92] Quoted from the "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

recorded 60 cases of safe abortion in the second quarter of 2006. However, hospital records do not indicate if these cases were for unwanted pregnancies or whether they were offered through the PAC programme following miscarriages.

3.6.4 Non-government effort

Non-government efforts to address abortion have not been included in this report due to the ambiguous legal status of abortion in Indonesia making it potentially risky to acknowledge the work of NGOs, private practitioners and clinics at provincial and district levels in supporting women's rights to safe abortion.

3.6.5 Discrepancies in laws, regulation, policies, strategies and implementation

National level

Barriers in laws and regulations[92]

There is a lack of legal protection for pregnant women in order to save their life in an emergency situation and the lack of recognition of the right to health in connection to abortion. Although several human rights treaties ratified by Indonesia, such as CEDAW, the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights, as well as the Constitution and the Law on Human Rights, require absolute protection for the right to life without discrimination, the Health Law (No. 23, 1992) does not provide clear protection for the right to life of women even in emergency situations. Article 14(1) of that Law states that "in an emergency situation as an effort to save the life of a pregnant woman and/or her foetus, certain medical actions can be conducted". The lack of absolute protection for the right to life of a women in an emergency situation is also contradictory to the official explanation of Article 9 (on the right to life) of the Law on Human Rights (Law 39/1999) that states that, in an extraordinary situation to save the life of the woman, abortion can be performed. Furthermore, deliberate termination of pregnancy is considered a crime under the Criminal Code (Article 346-348). Denying services that women need in order to save their lives and health is contradictory to the Constitution that protects the right to life and health, and also to international human rights standards.

Barriers in policies, strategies, plans and implementation[93]

In view of the legally restrictive nature of abortion, health care providers are unaware of the grounds on which abortion can be provided within the current law. Also there is a lack of training for providers in methods of safe abortion.

Data is needed to measure the magnitude of unsafe abortion as well as abortion complications contributing to maternal morbidity and mortality, so that policies and programs may be put in place to address the problems.

Provincial level

Barriers in laws and regulations

Provincial and district level stakeholders reaffirmed the barriers identified at national level.

Barriers in policies, strategies, plans and implementation

- Although demand for safe abortion services is proven to exist, and safe abortion can be provided by trained doctors and counsellors, the Provincial Governments are not yet confident enough to develop a policy or plan of action to provide safe abortion services.
- Representative population based data is still required to measure the rate of unsafe abortion and its contribution to maternal morbidity and mortality, so that policy makers are adequately informed in order to develop a systematic and effective policy to provide safe abortion services and reduce maternal mortality by doing so.
- Community socialization on the dangers of unsafe and traditional abortion practices is needed, so that women with unwanted pregnancies will seek safe abortion services before attempting unsafe methods.
- The current cost of abortion services in NTB and NTT (between 250,000 Rp and 600,000 Rp) is inhibitive for the majority of the population.

[92] Quoted from the "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).
[93] Quoted from the National Field Report: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

3.6.6 Recommendations for priority actions

National level

Legal and regulatory measures [94]

- The formulation of the new Health Law regarding abortion should reflect international human rights standards related to the protection of women's lives and health, and public health needs of women who may have unwanted pregnancies and may die due to the complications of unsafe abortion.
- The Criminal Code needs to be revised in order to decriminalize women who seek abortion services. The Criminal Code also needs to be revised in order to decriminalize medically qualified providers who provide safe abortion services when the law allows.

Those potentially responsible:

The Ministry of Health, the Ministry of Law and Human Rights, Ministry of Religious Affairs, Parliamentarians, professional associations.

Policy, strategy, and health system measures [95]

- Safe abortion services for all indications guaranteed by law must become an integral part of comprehensive reproductive health care and services in order to minimize the unnecessary death and morbidity caused by unsafe abortion.
- Data on unsafe abortion must be collected nationally in order to record its magnitude and impact on women's health.
- Wide public and professional awareness should be raised about the Fatwa No.4/2005 that allows abortion where the pregnancy is the result of rape (up to 40 days' gestation).

Those potentially responsible:

The Ministry of Health, BKKBN, Parliamentarians, professional associations, particularly POGI, IBI, IDAI), Ministry of Internal Affairs.

Provincial level

Legal and regulatory measures

NTB

Health Law No.23 of 1992 should be revised at the provincial level to stipulate implementation of safe abortion services in cases of rape and / or incest, in accordance with the Fatwa of Indonesian Ulamas Council (MUI/ Majelis Ulama Indonesia) and WHO standards.

NTT

The Government of NTT should revitalize Health Law No.23 of 1992 to allow abortion when medically indicated to safe a woman's life, and to assist victims of rape and / or incest.

Those potentially responsible:

Minister of Health, Head Provincial / District Health Office in NTB and NTT, National Parliament (DPR RI), Local Parliament (DPRD) of NTB and NTT, Minister of Religion.

Policy, strategy and health systems measures

- Raise the awareness of the community (including adolescents) and policy makers regarding the negative health impacts (physical, psychological and social) caused by unsafe abortion through IEC activities.
- Extend access to information, counselling and services for unwanted pregnancies (including contraceptive methods to prevent unwanted pregnancy and information regarding safe abortion services).
- Considering that cases of rape and/or incest occur in NTB, a referral policy should be developed to appoint competent health care providers and facilities to perform safe abortion for victims of rape and incest.
- A body needs to be established to coordinate services and support for victims of rape and / or incest to ensure their long-term recovery.
- Advocacy to religious leaders regarding the need for safe

[94] Ibid.
[95] Ibid.

abortion services.

- In NTB, wide spread dissemination of the Fatwa of Indonesian Ulamas Council (MUI/ Majelis Ulama Indonesia) No.4 of 2005 on safe abortion.
- Safe abortion services should be available at all district hospitals (RSUD).
- Refresher training and regular supervision should be conducted for abortion providers to ensure they are offering the highest quality services.
- Research should be conducted on the impact of unsafe abortion and its impact on maternal health.
- Safe abortion should be provided free of charge to the poor.

Those potentially responsible:

Governor, District Heads (Bupati/Walikota), Heads of Provincial / District Health Office, Local Parliament (DPRD), Directors of Hospitals (RSU & RSUD), Head of Local Office (Kantor Wilayah) of Ministry of Religion, Head of Social Welfare and Women's Empowerment Office, Head of Education and Sport Office, professional associations, Women's Studies Centres, NGOs.

3.7 Adolescent reproductive health: early marriage and pregnancy, and limited access to sexual and reproductive health education and services

3.7.1 Health-related considerations

National level[96]

Marriage at an early age is likely to lead to early childbearing, with its attendant, well-documented, high risks for both mother and newborn. Where childbearing is postponed, health outcomes for both women and their newborns are clearly better.

In Indonesia:[97]

- There has been a steady increase in the age at first marriage over the past two decades, with more educated women marrying at later ages than younger, less educated women. Since 1991, the median age of marriage has increased from 17 to 19 years. Nonetheless, marriage of girls 15 years and younger is still practiced in Indonesia, especially in the rural areas, and early childbearing varies considerably from province to province.
- A parallel improvement has occurred in the proportion of women giving birth age 15 or younger, with the current estimates showing only 1% versus 7% 30 years ago.
- The percentage of women age 15-19 years who began childbearing in 2002-03 was still 10.4 %.
- There is a substantial difference in fertility among adolescents who live in urban and rural areas. In rural areas the proportion of adolescents who have started childbearing is twice the proportion in urban areas (14% and 7% respectively).
- Women with less education are more likely to have begun childbearing during adolescence than women with higher education. While 14% of adolescents with no formal education have become mothers, only 4% of adolescents with secondary or higher education have done so.
- Unmarried adolescents are unable to access the services they need with regard to their reproductive health.
- Knowledge of adolescents about reproductive health and sexuality is still low. For example less than half of adolescents understand the human reproduction process, and less than 30% of adolescents know how to avoid HIV/AIDS.

Provincial level

Early marriage and pregnancy

Official statistics on age of marriage in NTB indicate that the median age of first marriage for women was 20 years in 2005.[98] In NTT official statistics estimated the median age at first marriage for women to be 22 years in 2006.[99] The Primary Data Survey (2007) found that of the women interviewed in 2 districts in NTB 40% (n= 201) were married by age 18 (the

[96] Ibid.
[97] Data from this section are taken from the Indonesian Demographic and Health Survey, (2002-2003), and the Indonesia Young Adult Reproductive Health Survey 2002-2003, Macro-DHS,(2003).
[98] NTB Public Welfare Indicators (2005).
[99] Susenus BPS (2006).

Anika Bierwirth

West Nusa Tenggara: A community volunteer teaches reproductive health © SISKES

youngest being 10 years old), and of the women in the 2 districts surveyed in NTT 18% (n=90) of women were married by age 18 (7 were married at 12 years old). In NTB, the proportion of women interviewed who had given birth to their first child by age 18 was 23%, and in NTT 15% of women in our sample had become mothers by age 18. These figures suggest that early marriage and early child bearing are still issues of considerable concern in the districts surveyed.

Inadequate access to reproductive health services

The fact that unmarried women are not legally eligible to access many of the services offered by BKKBN seriously compromises adolescent women's rights to health. Discrimination in the provision of reproductive health services to adolescents is also highly problematic because of the estimated increase in the number of young people who are sexually active prior to marriage, and due to the known health burden for young women of premarital pregnancy and unsafe abortion. It has been estimated that 50% of induced abortions in Indonesia are attempted by unmarried women and of those, between 10% to 25% are still in their teen years.[100]

While there is no reliable population based statistical data collected in NTB/NTT on adolescents' reproductive morbidity or even on adolescent sexual behaviour, extensive qualitative research has been conducted in NTB that highlights how and why young women experience discrimination when seeking reproductive health services.[101] This qualitative research (Bennett, 2005) showed that social stigma, the cost, and the discriminatory attitudes of reproductive health providers combine to make access for single women to reproductive health services considerably more difficult than access is for married women.

Moreover, the common misconception that all reproductive health concerns of unmarried women are related to premarital sex also prevents young women from accessing health services for complaints such as reproductive tract infections, menstrual problems, endometriosis, uterine fibroids and reproductive cancers.

As stated in the section on abortion, adolescents are also at greater risk of attempting unsafe non-medical methods of induced abortion and of waiting too long before seeking safe abortion services. When the difficulties of accessing reliable contraception are added to this scenario, the disadvantages faced by adolescent women in relation to protecting their reproductive and sexual health cannot be underestimated and should not continue to be left unaddressed by National or Provincial governments.

Lack of adequate reproductive/ sex education

While community based attempts to provide adolescents with comprehensive sex education, including the activities of NGOs and religious organizations, exist in both NTB and NTT there is still no systematic formal provision of sex education to youth in schools. Of 291 women in the primary Data Survey (2007) who were married by the age of 18, the majority (95%; n=277) reported never having received formal sex education. Moreover, less than 10% of women who were

[100] Singarimbun cited in Nurdiana, E. et al. (2002). "Hak Untuk Mengakhiri Kahamilan". in Perempuan dan Hak Keseahatan Reproduksi. Jakarta: Ford Foundation and Yayasan Lembarga Konsumen Indonesia: 117-140.
[101] Bennett, L.R. (2005) Women, Islam and Modernity: Single Women, Sexuality and Reproductive Health in Contemporary Indonesia. Routledge: London.

married by the age of 18 believed that they possessed enough knowledge of reproductive health at the time they were married. These findings clearly justify the imperative of providing reproductive/sex education prior to marriage for adolescent women.

Higher rates of secondary school drop out for adolescent women

Official data on educational attainment in NTB and NTT indicate discrepancies by gender, and between national estimates of women's educational performance and provincial estimates. The proportion of girls who have never attended school nationally is estimated to be 10.9%. In NTB estimates range between 23.37% and 45.80%, and in NTT 43.76% of girls are thought to have never attended school.[102] While female primary school enrolments for NTB and NTT as a percentage of male enrolments are high, even higher than male enrolments (NTB - 102.48% and NTT -107.2%), girls have a higher drop-out rate than boys once they reach secondary school. In secondary school female enrolments as a proportion of male enrolments for NTB are 97.63% and for NTT 93.14%.

Clearly, improvements in girls' access to secondary education in NTB/NTT will play a key role in promoting their health status and life options. The fact that parents appear to be enrolling girls in primary school at equal to or higher rates than boys suggests a high value on basic education for girls. Research into the reasons behind higher rates of secondary school drop outs for women is important to establish effective strategies for improving girls' educational attainment. In particular, research should be conducted to estimate the exact rates of school drop outs for adolescent girls as a result of unplanned teenage pregnancies.

3.7.2 Human Rights Considerations[103]

Governments, through international treaties and consensus documents as well as through their Constitutions and other national laws, agree to protect and promote the rights of adolescents to reproductive health education, information and care.[104]

Governments also agreed on the design and implementation of programs with the full involvement of adolescents, as appropriate, to provide them with education, information and appropriate, specific, user-friendly and accessible services, without discrimination, to address effectively their reproductive and sexual health needs, taking into account their right to privacy, confidentiality, respect and informed consent. Governments also recognized the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child and in conformity with the CEDAW and ensuring that in all actions concerning children, the best interests of the child are a primary consideration.[105]

The Committee on the Rights of the Child in its concluding observations to Indonesia noted the establishment in 1999 of the Commission on Reproductive Health, to deal, inter alia, with the problems of adolescent health, HIV/AIDS prevention and family planning. The Committee was nevertheless concerned that these issues remain a problem for adolescents and that no organized system of reproductive health counselling and services, nor education on HIV/AIDS and sexually transmitted infections (STIs) for youth exists. The Committee recommended to the State:

- to develop comprehensive policies and plans on adolescent health, taking into account the Committee's general comment No. 4 (2003) on adolescent health and development;
- to strengthen the implementation of the recommendations of the Commission on Reproductive Health, and promote collaboration between State agencies and NGOs in order to establish a system of formal and informal education on HIV/AIDS and STIs and on sex education;
- take into account the Committee's general comment No. 3 (2003) on HIV/AIDS and the rights of the child and the updated International Guidelines on HIV/AIDS and Human Rights in order to promote and protect the rights of children infected with and affected by HIV/AIDS;
- ensure access to reproductive health counselling and

[102] BPS NTB and NTB, Nusa Tenggara Barat dalam Anga and Nusa Tenggara Timor Dalam Angka (2006).
[103] Quoted from Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis, MOH and WHO Indonesian Office (2007).
[104] CRC, ICPD, CEDAW, GC 4 CRC, GC 24 CEDAW, CESCR, GR 14 CESCR.
[105] Beijing Plus Five (2000). Paragraph 79 (f).

information and services for all adolescents; The Committee was also concerned that despite the Committee's previous recommendation, the legal age of marriage of females (16) and males (19) is still discriminatory. The Committee also expressed its concern that a very large proportion of children, especially girls, are married by the age of 15, and that they are thereby legally considered to be adults, meaning that the Convention no longer applies to them. The Committee recommended that the State party review the age limits affecting children set by different legislation in order to ensure that they conform to the principles and provisions of the Convention. The Committee also specifically recommended that the State party:

- ensure that no discrimination based on sex remains, and that the age of marriage for girls is the same age as that for boys;
- take all other necessary measures to prevent early marriage;
- undertake awareness-raising campaigns on the harm and danger resulting from early marriage. [106]

3.7.3 Government effort

National level

The Indonesia Young Adult Reproductive Health Survey 2002-2003 reports that: "family planning services that are available to adolescents offer a wide range of information, education, and counselling.

However, provision of contraceptive methods to unmarried persons is not part of the national family planning programme."

Recently, the Government started to implement an adolescent reproductive health (ARH) programme. The goal of the programme is to prepare responsible adolescents in terms of reproductive health behaviour. The programme focuses on giving information and counselling for adolescents on reproductive health matters. In the government sector, the adolescent reproductive heath programme is implemented by BKKBN, Ministry of Health, Ministry of National Education, Ministry of Religious Affairs and Ministry of Social Affairs. For example, the Ministry of Health focuses on preparing health centers as referral centres while BKKBN focuses on empowering adolescent through community groups. Adolescent friendly reproductive health services are being implemented through Youth Friendly Health Services in a few centers on a pilot basis.

Increasing teenage pregnancy rates have prompted non-governmental organizations to provide reproductive health information and services to young people. In collaboration with PKBI (the family planning association) and BKKBN, UNFPA supports the production of educational materials to reach parents, policymakers, and community leaders promoting the message "sex before marriage is not appropriate among youth". [107]

Provincial level

In NTB adolescent reproductive health has received growing attention. National and Provincial Family Planning Boards (BKKBN/KBKS/BKBKS), the Regional Office of the Ministry of Religion, the Women's Empowerment Bureau (under the Governor's office), the Office of Women's Empowerment and local NGOs have collaborated to conduct socialization campaigns on the ideal age of marriage (a minimum 21 years), the prevention of early marriage (under 19 years) and the importance of marriage registration. These campaigns have used the mediums of Friday religious preaching, the establishment of an Ulama Forum, local Radio, Qur'anic studies groups, and youth forums.

The Provincial government in cooperation with local NGOs such as Annisa, the Women Centre at the University of Mataram, PKBI, YKSSI and UNESCO initiated an empowerment program for female adolescent school dropouts that provides reproductive health education.

A clinic providing adolescent reproductive health services has been established in Banyumulek West Lombok (2002-2006), which is jointly managed by the Family Health and Protection Information Centre (PIKPK/ Pusat Informasi Kesehatan dan Perlindungan Keluarga) and the Women's Studies Centre at Mataram University, and is funded by the Ford Foundation.

The Provincial government of NTT, through collaboration

[106] CRC/C/15/Add.223. 2004. Para 26.27.
[107] UNFPA, cited in Indonesia Young Adult Reproductive Health Survey 2002-2003, Macro-DHS(2003).

between BKKBN and KBKS in Kupang City, have also initiated programs to increase women's age of marriage through public education on ARH. This has involved discussions with youth in schools and radio broadcasts tailored to youth listeners. Additional programs directed at delaying marriage have been run in the form of youth group meetings. An education package on Life Skills in Adolescent Reproductive Health has been developed, which has involved collaboration between PKBI, the NGOs Yasmasa and Yayasan Tanpa Batas, as well as BKKBN, PHO and the Office of Education and Culture.

The Catholic Church and the Population and Civil Registration office have collaborated to increase official marriage registration, by offering marriage registration services as part of the wedding procession. Furthermore, mass wedding programs have been conducted in some districts for poor communities. As an effort to prevent delays in officiating marriage, due to the inability of a man and his family to pay belis (bride) price, the Government of East Sumba has set a standard for bride price.

3.7.4 Non-government effort

NTB

Local NGOs:

- Annisa – provides education for young women forced to leave school due to pregnancy or poverty, runs health and gender education programmes for high risk youth including street girls.
- YKSSI – provides IEC on HIV/AIDS for youth and trains youth peer educators to work among the tourism guide scene.
- Fatayat NU – provides reproductive sex education for youth.
- PKBI – provides reproductive sex education and counselling for youth.
- Desa Siaga – community based adolescent reproductive health classes and referral for health centre counseling.

NTT

Local NGOs

- PKBI NTT – runs a youth centre that provides reproductive health information
- Yayasan Tanpa Batas – provides reproductive education particularly aimed at street children and sex workers, and provides HIV testing, counseling and reproductive health examinations.

3.7.5 Barriers in laws, regulations, policies, strategies and implementation

National level

Barriers in laws and regulations

There are unequal legal provisions on age of marriage and inadequate protection of girls/women from early marriage. The Law on Marriage[108] which sets the marriageable age at 19 for men and 16 for women is contradictory to international obligations on the elimination of child marriage especially the provisions of CEDAW and the Convention on the Rights of the Child that consider early marriage and early pregnancy as a harmful practice. Additionally, in the context of equality between women and men, the CEDAW calls for states to take appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular that women have the same right to enter into marriage as men. Furthermore, the Convention on the Rights of the Child sets the minimum age of marriage at 18 years equally for girls and boys. All these principles are translated into the Child Protection Law that considers anyone below 18 to be a child and requires parents to be responsible and accountable for preventing under-age marriage (Article 26). That is why the Law on Marriage is contradictory to international commitments and national laws that require equal rights to enter into a marriage and sets the minimum age of marriage at 18 years equally for girls and boys.

Another discrepancy exists between the Law on Marriage and the Child Protection law with regard to consent. While the Law

[108] Law No. 1 of 1974 on Marriage, Article 7 Paragraph (1).

on Marriage requires parental consent to marry from those who have not reached 21 years, (Article 6, Paragraph: (2)) the Child Protection Law considers people to be children below the age of 18. That is why the Marriage Law is in contradiction with the Child Protection Law and the Convention of the Rights of the Child that defines children up to 18 years.

Polygamy

The other discrepancy found in the Law on Marriage (Law Number 1 of 1974 Article 3) relates to polygamy. Although the Law states that a man must have only one wife and a woman must have only one husband, it also states that the court may grant permission for a husband to have more than one wife if it is desired by the parties involved. This permission for a husband may be granted if the wife "cannot perform her duties as a wife, if she is physically disabled or suffers from an incurable illness, or if she is unable to have children."

This Law is contradictory to several international treaties, the Law on CEDAW (Law No.7 of 1984 on CEDAW (Article 1), the Law (No.39 of 1999) on Human Rights (Article 3 paragraph 3), as well as the Constitution (Article 28B paragraph 2), all of which protect the right to be free from discrimination.

The above cited provisions of the Law on Marriage undermine women's status in the society and this may have a direct or indirect impact on women's health and access to health services.

Inadequate legal protection for unmarried adolescents in relation to reproductive health services

International human rights treaties, as well as consensus documents such as the Programme of Action of ICPD and the Platform for Action of FWCW ratified and signed respectively by Indonesia, call upon the government to provide services that are available, accessible, and affordable and of good quality for all segments of the population without discrimination. The ICPD Programme of Action agreed that individuals or couples have the right to decide freely and responsibly the number and timing of their children, and to have the information and means to do so free of discrimination, coercion and violence.

Despite the fact that international commitments of the State call for the protection of everyone's - and specifically adolescents' – sexual and reproductive health without discrimination including provision of services, the Population Law allows family planning services only for married couples.

This means that unmarried adolescents who are not able to get access to contraceptives may be exposed to unintended pregnancy and are likely to seek an induced abortion that is often carried out in unsafe circumstances. Because of the restrictive nature of abortion, this is likely to be carried out by an unqualified provider in unsafe conditions, thus presenting a high health risk.

This is why the specific provision of the Population Law that allows only married couple to have family planning services, might be contradictory to the Constitution (article 34.(3), the Law on Human Rights (Article 49.(3), Article 62, the Child Protection Law (article 18), the Health Law (Article 4) and the Law on CEDAW (Article 12) all of which call for the provision of adequate health services and facilities to everyone without discrimination.Furthermore, it also contradictory to the provisions of Convention on the Rights of the Child and the Child Protection Law that calls for the protection of the right to health of the child including those up to the age of 18. According to the official interpretation of the Convention in the context of adolescents health and development, States should develop and implement programs that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) develop policies that will allow adolescent mothers to continue their education.[109] The Child protection law in accordance with the Constitution and the Convention of the Rights of the Child enshrines that every child shall have the right to healthcare services and social security in accordance with his physical, mental, spiritual and social needs.

The Government initiated steps to develop programmes that provide counselling and information on reproductive health for adolescents. However none of these provide contraceptive services, only information and education.

[109] General Comment No. 4. Adolescent health and development in the context of the Convention on the Rights of the Child. Committee on the Rights of the Child, thirty-third session (2003).

Barriers in policies, strategies, plans & implementation

- To prevent early marriage, the GOI (reflected in the BKKBN policy) promotes later marriage for both women and men. However, it recommends a minimum age for marriage of 21 years for women and 24 years for men. This policy contradicts CEDAW, which requires equal rights for women and man to marry and found a family.
- The establishment of adolescent friendly services in Indonesia is still in a pilot phase and is not widely disseminated across the country.
- National and provincial level implementation plans for adolescent sexual and reproductive health information and services are still inadequate. There are neither standards for youth centres, training of peer educators and peer counsellors, nor an accepted minimum content for reproductive health and sexuality education for adolescents.
- The primary focus of information and counselling for adolescents on reproductive health is on morality and abstinence. The content of IEC and counselling is not adequate to protect adolescents from unwanted pregnancy, STIs and sexuality problems.

Provincial level

Barriers in laws and regulations

- Local family planning and reproductive health services refer to national population law and often require young women to produce marriage certificates before giving them access to family planning and reproductive health services. This excludes unmarried women and adolescents from free government services.
- There are no local regulations requiring schools to offer comprehensive adolescent reproductive health education.

Barriers in policies, strategies and health system measures

- In NTB and NTT there are no specific provincial level policies related to the legal age of marriage.
- In NTB, even though specific advice has been issued by the Islamic Boarding School Forum (FKPP / Forum Komunikasi Pondok Pesantren) regarding the importance of preventing early marriage and divorce, there are still many marriages and divorces occurring under the age of 19 years.
- It is still culturally acceptable for many communities in NTB and NTT for women to be married in their teens.
- Higher rates of secondary school drop out for female adolescents mean that women are more likely to marry younger if they have concluded their education before completing secondary school.
- Schools remain reluctant to offer comprehensive reproductive education to adolescents as part of their standard curriculum. The capacity of schools to offer such education, both in terms of the skills of teachers and the provision of appropriate education materials, is still seriously lacking.
- In both provinces there is very low budget allocation dedicated to the specific promotion of adolescent reproductive health.
- In both provinces adolescents and adolescent women in particular, still face considerable discrimination in accessing reproductive health services.
- Existing activities aimed at educating adolescents and promoting their reproductive health, tend to have high dependence on donor agencies, and tend to be short term.
- The cost of private reproductive health services excludes most adolescents who do not have their own sources of income.
- The lack of privacy experienced in most clinics where reproductive health services are offered prevents adolescents from accessing services, particularly for females due to the high stigma attached to sex before marriage for women.

3.7.6 Recommendations for priority actions

National level[110]

Legal and regulatory measures

- The existing Law on Marriage should be revised in order to eliminate early marriage and early pregnancy by defining the minimum legal age of marriage in 18 for both women and men. Consent from the parents for marriage may be required up to 18 years.
- The provisions of the Law on Marriage, (Law Number 1,1974 - Article 3) that give authority to the court to grant permission for a husband to have more than one wife if it is desired by the parties involved and especially if the wife "cannot perform her duties as a wife, if she is physically disabled or suffers from an incurable illness, or if she is unable to have children", should be eliminated.
- Both the Law on Population and the Law on Health should be amended and revised to make comprehensive reproductive health services including contraceptive services available, accessible, and affordable for unmarried women and men, including adolescents.

Those potentially responsible:

The Ministry of Women's Empowerment, the Ministry of Education, Ministry of Religious Affairs and the Ministry of Law and Human Rights, BKKBN.

Policy, strategy and health system measures

- Policies and strategies should be developed to empower adolescents and young people with sexual and reproductive knowledge and skills; and to ensure the provision of adolescent's friendly services.
- Policies regarding the promotion of minimum age of marriage for women and men should be harmonized.
- The Commission on Reproductive Health should be revitalized with the participation of various stakeholders and should include young people.

Those potentially responsible:

The Ministry of Health and the Ministry of Women's Empowerment, in coordination with the Ministry of Education, the Ministry of Religious Affairs and BKKBN.

Provincial level

Legal and regulatory measures

- Local regulations should be issued to ensure the implementation of the Child Protection Law No.23 of 2002 at provincial and district levels. This requires that the National marriage law (Law No.1 of 1974), which stipulates the minimum age of marriage for female is 16 years is aligned with the Child Protection Law No.23 of 2002 that considers people below the age of 18 to be children.
- Local regulations should be issued stating adolescents have the right to access reproductive health services, regardless of their marital status.

Those potentially responsible:

Minister of Women's Empowerment, Local Parliament (DPRD), Governor, District Heads, Head of Regional Development Planning Board (Bappeda), Women's Empowerment Bureau, Provincial/District Health Office, BKKBN, Minister of Religion.

Policy, strategy and health systems measures

- Integrating comprehensive reproductive/sex education into the school curriculum.
- Training for teachers in the provision of reproductive/sex education, both on knowledge and teaching methods.
- Capacity building through the provision of training on ARH for health providers, religious leaders, community leaders, Family Welfare Development Organization (PKK), NGOs, community groups, School Health Teams (Tim Kesehatan Sekolah) and school counsellors.
- Strengthening the role and functions of the Committee for Child and Adolescent Protection.

[110] Quoted from: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

- Continued socialization of the community regarding the risks and dangers of early marriage and early pregnancy, and promotion of later marriage.
- Continued socialization of the community regarding the importance of marriage registration.
- Community socialization about the range of reproductive health issues experienced by adolescents, and the fact that adolescents who are not sexually active also need to access information and health services. This should aim to reduce the association of ARH services with premarital sex and social stigma.
- Establish an Adolescent Reproductive Health Information Center (PIKRR) at every school (including Islamic boarding schools and Catholic schools).
- Provision of an adolescent counselling room at every Public Health Clinic.
- Widespread and intensive training in appropriate counselling skills for health providers, teachers and other people who are able to support adolescents in relation to their reproductive health.
- In-school programmes should be developed to support adolescent women who become pregnant to continue their education, with the aim of reducing female dropouts in secondary school.

Those Potentially Responsible:

Governor, District Heads (Walikota/Bupati), Regional Development Planning Board (BAPPEDA), Women's Empowerment Bureau, Provincial/District Health Offices, Education Office, BKKBN, Local Office of the Ministry of Religion, NGOs, religious leaders and religious youth organizations/groups.

Karsten van der Oord

CHAPTER 4

NON-DISCRIMINATION, EQUALITY AND VULNERABLE GROUPS

4. NON-DISCRIMINATION, EQUALITY AND VULNERABLE GROUPS

Non-discrimination is a key principle of any rights based approach or application of human rights to development, including health. The application of a human rights approach requires that particular attention is given to discrimination, equality, equity and vulnerable groups. These groups include women, minorities, indigenous peoples and others, depending on the specific country situation.[111]

The provincial and district stakeholders from NTB and NTT provinces considered and reaffirmed the findings of the National Field Report on non-discrimination, equality and vulnerable groups. Groups that have been identified as vulnerable in these two provinces are elaborated below according to the different factors that render them vulnerable in terms of their health.

4.1 The right to non-discrimination and equality[112]

Non-discrimination is among the most fundamental principles of international human rights law. When governments, including the Indonesian Government, ratify the Covenant on Civil and Political Rights, the Covenant on Economic, Social and Cultural Rights, CEDAW, the Convention on the Rights of the Child and other human rights treaties, they become legally obliged to prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[113]

While the Constitution of Indonesia does not provide a definition of non-discrimination, the Law on Human Rights declares that "Discrimination means all limitations, affronts or ostracism, both direct and indirect, on grounds of differences in religion, ethnicity, race, group, faction, social status, economic status, sex, language, or political belief, that result in degradation, aberration, or eradication of recognition, execution, or application of human rights and basic freedoms in political, economic, legal, social, cultural, or any other aspects of life".[114] Bound to the principles of these international human rights treaties and national laws, the State is obliged to act against discrimination in all fields of civil and political rights and also of economic, social and cultural rights, including health. In line with international human rights treaties, Law No. 23 of 1992 on Health in article 4 states that: "Every person shall have the equal right to obtain optimal health".

The duty of States to ensure the right to health and other human rights related to safe motherhood, on a basis of equality and non-discrimination, implies an obligation to respect, protect and fulfil women's rights to health care, information and education, as well as an obligation to eliminate laws, policies and practices that discriminate on specified and unspecified ("other status") grounds.

It is therefore necessary to examine the ways in which states ensure that they eliminate discrimination on all grounds. While each of these forms of discrimination can be addressed separately, in practice they often overlap. For instance, sex discrimination is frequently aggravated by discrimination on grounds of marital status, race, age, rural residence and class, often leaving women of young age, of minority racial groups and of lower socioeconomic status living in rural areas the most vulnerable to the risk of maternal death. Thus, a state's government is required to address the intersections of different forms of discrimination.[115]

4.2 Non-discrimination in the context of maternal health and especially vulnerable groups in Indonesia

4.2.1 Gender

All Treaties ratified by Indonesia call for non-discrimination on the ground of sex. Law No. 7 of 1984 on ratification of CEDAW article 1 defines discrimination against women as "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective

[111] Human Rights in Development, OHCHR. Available at: http://www.unhchr.ch/development/approaches-04.html

[112] Quoted from : *"Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office* (2007).

[113] ICPPR article 2 and 26.

[114] 11 Law No.39/1999 on Human Rights article 1 point c.

[115] General Comment No. 28: Equality of rights between men and women, (article 3): 29/03/2000. CCPR/C/21/Rev.1/Add.10. para. 30.

of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. [116]

Governments that ratified CEDAW, including the Indonesian government, need to ensure compliance with the right to non-discrimination and assess the different ways in which women's right to non-discrimination might be violated in the health care context. For instance, States have an obligation to provide services that only women need thus ensuring women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

When possible, according to the CEDAW Committee, legislation criminalizing abortion could be amended to remove punitive provisions imposed on women who undergo abortion. [117]

4.2.2 Vulnerable groups in NTB and NTT: women

The data represented in the previous chapter has highlighted how women are vulnerable because of their gender in multiple ways. Only women get pregnant, and therefore only women face the risk of maternal mortality and only women face the risks associated with unsafe abortion. In the case of contraceptive failure, or lack of access to contraceptives it is women who bare the primary risks and burden of unwanted and unplanned pregnancies. Women are more vulnerable than men to domestic violence. They are also more vulnerable to HIV infection due to their physiology, the threat of violence and unwanted sex, the difficulties women face in negotiating condom use, and because of the tacit acceptance of polygamy in many communities in NTB, and the risks associated with the practice of sifon in NTT.

4.2.3 Age[118]

The right to non-discrimination based on age is commonly violated in connection with sexual and reproductive health. The Convention on the Rights of the Child that was ratified with Decree No. 36 in 1990 in Indonesia, as well as Law 23 of 2002 on Child Protection, defines a child as a human being below the age of 18 years. The Convention and the Law on Child Protection further declare that "the state shall respect and ensure the rights set in the Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status". This non-discrimination clause is accordingly applicable, among others, to Article 24(1) of the Convention that declares that "States parties shall strive to ensure that no child is deprived of his or her right of access to … health care services." Furthermore, Law No. 7 of 1984 on ratification of CEDAW states that the state shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. The Convention on Economic Social and Cultural Rights, that was ratified with Law No. 11 of 2005 in Indonesia, call for the provision of the right to health without discrimination, and the prohibited grounds includes age specifically.

Laws and clinical policies and practices that set chronological age limits for types of care, and deny sexual and reproductive health information and services to adolescents that they are capable to request according to their evolving capacities, are contradictory to international human rights treaties ratified by the Sate and national laws that protects the right to health without discrimination.

4.3 Vulnerable groups in NTB and NTT: girls and young women

Girls and young women are particularly vulnerable in nearly all the dimensions of reproductive health in Indonesia. Early marriage is still practiced in NTT and NTB (particularly in rural areas), which exposes adolescents to early sexual relations and pregnancy. Early childbearing often leads to health problems including maternal morbidity and mortality, infants with low birth weight, and very high parity for women in later life. Girls

[116] CEDAW, article 1.

[117] CEDAW, General Recommendation No. 24 (20th session, 1999) (article 12: Women and health).

[118] Quoted from the National Field Report: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

[119] World Bank. World Development Report 1993 – Investing in Health. New York, Oxford University Press (1993): 84-117.

Karsten van der Oord

East Nusa Tenggara: A family in a remote community on Sumba © SISKES

and young women also lack comprehensive reproductive sex education, and as the data in the previous chapter showed most feel that they do not have enough knowledge of reproduction when married. Both legal barriers and the stigma associated with premarital sex and pregnancy act as serious barriers preventing girls and young women from accessing family planning and reproductive health services. The lack of these essential reproductive health services leaves girls and young women especially vulnerable to resorting to unsafe methods of abortion.

4.4 Socio-economic and educational status and geographical residence[120]

Article 14 of Law No. 7 of 1984 on ratification of CEDAW states that the Sate shall take into account the particular problems faced by rural women and the significant roles, which rural women play in the economic survival of their families. The CEDAW Committee further clarified in its General Recommendation 24 on Women and Health that the full realization of women's right to health can be achieved only if States take steps to facilitate physical and economic access to productive resources especially for rural women, and recognize its interconnection with women's health. It means that States shall ensure access for rural women to adequate health care facilities, including information, counselling and services in family planning.

Furthermore, the Committee called on States to ensure equal access to education, thus enabling women to access health care more readily and reducing female students' drop-out rates, which are often due to premature pregnancy, as well as ensure women and girls specific educational information to help ensure the well-being of families, including information and advice on family planning. Non-discrimination on the grounds of socio-economic status, geographical residence and educational status has been recognized if other treaties, such as the Covenant on Economic Social and Cultural Rights ratified by Indonesia in 2005.

4.4.1 Vulnerable groups in NTB and NTT: poor women, women with low or no education, rural women

In NTB and NTT while great efforts have been made to increase the coverage of maternal health services to poor and rural women, these women still experience greater difficulty in accessing services. Many poor women remain reluctant to gain the necessary documentation (kartu miskin) required to access the health insurance programs for the poor. Poor and rural women also often lack the financial resources and financial autonomy needed for transport to health services. This is a critical factor that often leads to avoidable maternal mortality because women do not access health services or arrive too late.

Rural women were shown in this research to have lower levels of knowledge regarding STIs and HIV, they also tend to have lower overall rates of literacy and educational attainment. Research across the world has shown that women with low of no formal education have poorer maternal and child health outcomes, and this is consistent with the findings of this research. Infants whose mothers are poor and/or live in rural areas, and/or have little or no education, are also at higher risk of dying during the first month of life.

[120] Quoted from: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

4.5 Marital Status[121]

Law No. 7 of 1984 on ratification of CEDAW requires that women exercise their rights "irrespective of their marital status" and other treaties ratified by Indonesia also prohibit discrimination on the ground of other status that includes marital status. The Human Rights Committee, that monitors compliance with the Covenant on Civil and Political Rights explained in connection with the provisions of the treaty that the right of everyone to be recognized everywhere as a person before the law is particularly pertinent for women, who often see it curtailed by reason of sex or marital status. For instance, the stigmatization experienced by women who are pregnant outside marriage, even when they become so through sexual assault or abuse, may impair their access to care and the quality of the care they receive, aggravating their vulnerability to unsafe motherhood. The Committee called States to take measures to eradicate laws or practices that allow such treatment.[122]

4.5.1 Vulnerable groups in NTB and NTT: unmarried women

Marital status may be a protective factor in NTB and NTT because it provides an enabling condition for women to access reproductive health services. In some public health services in NTB and NTT providers request marriage certificates before offering women access to family planning and reproductive health services. Unmarried women who become pregnant are also highly vulnerable to being forced into marriage. Single pregnant women typically experience significant shame and social stigma, which impacts negatively on their psychological health and constrains their health seeking behaviour. This research showed that pregnant unmarried women attended no, or less, maternal health services including antenatal and postnatal care. It also showed unmarried women were more likely to delivery their babies at home and to be assisted by TBAs. Adolescents who become pregnant also experience discrimination in relation to education as they are expected to drop out of school.

4.6 Other status

The phrase "other status" includes other prohibited grounds of discrimination that can affect women's ability to exercise their rights to motherhood. It means that states have the responsibility to ensure that their legislation, policies and practice comply with the obligations to fulfil, respect and protect human rights with regard to all segments of the population, especially those who are particularly vulnerable.

4.6.1 Vulnerable groups in NTB and NTT: women living with HIV/AIDS, migrant workers and sex workers

In NTB in particular, female migrant workers are highly vulnerable to violence and sexual exploitation when abroad. Women married to male migrant workers are also more vulnerable to STIs including HIV when their husbands have extramarital sexual relations and later return to their wives. Women married to migrant workers are also vulnerable in terms of their access to family planning services, as in some areas of NTB, providers refuse to supply contraceptives to women whose husbands are working abroad. Sex workers are particularly at risk of contracting STIs including HIV/AIDS, this risk is compounded in NTB and NTT by the failure to properly promote widespread condom use and to ensure an constant supply of free condoms to sex workers.

Women living with HIV/AIDS are particularly vulnerable in these two provinces due to the extreme stigma associated with HIV/AIDS, and due to the fact that HIV medical treatment and social support services are still being developed.

[121] Quoted from: "Using Human Rights for Maternal and Neonatal health: A tool for strengthening laws, policies and standards of care; A Report of Indonesia Field Test Analysis", MOH and WHO Indonesian Office (2007).

[122] General Comment No. 28: Equality of rights between men and women, (article 3): 29/03/2000. CCPR/C/21/Rev.1/Add.10. para 19.

Karsten van der Oord

CHAPTER 5

CONCLUSIONS

5. CONCLUSIONS

This report represents the results of exploratory research into the fulfilment of Human Rights in Maternal and Neonatal Health at provincial and district levels in the two provinces of NTB and NTT, and considers these findings in reference to National level laws, policies, plans and strategies. It includes extensive data on the many existing efforts of the provincial governments and NGOs towards the promotion of human rights related to maternal and neonatal health. It also contains specific recommendations on how to improve the fulfilment of human rights in maternal and neonatal health, which were developed and approved by stakeholders at the multi-stakeholder workshops held in June 2007 in Bali, and in each province in August and September 2007. What emerges very clearly in this report is that there are a number of legal, regulatory, policy and health system barriers that still need to be addressed in order to accelerate progress towards reduction of maternal and neonatal mortality and morbidity in NTB and NTT provinces. Examining these barriers in the context of Indonesia's human rights obligations under international and national law has demonstrated that action is required to be taken by not only by the Ministry of Health but also by numerous other national, provincial and local government and non-governmental actors. It is evident that extensive collaboration between the different stakeholder groups who participated in this research process is needed to ensure the desired improvements in human rights relating to maternal and neonatal health.

Through the process of preparing this report, stakeholders have already identified the different actors across multiple sectors who will be responsible for taking the recommendations forward. The provincial and district level actors who will lead the changes required to improve the fulfilment of human rights in maternal and neonatal health in NTB and NTT provinces include: The Governors' Offices of NTB and NTT; Local Parliaments (DPRD); District heads; PHO and DHO in NTB and NTT; BKKBN of NTB and NTT; BAPPEDA NTB and NTT; The Office of Manpower (including section of Transmigration) NTB and NTT; The Department of Education in NTB and NTT; The Demographic Offices and Civil Registration Institutions of NTB and NTT; The Women's Empowerment Bureau NTB and NTT; The Office of Law and Human Rights NTB and NTT; Police Departments of NTB and NTT (POLDA); The Family Welfare Associations of NTB and NTT; The Women's Studies Departments of Universities in NTB and NTT; The Department of Religion, religious leaders and institutions; The Regional AIDS Prevention Commissions in NTB and NTT; health providers in both the private and public systems; professional organizations of midwives and doctors, local NGOs identified in this report; support groups for people living with HIV/AIDS; and INGOs and other international donors identified in this report.

On the basis of this report, there will be a series of meetings with different stakeholders to plan follow-up activities that can be integrated within existing plans of action for these two provinces. Where current plans of action cannot accommodate a human rights approach, independent interventions will be designed with stakeholders to promote human rights. Improvements in human rights will be achieved through the commitment of this broad group of stakeholders to a collaborative approach that will involve multiple Government and non-government sectors working together for this common goal.

Key observations related to the research methodology include:

- The use of the WHO Tool A at decentralised levels has been an appropriate methodology. However, at present researchers with post tertiary education are required to administer the tool. We believe that the capacity of local stakeholders to be more participative in the research process could be increased by simplifying the complexity of the Tool A and tailoring it further to fit with standard terminology and indicators used for discussing maternal and neonatal health in Indonesia.

- The development of a complimentary Tool for primary data collection is a suitable method to gain additional information from communities, which balances the research because it is derived from a client perspective, whereas most of the Tool A data was derived from government agencies and institutions that act as providers of difference services. Tool B also enabled extensive involvement and capacity building for indigenous non-government organizations in the areas of human rights and maternal and neonatal health. The involvement of NGO staff as researchers also improved the interaction between NGOs and government offices involved in addressing maternal and child health, and we hope these improved relationships will lead to ongoing collaboration.

- The weakness of both Tools is that they would most likely require an external funding source to support the research process, especially in relation to: -stakeholder training/ sensitization on a human rights approach; -researcher training, field costs; -and qualitative data analysis and interpretation.

- In concluding, it is hopeful that this report will assist in galvanising understanding of how maternal and neonatal health are questions of human rights, and to the support the actions to be taken by all those involved in improving maternal and neonatal health within decentralized systems.

Kupang, Mataram and Jakarta
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