

LEFT WITHOUT A CHOICE

BARRIERS TO REPRODUCTIVE
HEALTH IN INDONESIA

HEALTH IS A
HUMAN RIGHT
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Cover photo: A pregnant woman sits outside a community health centre in Jakarta, Indonesia, March 2010.

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GLOSSARY

IN ENGLISH

ARROW: Asian-Pacific Resource and Research Centre for Women

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CRC: Convention on the rights of the Child

ICCPR: International Covenant on Civil and Political Rights

ICESCR: International Covenant on Economic, Social and Cultural Rights

IDHS: Indonesia Demographic and Health Survey

ILO: International Labour Organization

IPPF: International Planned Parenthood Federation

MDG: Millennium Development Goals

MMR: Maternal Mortality Ratio

WHO: World Health Organization

IN INDONESIAN

Bappenas (Badan Perencanaan dan Pembangunan Nasional): National Development Coordination Agency

BKKBN (Badan Kependudukan¹ Keluarga Berencana Nasional): Department of Population and Family Planning (formerly known as the Family Planning Coordination Board)

Komisi Perlindungan Anak Indonesia (KPAI): The Commission on Child Protection

Komnas HAM (Komisi Nasional Hak Asasi Manusia): National Commission on Human Rights

Komnas Perempuan (Komisi Nasional Perempuan): National Commission on the Elimination of Violence against Women

KUHAP (Kitab Undang-undang Hukum Acara Pidana): Criminal Procedure Code

KUHP (Kitab Undang-undang Hukum Pidana): Criminal Code

PKBI (Perkumpulan Keluarga Berencana Indonesia): Indonesian Planned Parenthood Association

PIK-KRR (Pusat Informasi Kounselling Kesehatan Reproduksi Remaja): The Centre of Reproductive Health Information and Counselling for Adolescents

Posyandu (Pos Pelayanan Terpadu): Health Post

Puskesmas (Pusat Kesehatan Masyarakat): Community Health Centre

UU PKRDT (Undang-Undang Penghapusan Kekerasan Dalam Rumah Tangga): Domestic Violence Law

MAP OF INDONESIA



Provinces in Indonesia

1. INTRODUCTION AND SUMMARY

THE CASE OF MIRIANA

Miriana is a 21 year old Jakarta-based domestic worker. She dropped out of school when she was 12, and married when she was 14 years old.

“I married when I was 14 years old... before [I got married] I didn't know anything about family planning... what to do... the devices... how to use them... I didn't know anything... also what to do when married... I didn't know... I had my first child when I was 15 years old... I learnt about family planning when my first child was three months old.”²

Miriana, like many women and girls from poor and marginalized communities in Indonesia,³ faces significant challenges in accessing sexual and reproductive health information and services. Some of the barriers she faces result directly from laws and policies implemented by the state that discriminate against women and girls. Other barriers arise from discriminatory attitudes and practices amongst health workers⁴ and other members of the community, which the state is failing to challenge.

Despite Indonesia's commitment to promote gender equality, women and girls across Indonesia continue to face serious obstacles in fulfilling their human rights. In this report, Amnesty International highlights the multiple barriers women and girls face in realizing their sexual and reproductive rights. The barriers that are described in this report constitute violations of Indonesia's international human rights obligations to protect women and girls from discrimination, as well as violations of the right to health, in particular reproductive health.

The report examines the specific barriers to women's and girls' reproductive health, including particular obstacles faced by unmarried women and girls; married women and girls, including those who are childless; and victims of sexual abuse. Chapter 4 describes the impact of the criminalization of abortion on reproductive health. Chapter 5 examines the case of domestic workers, who face additional obstacles to the attainment of sexual and reproductive rights. The report concludes with a series of recommendations to the Indonesian authorities, which, if implemented, would greatly improve the realization of the human rights of women and girls in Indonesia, including their reproductive health.

Because women and girls can become pregnant, they are disproportionately affected by the state's restrictions on sexual and reproductive rights, and its failure to protect and fulfil these rights. The state's restrictions include, among other things, laws that support gender stereotyped roles, in particular regarding marriage and childbearing; laws that criminalize consensual sex and the provision of information on sexual and reproductive rights; laws and policies that discriminate on the grounds of marital status and exclude unmarried women and girls from full access to reproductive health services; laws which require the husband's consent for married women and girls to access certain reproductive health services; and the criminalization of abortion in all cases unless the health of the mother or foetus is endangered, or in the case of rape victims.

Sexual and reproductive rights in Indonesia are further compromised by the state's failure to challenge attitudes and practices that discriminate against women and entrench stereotyped roles for men and women. For example, health workers often deny childless married women and girls the full range of

available contraceptive services, in part due to specific views about gender roles and the importance of childbearing.

The state is also failing to ensure that all women and girls who are victims of rape can effectively access reproductive health information and services. Although abortion is legally available to women and girls who become pregnant as a result of rape, this fact is not well known, even amongst health workers, and victims of rape can face significant obstacles to accessing safe abortion services.

This overall context puts many women and girls in Indonesia at risk of unwanted pregnancies, which in turn may leave them vulnerable to a range of health problems and human rights violations, including being forced to marry young or drop out of school. Some may seek an abortion, often in unsafe conditions as was the case of Sharifah who died two days after having a clandestine abortion in unsafe conditions.

THE CASE OF SHARIFAH

Sharifah died two days after she had a clandestine unsafe abortion. She was a 17 year old unmarried girl.

“My friend, [Sharifah], was in second grade of Senior High School... She was 17 years old... She had a boyfriend... [who] was a college student... They had been together for a year and a half... They were using condoms but then she stopped because it was not nice... When [Sharifah] fell pregnant [her boyfriend] didn't want to be responsible... They expelled her from school... She was crying... She told my mum [about the pregnancy]... [Sharifah] asked me to accompany her to a place, a local hut in the village... I did not go inside... The place was scary... [There were] many cassava trees surrounding the place... I think she had the abortion there... She became sick and didn't want to eat anymore. She went to see the doctor, who said that she was losing blood. Two days after the abortion, she died.”⁵

Laws and practices that restrict access to sexual and reproductive health information and services, combined with the criminalization of abortion, may be significant factors in the high number of unsafe abortions in Indonesia each year.⁶ A 2001 study by the University of Indonesia estimated that there may be up to two million induced abortion cases per year in Indonesia – 30 per cent of them among unmarried women.⁷ Many of these abortions are conducted in unsafe conditions. According to official government figures, unsafe abortions account for between five and 11 per cent of maternal deaths in Indonesia.⁸

Some groups of women and girls face additional threats to their sexual and reproductive rights, often because the state has failed to take adequate action to protect them in contexts where they are vulnerable. One example is the plight of domestic workers – an estimated 2.6 million people, the vast majority of whom are women and girls. They face specific risks of abuse because they are not fully legally protected as workers; their work takes place in the employers' home; and they are often isolated from their families and other support. The state's failure to adequately protect the rights of domestic workers leads to additional barriers to their enjoyment of sexual and reproductive rights. Women and girl domestic workers can face challenges accessing information and education on sexuality and reproduction because of restrictions placed on their movements; they may face sexual and other gender-based violence at their place of work; and they are at risk of abuses during and following pregnancy.

The failure to ensure that women and girls can realize their sexual and reproductive rights free from discrimination, coercion and criminalization is undermining Indonesia's ability to achieve the UN Millennium Development Goals (MDGs), and in particular MDG 3 on gender equality and MDG 5 on improving maternal health.

BOX 1: WHAT IS DISCRIMINATION AGAINST WOMEN?

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) defines the term “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 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.⁹

By ratifying CEDAW, states commit themselves to undertake a series of measures to end discrimination against women in all forms, including:

- To incorporate the principle of equality of men and women in their legal system, abolish all discriminatory laws and adopt appropriate ones prohibiting discrimination against women;
- To establish tribunals and other public institutions to ensure the effective protection of women against discrimination; and
- To ensure elimination of all acts of discrimination against women by persons, organizations or enterprises.¹⁰

In order to combat gender discrimination, and address barriers to reproductive health which, amongst other factors, contribute to high levels of maternal mortality, Amnesty International recommends that the authorities take the following steps as a matter of priority:

- Repeal all laws and regulations, at both the central and local levels, that violate sexual and reproductive rights, and ensure women and girls can realize their rights free from coercion, discrimination and the threat of criminalization. Legal and policy provisions on matters related to sexual and reproductive health that discriminate on the grounds of marital status should be removed, as they constitute particular obstacles in ensuring that women and girls who are not married can access the reproductive health information and services they need;
- Decriminalize abortion in all circumstances in order to combat the high number of clandestine unsafe abortions. In cases where women and girls have an unwanted pregnancy as a result of rape, or where a pregnancy poses a threat to the woman’s life or health, ensure they have access to safe abortion services;
- Enact a Domestic Workers’ Law in line with international standards, to ensure that women and girl domestic workers are afforded the same level of protection as other workers in Indonesia. The law should include provisions pertaining to women’s special needs, including maternity provisions.

1.1 METHODOLOGY AND ACKNOWLEDGEMENT

This report builds on Amnesty International’s earlier work on violence against women within poor and marginalized communities in Indonesia. Amnesty International’s February 2007 report, *Exploitation and Abuse: The Plight of women and girl domestic workers in Indonesia*, highlighted the factors that put women and girl domestic workers at risk of domestic violence, as well as their lack of legal protection as workers.¹¹ Subsequently Amnesty International made a submission to the Committee on the Elimination of all Forms of Discrimination against Women (the CEDAW Committee) in July 2007.¹²



Demonstration on International Women's Rights Day highlighting how the government has failed women in Indonesia, 8 March 2010. © AI

This report also follows on from Amnesty International's 2009 report, *Unfinished Business: Police accountability in Indonesia*, which highlighted, among other things, the vulnerability of women and girls from poor and marginalized communities, in particular in urban settings, to police abuse without adequate access to legal remedy.¹³

This report reflects Amnesty International's recent analysis on the extent to which certain Indonesian laws have incorporated international human rights law and standards, including provisions contained in CEDAW, to which Indonesia is a state party. In particular, it builds on a series of open letters addressed to Indonesian authorities in late 2009 and early 2010, which highlighted some of the shortcomings of certain laws in guaranteeing non-discrimination and sexual and reproductive rights.¹⁴ At the time of writing Amnesty International had not received a written response to this correspondence.

The findings of this report are based primarily on a March 2010 visit to Indonesia by Amnesty International. Amnesty International delegates visited Java (West Java, Banten, Jakarta, Yogyakarta and East Java); Sumatra (Aceh and North Sumatra); Bali; and

Lombok in West Nusatenggara (Eastern Indonesia). Two separate one-day workshops were held in March 2010 to consult with various non-governmental stakeholders in Jakarta and Lombok about the organization's planned work.

Delegates interviewed, individually or through focus group discussions, over a hundred former and current Indonesian women and girl domestic workers, living on or outside their employers' premises, on issues pertaining to sexuality and reproduction. They were between 13 and 58 years old, and approximately one third were married. Interviews with domestic workers were conducted in five provinces of Indonesia: West Java Province; Banten Province; the Special Capital District of Jakarta; Aceh Province in Western Indonesia; and West Nusa Tenggara in Eastern Indonesia. The overwhelming majority of the interviews were conducted in urban settings. However, many of the respondents came from rural areas, and gave birth at their village of origin, outside the main cities. Delegates also interviewed individually or through focus group discussions an additional 33 women and girls on sexual and reproductive rights issues in Lombok and Aceh.

Over the course of the research in March 2010, 18 midwives and doctors were interviewed in West Java, Yogyakarta, Jakarta, Lombok and Aceh. Other reproductive health providers and traditional birth attendants were also interviewed. Amnesty International met 16 local government officials in Jakarta, Yogyakarta, Lombok and Aceh (some of whom were also doctors). Amnesty International also met women's rights activists, non-governmental organizations (NGOs), lawyers, police officials, United Nations officials, donor agencies' representatives, and academics on issues pertaining to gender-based violence, sexuality and reproduction. Central government officials were informed about Amnesty International's planned

research prior to the visit.

This research also relies on daily news monitoring of issues related to sexual and reproductive rights in Indonesia over the last two years; extensive reading of academic and other professional publications on preventable maternal mortality¹⁵ and morbidity;¹⁶ an analysis of laws and local regulations; and information from lawyers, NGOs and other relevant contacts in Indonesia.

This study focuses primarily on public health facilities (there are also private health structures operating in Indonesia).¹⁷ Statistics mentioned in this report are drawn mainly from official data sources, notably the Indonesia Demographic and Health Survey (IDHS) which provides statistics on reproductive health among “ever married”¹⁸ women and men,¹⁹ and the Indonesia Young Adult Reproductive Health Survey which provides data on “never married”²⁰ young people aged 10–24 years old.²¹

Amnesty International’s research was conducted with the assistance of numerous local organizations whose names have been withheld to guarantee their protection. Amnesty International would like to express its deep appreciation for their help, as this research would not have been possible otherwise.

Amnesty International thanks all the women and girls who generously agreed to share their stories. The organization also extends its deep admiration for the remarkable and inspiring work of hundreds of human rights activists across Indonesia who promote sexual and reproductive rights tirelessly, often in difficult contexts, and who support women and girls from poor and marginalized communities in the exercise of their rights.

This report is issued as part of Amnesty International’s global Demand Dignity Campaign, launched in 2009, which aims to expose and combat the human rights violations that drive and deepen poverty.²²

BOX 2: WHAT ARE SEXUAL AND REPRODUCTIVE RIGHTS?

Sexual and reproductive rights are grounded in human rights that are recognized in international human rights treaties, regional standards, national constitutions and other relevant human rights standards. The realization of sexual and reproductive rights requires respect for rights relating to physical and mental integrity, including the rights to life, to liberty and security of person; to freedom from torture and other cruel, inhuman or degrading treatment; and to privacy and respect for family life; as well as rights related to freedom of conscience and expression and freedom from discrimination. These rights correspond directly to the principles underpinning sexual and reproductive rights – the physical and mental integrity of the individual, his or her autonomy, and the principle of non-discrimination on grounds such as gender, race, national origin, sexual orientation, disability or socio-economic status.

The table below provides a summary of some of the main components of sexual and reproductive rights:²³

Sexual rights	Reproductive rights
Freedom to choose whether or not to be sexually active;	Access to services and information on contraception and family planning;
Freedom to engage in consensual sex;	Access to sexual health education, including for children and adolescents;
Freedom to engage in sex that is not linked to reproduction.	Access to goods and services to prevent avoidable maternal mortality and morbidity;
	Non-discriminatory access to fertility treatments;
	Ethical use of new reproductive technologies;
	Freedom from forced sterilization, forced abortion and forced pregnancy.
Access to prevention and treatment of sexually transmitted diseases, including HIV/AIDS;	
Elimination of forced marriage (including of children) and harmful traditional practices endangering sexual and reproductive health;	
Freedom from Female Genital Mutilation (FGM).	

Sexual and reproductive rights are central to the realization of every individual's human rights. Respect for these rights is essential to human dignity and to the enjoyment of physical, emotional, mental and social well-being. Their fulfilment enhances life and personal relationships and helps to achieve gender equality and empowerment. All people must be allowed to enjoy their sexual and reproductive rights free from coercion, discrimination and violence.

2. GENDER STEREOTYPING AND ITS CONSEQUENCES

“Gender inequality has long been a problem... women don't have the right to make important decisions, even decisions that impact their own lives”

Dr Budiharja Moehamad Singgih, Director

General Community Health, Ministry of Health, Indonesia, 2010.²⁴

Gender stereotyping in the area of family relations is prevalent in Indonesia and women and girls are under pressure to adopt attitudes which reflect narrow stereotypes of a woman's sexuality. This situation exposes women and girls to discrimination and abuses of their human rights. It also impairs women's and girls' ability to make decisions freely about their lives. By failing to challenge gender stereotypes, the state is failing to respect its international human rights obligations, in particular provisions in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

2.1 WOMEN'S ROLES DEFINED THROUGH MARRIAGE AND CHILDBEARING



A 50 year old mother of four from Java. She was married at age 13 and had her first child at age 14. © AI

Although the status of women in Indonesia has changed in recent decades, especially with the increase in women's participation in the formal workforce, their role and status are still perceived mainly in relation to marriage and motherhood.²⁵ The two aspects – being married and having children – are widely viewed as essential and mutually inclusive in a woman's life: all women should be married and have children, and any woman having a child should be married.

The importance of marriage for women and girls is one factor in the prevalence of early marriages in Indonesia. Although decreasing, marriage at a young age is still relatively widespread, especially in rural areas and slums.²⁶ A recent study found that there were 690,000 marriages involving children (under the age of 18) in Indonesia in 2009,²⁷ accounting for a third of all marriages. Over the course of its interviews, Amnesty International met many women and girls who married when they were still children,²⁸ sometimes as young as 13. Despite their young age, many had their first child shortly after being married (see the case of Susun below).

THE CASE OF SUSUN

Susun is a 34 year old domestic worker in West Java. She has three children. She dropped out of school when she was 12 years old. She married for the first time when she was 16 years old, and the second time when she was 22 years old. Her second husband works as a motorbike taxi driver. Susun's daughter married when she was 15 years old.

"I married for the first time when I was 16 years old. My parents forced me to marry my cousin... He was 28 years old. I hated so much the idea of marrying with him. I told my friends [at the time]. After we married, I became pregnant within four months. [And then] when I was seven months pregnant, he left me... One of my children, [Aria], married... when she was 15 years old... Her husband was 22 years old [at the time]... They liked each other. [She] followed family planning information sessions [after she got married]... However she did not use [contraception straight away]... She had a child first and is now using contraception."²⁹

Early marriage leading to early pregnancy can greatly increase girls' risk of dying in pregnancy and childbirth. Girls aged 10–14 are five times more likely to die in pregnancy or childbirth than women in their twenties. Girls ages 15–19 are twice as likely to die.³⁰

THE MARRIAGE LAW

The stereotyping of women's – as well as men's – roles is codified in law. The Marriage Law (No. 1/1974) states that "*the husband is the head of the family while the wife is the head of the household*" (Article 31.3). "*[T]he husband has the responsibility of protecting his wife and of providing her with all the necessities of life in a household in accordance with his capabilities*" (Article 34.1), while the wife "*has the responsibility of taking care of the household to the best of her ability*" (Article 34.2).

The Marriage Law provides that the legal age of marriage in Indonesia is 16 for women, and 19 for men (Article 7). The Marriage Law authorizes polygamy.³¹ According to Article 4.1 and 4.2, men may seek to have more than one wife provided that (a) their wife does not fulfil the obligations of a wife; (b) their wife has a health condition which cannot be treated; or (c) their wife has not borne a child (*isteri tidak dapat melahirkan keturunan*). Provisions pertaining to polygamy violate the right to equality before the law as men are entitled to marry more than one woman, but women are not permitted to marry more than one man. Furthermore, such provisions support gender stereotyped roles and differential treatment between women and men. For example, the pre-condition set in Article 4(c) (a man can seek another wife in case his wife cannot have children) supports a gender stereotypical view that women's primary function is to bear children.

This provision implies that it is a woman who is the one at fault should a married couple not have children – a medically unfounded assumption as either a man or a woman may not be able to have children for various reasons, such as infertility. It stigmatizes married women and girls who cannot have children, or who have no children and want to delay pregnancy. Further, it reinforces the assumption that marriage should be undertaken for the purpose of procreation and thereby stigmatizes couples who decide against becoming parents, either temporarily or in principle.

2.2 ATTITUDES TOWARDS FEMALE SEXUALITY

THE CASE OF SIRI

Siri is a 38 year old domestic worker from West Java. She married when she was 18 years old and only completed elementary school [up to 12 years old]. She has two children and earns 200,000 Indonesian Rupiah (Rp) per month (22.08 US Dollars (USD)).

“I have two children... one girl and one boy... My husband works at the confection factory... My [baby] girl was circumcised when she was eight days old... Where I live lots of people circumcise girls... [Although] the midwife says it is no longer necessary... she [still] circumcised my baby girl... she cut a little bit... girls must be circumcised so that it is clean... it's for Muslims... so that there are no diseases... I have received information on family planning [from the midwife and the Health Post]... it's in Indonesian... there are bits I understand and bits I don't [understand]... Yes I know about [sexually transmitted diseases]... naughty people have it... It's because they have lots of partners... We must not be naughty... changing partners.”³²

In Indonesia, sex remains a taboo subject which is not openly discussed. Attitudes towards female sexuality and the role of women in the context of sexual relationships are generally conservative. Virginity before marriage is highly valued,³³ and women and girls who have sex outside marriage (or are believed to have done so) are stigmatized.³⁴ Female sexuality is largely viewed within the context of childbearing, with little emphasis on female pleasure. Within marriage, women and girls are expected to be faithful to their husband and to fulfil domestic roles.³⁵ According to the 2007 Indonesia Demographic and Health Survey, a third of “ever married” women interviewed believed that a wife was not justified in refusing to have sex with her husband if she was tired or not in the mood.³⁶

In recent years, conservative attitudes to issues of sexuality have become more prevalent in some parts of the country, sometimes as a result of pressure from radical groups. The human rights of women and lesbian, gay, bisexual/pansexual and transgender people have been particularly restricted as a result, sometimes in a violent way.³⁷

FEMALE GENITAL MUTILATION

“The first time I saw clearly how female sexuality was oppressed was in the case of my own daughter. I knew that female circumcision was not compulsory – that it was a means to control women’s bodies and their sexuality...” Nursyahbani Katjasungkana, women's rights activist, 2010.³⁸

“I have a three year old daughter. As soon as she was born, she was circumcised” Lila, a 23 year old, West Java-based domestic worker, 2010.³⁹

Female Genital Mutilation (FGM) can take diverse forms and have different effects on women and girls. When it entails the cutting, stitching or removal of part or all of the female external genital organs for non-therapeutic reasons, it has a detrimental impact on the health and well-being of women and girls. FGM is associated with a range of health complications around pregnancy and childbirth, including fistulas resulting from obstructed labour, and an elevated risk of emergency caesarean sections.⁴⁰

FGM remains prevalent in Indonesia. A 2003 study conducted by the Population Council in Jakarta with the support from the Ministry for Women's Empowerment concluded that FGM practices in Indonesia can be divided into two main groups: "symbolic only" types where there is no incision or excision (28 per cent of all the cases in the study); and "harmful" forms, involving incision (49 per cent) and excision (22 per cent). The study concluded that the findings "*did not reveal any clear immediate or long-term physical or psychological complications of [FGM] for girls or women. However, direct observation of procedures showed that [FGM] practice in Indonesia certainly involves pain and real genital cutting in about three-quarters of cases*".⁴¹

FGM constitutes a form of violence against women which should be combated. Where the state fails to effectively challenge the practice of FGM, this also reinforces the perception that others are entitled to control a woman's or a girl's sexuality, that is, to decide on her behalf under what circumstances she should (or should not) engage in sexual activity.

There are no laws in Indonesia that specifically ban the practice of FGM, even though it constitutes a form of violence against women.⁴² A 2006 government circular, signed by the Director General of Community Health, specifically warns about the negative health effects of FGM on women.⁴³ Although most midwives and doctors interviewed by Amnesty International were aware of the government circular, many still performed FGM, according to them "symbolically", at the request of the family. Health workers felt that in doing so they were not harming the baby, and were respecting the guidelines set out in the government circular. In one case, a Jakarta-based midwife told Amnesty International that she used betadine, which looks like blood, to make it appear as if she had performed FGM.⁴⁴ In another case, a West Java-based midwife explained she only cleaned the clitoris of the baby if the family asked for FGM.⁴⁵

The majority of the women and girls Amnesty International interviewed in March 2010 had been subjected to FGM when they were a baby or else had chosen FGM for their own baby girl in recent years. The practice is generally undertaken by a traditional birth attendant within the first six weeks after the baby girl is born. The women interviewed said they had asked that their baby girl have FGM performed for religious reasons. On the basis of their own understanding, FGM is required for Muslims, a religious basis which has been challenged by some Muslim groups and experts.⁴⁶ Other reasons women cited ranged from wanting to ensure the girl's "cleanliness" (the external female genitalia is considered dirty)⁴⁷ and avoiding diseases; to perpetuating cultural or local practices; to seeking to regulate or suppress the girls' urge towards "sexual activity" during adulthood.⁴⁸ Some women described the procedure as being merely a "symbolic scratch", while in other cases they explained that it consisted of cutting a small piece of the clitoris. Many women interviewed agreed that there would be a bit of bleeding as a result.

In its 2007 concluding observations, the CEDAW Committee recommended that Indonesia develop a plan of action to eliminate the practice of FGM, including implementing public awareness-raising campaigns to change the cultural perceptions connected with FGM, and provide education regarding the practice as a violation of the human rights of women and girls that has no basis in religion.⁴⁹

2.3 VICTIMS OF SEXUAL VIOLENCE

THE CASE OF LILA

Lila is a 23 year old domestic worker in West Java. She married when she was 19 years old. She studied up until Junior High School [15 years old]. She told Amnesty International about the physical and sexual violence she suffered from her husband for at least two years. She is now getting divorced.

“Before I worked as a domestic worker, I worked at a [local] factory, very long shifts... I could only work there because I had the [official] consent of my husband. I was often away from the house so my husband was angry... and met someone else... My husband was very violent with me [for at least two years]. One time, he hit me and I had blood on my lips. He threw the phone at me and shouted angry words. There were times [when] he said he was going to cut my throat. Each time he said he was going to change but he kept being violent with me. Sometimes he forced me to have sex. It felt like I was being raped by my own husband. I went to see the midwife after this because I felt pain when I wanted to urinate. It was really sore... I did not tell the midwife what had happened. I said I had fallen. She did not believe me but she did not ask further questions. I have never told anyone about the sexual abuse [by my husband]... It is too intimate and I feel so ashamed. I have only told about the [physical] attacks to my parents and the Pastor... but I never reported it [to the police]. I was scared people would ask questions... We are now getting divorced.”⁵⁰

The Criminal Code (*Kitab Undang-undang Hukum Pidana*, KUHP) has traditionally been the law under which cases of violence against women are dealt with. With the enactment of the Domestic Violence Law (No. 23/2004) in 2004 and the passing of the Witness Protection Act (No.13/2006) in 2006, the legal protections available to victims and witnesses of domestic violence have considerably increased.⁵¹

However, women and girls who are victims of sexual violence continue to face a range of obstacles in law and practice when they report to the police. The definitions referring to “rape” or “sexual violence” contained in the Domestic Violence Law and the Criminal Code lack clarity. The definitions are narrow and not consistent across the two pieces of legislation, which leads to a level of uncertainty about what is and is not a criminal offence.⁵² For example, marital rape has yet to be criminalized in the Criminal Code, and the Domestic Violence Law refers to sexual violence (*kekerasaan seksual*), but not specifically to rape (*perkosaan*). Moreover, the law requires that there be two elements of proof of rape (for example testimony from the victim; the defendant; an expert etc) – which in reality can be very difficult for victims to demonstrate.⁵³

There are also problems with the application of the Domestic Violence Law. For example, a study from an Indonesian NGO, Rifka Annisa, highlighted that police officials tend to require a civil marriage certificate from a victim of domestic violence who reports violence by her partner,⁵⁴ which excludes in practice women and girls who are not married or who do not have a civil marriage certificate (for example *nikah siri*).⁵⁵



Girl domestic workers between the ages of 13 and 15 years old, Java. Child domestic workers often work in isolation and are vulnerable to physical, psychological and sexual violence. Domestic workers are legally protected under the Domestic Violence Law. © AI

For women and girls who become pregnant as a result of sexual violence, these obstacles also become barriers to ensuring that they can access the reproductive health care they need. For example, although rape victims are now legally entitled to abortion services, they can only legally access these services after reporting to the authorities and within the first six weeks of pregnancy (see Chapter 4, “Unsafe abortions and the threat of criminalization”, p33.

Violence against women in Indonesia remains prevalent. According to the 2010 report of the National Commission on the Elimination of Violence against Women (*Komnas Perempuan*), domestic violence in the home and in the context of personal relationships (*kekerasan dalam rumah tangga dan relasi personal*) constitutes the overwhelming majority of their reported cases, involving sexual violence in over 45 per cent of these cases, and violence by a husband towards his wife in over 95 per cent of the cases. Young women and girls aged between 13 and 18 years old are the age group with the highest recorded cases involving violence in the community (for example trafficking, violence in the workplace, etc).⁵⁶

2.4 CRIMINALIZATION OF PRIVATE BEHAVIOURS

“The idea is simple. Parents are obviously afraid of their daughters being deflowered before the time comes, so before they continue their studies, they can undergo the virginity test and automatically protect their dignity” Bambang Bayu Suseno, a Jambi legislative councillor, Central Sumatra, proposing a pre-school test for the virginity of women and girls, September 2010.⁵⁷

In recent years, particularly as a result of the process of decentralization, there has been an increase in the enactment of laws that restrict sexual and privacy rights, including laws that criminalize consensual sex between adults or punish unmarried adult men and women who are alone together, unless they are close relatives (for example *khalwat*). Women and girls are often disproportionately affected by these laws, due to gender stereotyped views on sexuality, and because they can become pregnant, pregnancy outside marriage can be interpreted as proof of a crime.

CONSENSUAL SEX AND THE THREAT OF CRIMINALIZATION

Consensual sexual relationships between men and women, if at least one of those involved is married, are criminalized in national law (adultery or extramarital relationships). The Criminal Code provides that any married or unmarried man or woman who has a consensual sexual relationship with someone who is already married shall be punished by a maximum imprisonment of nine months (Article 284).

Laws and regulations which criminalize consensual extramarital sexual relationships violate the right to privacy, equality before the law, and sexual and reproductive rights. As women and girls face social ostracism if they are known to have, or suspected of having, engaged in sexual contact, they are disproportionately affected in comparison with men.

THE CASE OF SARI

Police officials accused Sari, a 14 year old girl, of adultery when she went to report that she had been raped.

Sari went to a police station in Aceh to report that she had been raped by a 25 year old married man. However, police officials initially did not believe her. Instead they alleged that she had sex with a married man because they liked each other. Police officials accused her of breaching the legal provision on adultery.⁵⁸

CRIMINALIZATION IN THE CONTEXT OF THE DECENTRALIZATION PROCESS – THE CASE-STUDY OF ACEH

“[W]hen women don’t dress according to Shar[i’a] law, they’re asking to get raped”

Ramli Mansur, West Aceh District Head, commenting on the reasons why a bylaw on dress codes is being implemented in West Aceh District, August 2010.⁵⁹

As part of the decentralization process which started in 1999–2000, and special autonomy packages for certain provinces in Indonesia, there has been an increase in locally enacted bylaws and regulations on a number of issues, such as health, education, and family affairs.⁶⁰ Some of these laws and regulations do not conform to international law and standards, nor do they respect provisions in Indonesia’s Constitution and the Human Rights Act (No. 39/1999). A 2009 study published by the Indonesian Commission on the Elimination of Violence against Women recorded over 60 local regulations which are discriminatory towards women.⁶¹

In Aceh a bylaw on *khalwat*, which was passed in 2003 (No. 14/2003),⁶² prohibits unmarried adult men and unmarried adult women who are not close family members being together without the presence of other people, with caning as punishment.⁶³ The Indonesian Commission on the Elimination of Violence against Women has commented:

“In practice, the argument that khalwat could happen anywhere [at] anytime has often been used in the enforcement of the... legal regulation. This causes the criminali[z]ation of women in all kinds of

social relations with the opposite sex. With this *khalwat*, the accused, especially the women, are regarded as criminals who... conducted immorality and who are fit to be shamed. For example, a victim... said she was arrested while sitting with her boyfriend in a foodstall on a roadside... by the Wilayatul Hisbah [the Aceh Shari'a local Police]... Although they did not do anything wrong, the victim and her boyfriend were interrogated for hours.⁶⁴

Many people misunderstand *khalwat*, believing that it only criminalizes sexual relations outside marriage when in fact it criminalizes merely being alone with someone of the opposite sex who is not a relative.⁶⁵ According to the Commission, the application of the bylaw on *khalwat* has led to “mistaken” arrests and detentions. In some cases, these arrests and detentions have also led to women being forced to admit that they had sexual intercourse with someone who is not their husband. In one case, it led to the long-term exclusion of a woman from her village because she was stigmatized by the community at large as a result of the assumption that she had sex outside marriage.⁶⁶



Signpost warning the local community in Aceh that *khalwat* is prohibited. *Khalwat* is defined as two unmarried adults of the opposite sex who are not close relatives and who are together without the presence of other people. © AI

In September 2009, the Aceh local parliament passed the Aceh Criminal Code (*Qanun Hukum Jinayat*), which also contains a number of provisions violating international human rights law. It criminalized a number of acts, including unmarried adults who are alone in isolation (*khalwat*); consensual sexual relationships involving a married person (adultery, known as *zina*); intimate relationships between unmarried people such as kissing (known as *ikhtilath*), and homosexuality. The Aceh Criminal Code has not been implemented since it came into force, in part due to heavy criticism at the local, national and international level. It has now returned before the Aceh local parliament although the timeframe for review is unclear.⁶⁷ The bylaw provides for punishments including stoning to death for adultery and caning of up to 100 lashes for homosexuality.⁶⁸

3. BARRIERS TO REPRODUCTIVE HEALTH

“[H]igh risk pregnancy and abortion... require special attention. Critical measures to reduce maternal mortality are improving the contraceptive prevalence rate and reducing the unmet need through expanding access and improving quality of family planning and reproductive health services” 2010 MDG Report by the Indonesian government, September 2010.⁶⁹

The overall context of gender stereotyping with regard to sexuality, marriage, and childbearing is supported by discriminatory laws, policies and practices which constitute barriers to the reproductive health of women and girls in Indonesia. In particular, unmarried women and girls are at risk of unwanted pregnancies and inadequate access to reproductive health services during pregnancy. Married women and girls face curtailment of their sexual and reproductive rights, in particular in the area of family planning. This leaves many women and girls at risk of unwanted pregnancies, and other health-related risks (for example unsafe abortions and sexually transmitted diseases, including HIV which is on the rise in Indonesia).⁷⁰

3.1 DISCRIMINATION AGAINST UNMARRIED WOMEN AND GIRLS

In Indonesia the government has explicitly made a distinction in law and policy between married and unmarried women and girls in respect of access to sexual and reproductive health information and services.

A DISCRIMINATORY LEGAL FRAMEWORK

The Indonesian Constitution provides that *“[e]very person shall have the right to establish a family and to procreate based upon lawful marriage”* (Article 28B (1)). However, the Constitution does not contain specific provisions which guarantee the right for unmarried men and women to have children. This lack implies that the right to establish a family and procreate is only protected in the context of marriage.

Both the Population and Family Development Law (No. 52/2009)⁷¹ and the Health Law (No. 36/2009) provide that access to sexual and reproductive health services may only be given to legally married couples, thus excluding all unmarried people from these services.

Under Articles 72 and 78 of the Health Law, access to sexual and reproductive health services may only be provided to “legal partners” (*pasangan yang sah* and *pasangan usia subur*), which implies that in practice only married couples can access family planning services. According to the Law on Population

and Family Development, reproductive rights and family planning provisions are aimed at couples who are legally married (*perkawinan yang sah*).⁷² Article 21.1 provides that the policy of family planning is aimed at supporting husbands and wives (or future husbands and wives) in making the right decision about their reproductive rights (*hak reproduksi*). Articles 24.1 and 25.2 provide that contraceptive services are aimed at legally married couples (*pasangan suami isteri*).

These provisions violate Indonesia's Human Rights Act and international human rights treaties Indonesia has ratified, including the International Covenant on Civil and Political Rights (ICCPR) and CEDAW.⁷³ They are discriminatory, both on the grounds of gender and marital status. They place unmarried women at risk of unwanted pregnancy. As described above, unwanted pregnancy can lead to a range of serious risks for unmarried women who may be unable to access reproductive health care services and who can be socially stigmatized.

BOX 3: GAPS IN GOVERNMENT INFORMATION PROGRAMMES FOR UNMARRIED ADOLESCENTS

The government has in place various information programmes⁷⁴ on reproductive health for adolescents;⁷⁵ however there are substantial gaps in what is covered by these programmes. These gaps to some extent reflect cultural attitudes and legal restrictions on access to reproductive health services for unmarried people, and on providing information on sexuality and reproduction (see Chapter 3.4, "Other impediments to sexual and reproductive rights", p30. In particular, there appears to be great reluctance to include information on contraceptives, such as condoms, as part of reproductive health programmes targeting unmarried adolescents for fear of being seen as promoting "free sex".

Although some schools provide information on reproductive health to adolescents, the impact of these programmes remains limited. According to the Young Adult Reproductive Health Survey 2007, only 30 per cent of women and girls who had attended school were taught about family planning at different educational levels.⁷⁶

Local NGOs who provide information on sexual and reproductive health to unmarried adolescents expressed concerns that government reproductive health programmes are not tailored to the needs of adolescents. They do not provide adequate information about the particular age-related health risks they confront (for example early pregnancy). Such programmes explain the reproductive systems of men and women but fail to deal with adolescents' need for information about sexual relationships and prevention of unwanted pregnancy, including through the use of contraceptives.⁷⁷

BARRIERS TO ACCESS TO REPRODUCTIVE HEALTH SERVICES

"[It] is very taboo for an unmarried person to look for contraceptives... S/he will be seen as looking for free sex" A human rights activist, March 2010.⁷⁸

"It is not possible to access family planning services without a marriage certificate" Lila, a 23 year old domestic worker.⁷⁹

Government midwives and doctors interviewed by Amnesty International in March 2010 confirmed that they do not provide reproductive health services, including contraception and family planning, to unmarried women and girls.

Although health workers did not directly refer to the law, they explained that family planning provisions

are only intended for married couples. District health officers and other government officials interviewed in March 2010 confirmed that contraception and family planning services are intended solely for married people in accordance with laws and policies.⁸⁰

The Committee on Economic, Social and Cultural Rights (the ESCR Committee), which monitors state's implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), has stated that “[s]tates should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information”.⁸¹

By denying unmarried women and girls access to family planning methods such as contraceptives, the state is perpetuating discrimination on two grounds. First there is discrimination on the grounds of marital status. Second, the denial of contraceptive services to unmarried women and men has a disproportionate impact on women and girls because they can become pregnant, meaning that there is also discrimination – in practice – on the grounds of gender. As a state party to the ICESCR, the Indonesian government has a duty to ensure that health information and services, including on sexual and reproductive health, are provided free from discrimination and that the most vulnerable and marginalized groups be prioritized (see Box 4: The right to health).

Because unmarried women and girls face barriers in law, policy and practice to accessing contraceptive information and services, they are at risk of unwanted pregnancies, sexually transmitted diseases, and human rights abuses. For example, unmarried adolescents who become pregnant are often forced to stop schooling.⁸² Instead of risking rejection by the wider community, some women and girls may decide – or be forced – to marry when they become pregnant, or else to seek an unsafe abortion which puts them at risk of serious health problems and maternal mortality.

An activist working on sexual and reproductive rights in Aceh explains:

*“There are young people who come to us because they are pregnant outside marriage... they are a few months pregnant and they are trying to find a solution... some are ashamed to continue school... some ask for an abortion...”*⁸³

THE CASE OF AIDA

Aida became pregnant outside of marriage. She sought an abortion in unsafe conditions.

In [February 2010], a girl came to [the community health centre with her older sister]... she was not married and told us that her stomach ached... we found out that she was pregnant... we asked her if she had an induced abortion and she said yes. She went to a place where they gave her medicine and then she returned home and started bleeding. The girl was ashamed because she was not married and was still at school. She was four months pregnant... She lost the baby at our clinic. She has now made a full [medical] recovery”.⁸⁴

For unmarried women and girls who want to keep the baby, it remains unclear how they can access reproductive health services during pregnancy and at the time of the birth, without getting married first. Amnesty International's research suggests that the fear of stigmatization can discourage pregnant women and girls, especially if they are from poor and marginalized communities, from seeking antenatal and postnatal care when they are not married.⁸⁵

Health workers interviewed in Lombok and Aceh explained that unmarried adolescents sometimes come to them to receive reproductive health services, saying they have been raped.⁸⁶ However, the health workers believe many adolescents may have had sex with their boyfriends voluntarily, and because they actually liked each other (*suka sama suka*), and claim to have been raped in order to avoid the stigma attached to premarital sex and/or as a means to access reproductive health services. In such cases, they advised the girl to get married, rather than have the child outside of wedlock.

Although reproductive health support was given in some cases to unmarried women and girls by government health centres (for example post-abortion care, see the case of Aida above), there is no comprehensive system in place to ensure unmarried women and girls who become pregnant can access the reproductive health care they need from community health centres, regardless of their marital status.

A 2009 joint study by the Ministry of Health and local governments in Nusa Tenggara (Eastern Indonesia) concluded:

*"[P]regnant unmarried women attended no, or less, maternal health services including antenatal and [postnatal] care. It also showed unmarried women were more likely to deliver their babies at home and to be assisted by [traditional birth attendants]."*⁸⁷

3.2 UNMARRIED VICTIMS OF SEXUAL ABUSE

THE CASE OF ENNI

Enni is a 39 year old woman who is not yet married. She became pregnant last year after she was reportedly raped in Eastern Indonesia.

At the beginning of her pregnancy, Enni went to see a doctor; however she stopped when her pregnancy was beginning to be noticeable to others. She decided to stay home instead. At the time of Amnesty International's visit in March 2010, she was seven months pregnant and did not want to go to hospital because she was worried about what other people might say as she is not married. If she faced obstetric complications, she told local NGOs that she might be too ashamed to access services at the local state hospital. Local NGOs told Amnesty International that should she require an operation (such as a caesarean section), she would need to have the consent of her husband which is not possible in her situation as she is not married.⁸⁸

At the time of writing, Enni has given birth to a baby boy; however she has decided not to keep him, because she cannot afford to raise a child. She has given the baby up for adoption to a richer family who live in Western Indonesia.⁸⁹

Unmarried women and girls who are rape victims may not receive access to reproductive health services, either because they do not know they are entitled to these services or due to the fear of stigmatization (see the case of Enni above). Unmarried victims of sexual abuse who became pregnant can face serious challenges in accessing health care services and discriminatory attitudes can result in rape victims being encouraged by their family or the community at large to marry the perpetrator instead of having a child outside of wedlock.

Tanya, a 22 year old domestic worker, was forced by her employer in Jakarta to have sex with his younger brother between June and October 2004. When she became pregnant, the employer's family held a meeting, where they asked the brother to marry her. However, the brother refused, saying she was ugly. On 15 November 2004, the family expelled the domestic worker from the household. She was only paid

her outstanding wages and given 40,000 Rp (4.41 USD) to cover transportation costs.⁹⁰

When the state fails to ensure rape victims are guaranteed access to health care in practice, it violates women's sexual and reproductive rights; moreover the state is failing in its duty to provide the reparation to which victims are entitled under international human rights law and standards.



Non-governmental shelter for women and girl victims of abuse, Eastern Indonesia. © AI

3.3 RESTRICTIONS ON MARRIED WOMEN'S AND GIRLS' REPRODUCTIVE CHOICES

According to the 2007 Indonesian Demographic and Health Survey, levels of unmet need for family planning and contraception information and services among married women and girls remain high, especially among those living in poverty.⁹¹ However, Amnesty International's 2010 research found that there are significant restrictions on married women's and girls' access to family planning services and information. This was in part due to the requirement for the husband's consent and restrictions on childless married women and girls in exercising their rights to decide on whether or not to have children.

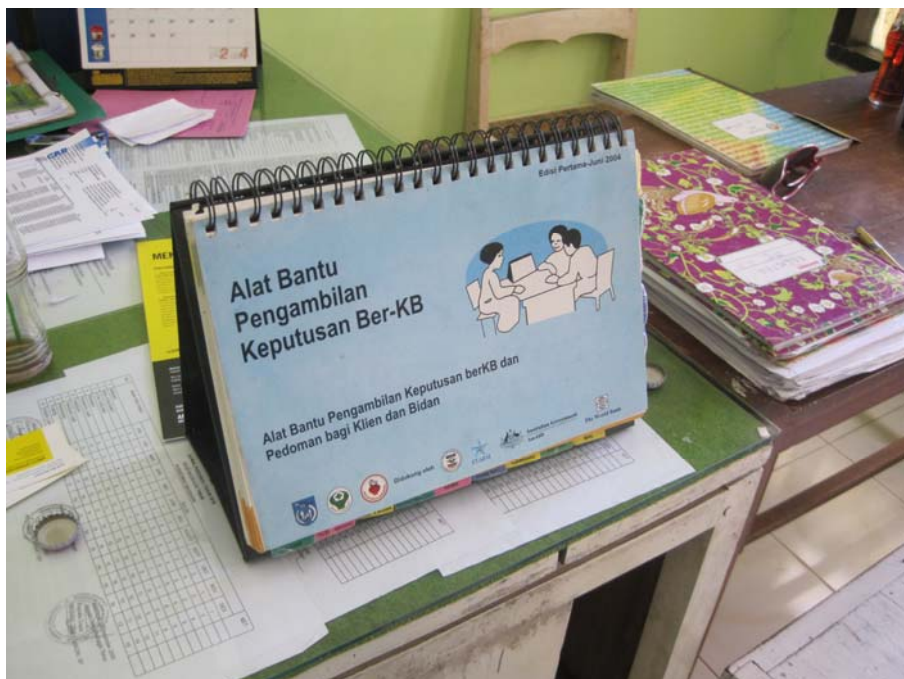
REQUIREMENT FOR HUSBAND'S CONSENT IN CONTRACEPTION PROVISION

“A [woman] has to get the permission of her husband [if she wants to purchase contraception devices]... because her husband may want more children” A male domestic worker recruitment agent in Jakarta, 2010.⁹²

Married women and girls face restrictions – based on law and practice – that undermine their ability to make decisions freely about when and whether to become pregnant. Although women and girls may be able to obtain certain types of contraceptives, such as the pill (which they may be able to obtain in local shops without their husband's consent), they are still restricted in their ability to freely access information and services on all types of contraception from health workers. Both law and practice require that they seek their husband's permission in order to obtain certain types of contraceptive services from government-run health facilities.

Indonesia's Population and Family Development Law states that decisions about family planning should be taken jointly between married couples.⁹³ In the Population and Family Development Law, the choice over contraception is not up to the individual alone. Article 24.1 states that contraceptive services are the

responsibility of the married couple (*pasangan suami isteri*) in accordance with their choice and health consideration. Furthermore, Article 26.1 provides that in the event that contraceptive use carries a health risk, there needs to be a formal agreement between the husband and wife (*persetujuan suami dan istri*).



Education tool used by a midwife in Indonesia to discuss choice of contraception for married couples. © AI

A midwife working at a community health centre in Aceh told Amnesty International in March 2010:

*"[If they want] the pill... they must have the consent of their husband... because family planning involves two people... the same with injections... they must have the consent of their husband."*⁹⁴

A West Java-based midwife confirms:

*"Patients who want to get contraception need to have the consent of their husband... [We can] only give access to contraception if there is the informed consent of their husband.... If the husband does not agree, it's not allowed... For patients who use injections, an oral consent is enough, but for those who want to have an IUD [Intrauterine Device] implant, or a medical intervention [Medis Operasi Wanita, MOW], they need a written consent... We do this so that we do not do the wrong thing with the husband who may not agree that his wife is purchasing contraception... sometimes the husband comes... sometimes [the wife] tells us that her husband does not allow it."*⁹⁵

THE CASE OF MARTA

Marta, a 30 year old domestic worker from Jakarta, went to the community health centre prior to becoming pregnant; however the midwife refused to provide her with contraceptives.

“After I had just married I went to the community health centre, but they said ‘if you don’t have children, don’t use contraception, have children first... otherwise it will be difficult for you to have children... you may become barren...’ Then I didn’t use contraception... I didn’t have much experience and soon I became pregnant... After I had my first child, then they told me about contraception... Now I use contraception.”⁹⁶

Beyond the interpretation of the Population and Family Development Law which requires the husband’s consent, Amnesty International’s research also found that access to contraceptives was often restricted for married women and girls if they had not yet had children.

A West Java-based midwife told Amnesty International:

“If they have just married... they do not really need family planning... to use [modern] contraception methods... I tell them about [traditional methods] such as interrupting sexual intercourse [withdrawal] or the calendar method... for those who do not have children we recommend that they use these methods first... for those who have already children we tell them about injections and the pill.”⁹⁷

Amnesty International’s interviews with health workers suggest that they fear that they would be held responsible if a woman does not have children after having been given a contraceptive method. A midwife interviewed in Aceh explained that although she did not think contraception devices could cause infertility, she preferred not to provide childless women access to modern contraception methods. She explained that she did not want to challenge the communities’ cultural beliefs and be held accountable for this.⁹⁸

Health workers’ fear of being held responsible by members of the community can be explained in part by the high value placed on childbearing in Indonesian society. A midwife who works very closely with local people at the community level may not want to be blamed if a couple cannot have children. Beyond the fact that the law does not allow them to provide contraception procedures or treatment which contain a health risk without the husband’s permission (Article 26.1 of the Population and Family Development Law), these cultural attitudes explain why midwives also request written permission from a husband to provide certain types of contraceptives or access certain procedures (for example sterilization).⁹⁹

The Indonesian Policy on Reproductive Health (2005) clarifies that family planning services should be provided to women and girls who are the most vulnerable to maternal mortality and maternal morbidity: that is, the youngest; those who have a large number of children; those who have children close in age to each other; and those who are older.¹⁰⁰ However, the refusal by health workers to provide contraceptives to childless women and girls means that many young women, especially if they have no other means to obtain information and services, are likely to have misconceptions and a poor understanding of contraception and family planning.¹⁰¹ They may become pregnant even where they are trying to avoid it.

CEDAW guarantees the right of women, on the basis of equality with men, to decide freely and responsibly

on the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right.¹⁰²

3.4 OTHER IMPEDIMENTS TO SEXUAL AND REPRODUCTIVE RIGHTS

Indonesia's laws, including the Criminal Code, contain a number of provisions which restrict access to sexual and reproductive rights, or have a chilling effect on the provision of sexual and reproductive health information and services.

RESTRICTIONS ON PROVIDING INFORMATION ON SEXUALITY AND REPRODUCTION

Indonesia's Criminal Code contains legal provisions which criminalize supplying information to people relating to the prevention and interruption of pregnancy (see Articles 534, 535 and also 283).¹⁰³ Punishments range from between two and nine months' imprisonment.

These provisions compromise the ability of state officials in the health and education systems, sexual and reproductive service providers and activists to disseminate age-appropriate information on sexuality and reproduction. Furthermore, they run contrary to the state's duty to ensure everyone has access to age-appropriate information on sexual and reproductive health in accordance with international human rights law and standards, and in particular provisions contained in the Convention on the Rights of the Child (CRC).¹⁰⁴

These provisions mean that a person giving written or other visual materials for the purpose of sex education or information about sexuality and reproduction, including contraceptives, can be found in breach of the law and subject to criminal proceedings. Although Amnesty International is not aware of individuals being sentenced to terms of imprisonment for having violated these legal provisions, the fact that they remain part of Indonesian law has a chilling effect on information providers. This is particularly acute when the information is aimed at a group which is already subject to other legal restrictions of their sexual and reproductive rights (for example unmarried men and women).

Some of the sexual and reproductive rights activists interviewed in March 2010 told Amnesty International that they felt at particular risk of being arrested for providing information on modern contraceptives such as condoms.¹⁰⁵ They also expressed concerns about the new Pornography Law (No. 44/2008) which has recently been passed and which they said could prevent them from disseminating information on sex education free from the threat of criminalization.

The Pornography Law defines pornography broadly. It encompasses material that "*contravenes norms of community morality*", and provides for punishment of between four and 15 years of imprisonment for those who produce, disseminate, fund or use such material.¹⁰⁶ This new law and its broad provisions add to the chilling effect of other legal restrictions on provision or dissemination of information or education on sexual and reproductive rights issues.

A Yogyakarta-based human rights defender explains:

"So far the [Pornography] [L]aw has not been used but it's possible in the future. The problem is that it is up to society to decide if [an action] violates societal norms... As long as information on sexual and reproductive rights violates social norms, I and my fellow friends can be arrested and charged..."

*if people feel uncomfortable and think I am promoting sex, this can be a problem... it always depends on community leaders... if they are very fundamentalist then there is a high chance [we will be arrested]."*¹⁰⁷

RESTRICTIONS IN ACCESS TO EMERGENCY CONTRACEPTION

Article 299 of the Criminal Code provides for up to four years' imprisonment for any person who gives treatment to a woman which contributes to the termination of her pregnancy or which makes her believe that it is intended to induce termination of pregnancy. If the person who gives this treatment is a health professional such as a doctor, midwife or pharmacist, and is found guilty of violating this legal provision, he or she will be barred from practicing.

There appears to be a contradiction between Criminal Code provisions criminalizing emergency contraception, and the fact that the government has taken some tentative steps in formulating guidelines on such treatment.¹⁰⁸ Although one type of morning after pill (Postinor) has been commercially available since 2004,¹⁰⁹ government guidelines describing the conditions under which it can be made available to women and girls do not appear to have been implemented in community health centres across Indonesia.¹¹⁰ Not only does this situation leave health professionals facing uncertainties about their rights and duties in relation to providing information and services on emergency contraception, but it leaves many victims of sexual violence – as well as women who have experienced contraceptive failure – at risk of unwanted pregnancies.

A local government health official who works in Jakarta told Amnesty International:

*"Obviously there are no [morning after pills] at the Puskesmas [community health centres] and it has not become a programme. The morning after pills can only be provided in certain cases, if there has been a medical examination and perhaps it is then given by the hospitals."*¹¹¹

A doctor who works at a community health centre in Lombok told Amnesty International that they do not provide emergency contraception to women and girls as they fear it could be used for the "wrong reasons". According to her, many patients come to them to terminate the pregnancy alleging they were raped but in fact they were not. The doctor believed that they had sex prior to marriage and they were ashamed. She emphasized that emergency contraception was not suitable for a place like Lombok as it is a Muslim area.¹¹²

The 2009 joint study by the Ministry of Health and local governments in Nusa Tenggara notes:

*"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 [information, education and communication] on emergency contraception is not yet part of [the Department of Population and Family Planning] policy."*¹¹³

BOX 4: THE RIGHT TO HEALTH

Indonesia has ratified many of the human rights treaties that guarantee the right to the highest attainable standard of health, including the ICESCR and CEDAW. The right to health includes the right to maternal, child and reproductive health.

The Government of Indonesia has an obligation to realize the right to health, including the right to sexual and reproductive health. The government is also under a duty to prioritize the most vulnerable and marginalized groups when allocating resources, and to address discrimination in health services and information. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.

Health care facilities, goods and services have to be available, accessible, acceptable and of good quality. In practice, these four interrelated and essential elements of the right to health mean:

1. Availability – the Indonesian government is obligated to ensure that functioning public health and health care facilities, goods and services, as well as programmes, are available. This includes the underlying determinants of health such as access to safe water, adequate sanitation, nutrition and also hospitals, clinics and other facilities; trained medical and professional personnel receiving domestically competitive salaries; and essential drugs.
2. Accessibility – health facilities, goods and services have to be accessible to everyone without discrimination.
3. Acceptability – all health facilities, goods and services have to be respectful of medical ethics and culturally appropriate.
4. Quality – health facilities, goods and services have to be scientifically and medically appropriate and of good quality. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs, and hospital equipment.

4. UNSAFE ABORTIONS AND THE THREAT OF CRIMINALIZATION

“Usually the [illegal] abortion is done because they are ashamed... because they are pregnant but not married... they go to a dark place with their boyfriend and have sex... they are scared of their parents... the men do not want to be responsible”

Focus group discussion with domestic workers, 15 March 2010

Abortion is criminalized in most cases in Indonesia. A woman or girl seeking an abortion (the legal age for criminal responsibility in Indonesia is eight),¹¹⁴ or a health worker providing one, may be sentenced to up to four and 10 years' imprisonment respectively. This has meant that abortions in Indonesia are often performed clandestinely in unsafe conditions. According to the 2007 MDG Report by the Indonesian government, unsafe abortions account for an estimated 11 per cent of maternal mortality in Indonesia.¹¹⁵ However, in its 2010 MDG Roadmap Report, the government indicated that unsafe abortions account for only five per cent of maternal deaths in Indonesia.¹¹⁶

4.1 UNKNOWN LEGAL EXCEPTIONS

There are only two exceptions under Indonesian Law in which a woman may legally seek and health workers perform an abortion.

Article 75.2(1) of the Health Law provides that abortion is not a crime: (1) when there are “*[i]ndications of medical emergencies detected from the early age of pregnancy, both threatening the life of the mother and/or infant, suffering from severe genetic diseases and/or congenital defects, or which can not be repaired so as to make it difficult for the infant to live outside the womb*”, and (2) in the case of pregnancy resulting from rape.

Amnesty International has welcomed these exceptions, although some aspects of the law pertaining to safe abortion services continue to violate women's human rights.

Currently, a woman who is pregnant as a result of rape, or a woman experiencing life-threatening complications as a result of pregnancy, has to pass five selection criteria out of six,¹¹⁷ to access abortion services under the Health Law (see Articles 75 and 76).

Articles 75 and 76 provide that abortions can only be performed legally in these two cases in the following circumstances:

- Following the intervention of a health adviser (*konseling dan/atau penasehatan*) before and after the medical intervention, who is competent and has the authority to do so;
- Before the end of the six week period from the date of the first day of the woman's period, except in cases of medical emergencies;
- By a health worker who has the skills and a certificate delivered by the Minister of Health which acknowledges his/her authority;
- With the woman's consent;
- With the permission of the husband, except for victims of rape; and
- Provided the services meet the requirements set out by the Minister of Health.

Some of these criteria can be very difficult to meet in practice, especially for women and girls who live in remote areas or who have limited access to health care services generally due to distance and/or other socio-economic and cultural factors. Amnesty International's March 2010 research suggests that women and girls may not be able to access the safe, legal abortion services they are entitled to for a range of reasons, including socio-cultural, financial, and administrative barriers.

HUSBAND'S CONSENT IN LIFE-THREATENING CASES

To access legal abortion services in the event of pregnancies that are life-threatening for the mother or the foetus, the Health Law requires the consent of the husband (Article 76(d)). In other words, a woman is not allowed under law to access legal abortion services in Indonesia unless she has a husband, and her husband consents. The only exception to this criterion is for a rape victim, who can seek an abortion regardless of marital status.

Provisions pertaining to husbands' consent discriminate on the grounds of marriage and sex as they legally exclude unmarried women and girls from safe legal abortion services. Furthermore, requirements pertaining to a husband's consent in cases that are life-threatening to a woman may put her life at risk.

The CEDAW Committee has expressed its concerns over these requirements in Indonesia. In its concluding observations, it stated that:

"The Committee is further concerned about the requirement that a woman obtain her husband's consent regarding sterilization and abortion, even when her life is in danger".¹¹⁸

RAPE VICTIMS AND THE SIX WEEK DEADLINE

Legal abortion provisions for rape victims are only permitted within the first six weeks of pregnancy. The limited timeframe means that most rape victims may not be able to access safe abortion provisions within the required timeframe as they may not even know they are pregnant by then. Rape victims may take more time to acknowledge and report to the authorities they have been raped, especially in a context where premarital and extramarital sex is stigmatized, and in some cases criminalized.

A recent study by the Asian-Pacific Resource and Research Centre for Women (ARROW) concluded that

rape victims face various barriers to obtain information and services related to safe abortions, including the need to press charges against the aggressor, obtain police reports and court authorization, or complete other medical test to qualify.¹¹⁹ Some of these barriers relate to shortcomings in law and practice, which fail to fully protect victims of sexual abuse. For example, it remains unclear how married women and girls who are a victim of rape in the context of marriage can access legal abortion services entitled to rape victims (*kehamilan akibat perkosaan*) as marital rape has yet to be fully incorporated within criminal law (see Chapter 2, “Gender stereotyping and its consequences”, p15).

The Human Rights Committee which monitors state compliance to the ICCPR, has stated that to compel a victim of rape to carry a pregnancy to full term or seek an unsafe abortion constitutes a violation of the prohibition of torture in Article 7 of the Covenant (see Chapter 7, “Indonesia’s human rights obligations”, p48.¹²⁰

LAWFUL EXCEPTIONS UNKNOWN

“This is the first time I hear about it [the legal provision for rape victims in the 2009 Health Law]” a Jakarta-based doctor who works at a local community health centre, March 2010.¹²¹



The new Indonesian Health Law passed in 2009 which now allows access to abortions in the case of pregnancy resulting from rape. ©AI

Health workers interviewed by Amnesty International in March 2010 were only aware of one abortion exception, that is, legal abortion services could be made available to women and girls if there were complications related to the woman’s or the foetus’ health. They were generally not aware of the exception with respect to legal abortion services for victims of rape. Most local government officials interviewed by Amnesty International were also unaware of this new provision, which was introduced in 2009.¹²²

This lack of understanding seems to suggest that health workers and government officials continue to rely on their knowledge of legal abortion provisions based on the former Health Law (No. 23/1992), which provided that certain medical procedures (*tindakan medis tertentu*) were permitted in case of life-threatening complications for the mother or foetus (Article 15). The 1992 Health Law was replaced in September 2009 by a new Health Law which extends lawful exceptions to rape victims.

The vast majority of women and girls from poor and marginalized communities interviewed by Amnesty International in March 2010 did not distinguish between legal and illegal abortion services. They believed abortion was illegal in all cases and contradicted moral and religious precepts.

The lack of awareness among women and girls from poor and marginalized communities of the new provisions pertaining to rape in the 2009 Health Law, and of legal exceptions generally, is worrying. It means women and girls may seek clandestine unsafe abortions, or else terminate the pregnancy on their own through unsafe means, even though they may be legally entitled to an abortion.

ATTITUDES OF HEALTH WORKERS

There appears to be reluctance amongst some health workers to provide women and girls with access to safe abortion services, due to their own moral or religious convictions. Local NGOs in Surabaya explained that many doctors and midwives refuse to perform abortions, even when it is legal, for moral and religious reasons. They reported that doctors tend to recommend that the women and girls continue with the pregnancy, telling them it is a “sin” to abort. According to NGOs, this can lead many women and girls to seek unsafe abortions.¹²³

When health providers do not provide information on legal safe abortion services to women and girls who may be entitled to these services, they are undermining their sexual and reproductive rights. The state has the duty to ensure that health care providers offer information on all available options related to a woman’s reproductive health so that women and girls can make informed choices about their sexual and reproductive rights.

4.2 THE CRIMINALIZATION OF ABORTION AND ITS CONSEQUENCES

Both the Criminal Code and the Health Law provide for heavy terms of imprisonment for women, and individuals, including health workers, who seek and/or perform an illegal abortion. Furthermore, the Population and Family Development Law states that abortion as a method to regulate pregnancies is forbidden (Article 21.3).

Under the Criminal Code, a woman who seeks to terminate her pregnancy in circumstances where it is not legal may face up to four years’ imprisonment (Article 346)¹²⁴ and individuals, including health workers, who perform or facilitate an illegal abortion may be jailed for up to 10 years (Article 349).¹²⁵ Furthermore, the Health Law provides that any person who performs an abortion may be sentenced to 10 years’ imprisonment or a fine of up to one billion Rp (110,411.83 USD, Article 194).

Over the course of Amnesty International interviews in March 2010, a health worker expressed concern about the six week timeframe for rape victims, explaining that for her and her colleagues the implications of the timeframe is unclear. There is uncertainty amongst health workers as to what happens if a medical practitioner performs the abortion procedure after the six week deadline.¹²⁶

An expert on reproductive health told Amnesty International that the Health Law has had a chilling effect on some health workers in Indonesia who are now more frightened to perform abortions.¹²⁷ A doctor who performs abortions in Eastern Indonesia confirmed that her colleagues are reluctant to practice abortions, in part because they fear the risk of criminalization.¹²⁸

Amnesty International's interviews with health workers, traditional birth attendants and NGOs suggest that the threat of criminalization is having a strong deterrent effect on the health profession. To Amnesty International's knowledge, prosecutions of people performing abortions are rare.¹²⁹ However, there have been some arrests on abortion charges in recent months. For example, a 48 year old midwife from East Java was recently arrested on abortion related charges. According to the news article, many of her patients were students.¹³⁰

UNSAFE ILLEGAL ABORTIONS WIDESPREAD

“There are often women who ask my help so that the baby can be aborted but I never help them because I am scared of committing a sin. Usually they tell me that they want to have an [illegal] abortion because their husband does not want to be in charge and their child is still small” Interview with a traditional birth attendant, West Java, March 2010.¹³¹

It is difficult to assess the number of unsafe, illegal abortions, as there is a lack of comprehensive and recent data on the issue in Indonesia. A 2001 study conducted by the University of Indonesia estimated that there may be up to two million induced abortion cases per year in Indonesia – 30 per cent of them among unmarried women.¹³² Many of these abortions are conducted in unsafe conditions. According to official government statistics, unsafe abortions account for between five and 11 per cent of maternal deaths.¹³³ Unsafe abortions also result in health associated risks including recurrent thrush; vaginal bleeding; the high possibility of a reproductive tract infection or of contracting sexually transmitted diseases; and compromised fertility.¹³⁴

Domestic workers, health workers and NGO activists told Amnesty International of many cases of women and girls who sought to have an abortion clandestinely, through the help of a traditional birth attendant. Many of these clandestine abortions occurred in unsafe conditions.

Detty, an 18 year old domestic worker recalls:

“I had a friend who was pregnant when she was in “kelas 2” [grade of Senior High School]... she tried to have an abortion with out of date medication when she was 40 days pregnant but it didn't work... in the end the baby was born with complications... Now her child is not normal... [s/he] cannot walk properly and [s/he] cannot speak normally.”¹³⁵

DECRIMINALIZING ABORTION

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has clarified that “[p]unitive provisions against women who undergo abortions must be removed.”¹³⁶

Decriminalizing abortion in Indonesia would ensure that neither women nor health workers would face

criminal prosecutions simply for seeking an abortion or providing appropriate medical assistance. When women and doctors no longer face the threat of criminalization, safe abortion services are more likely to be accessible to a larger number of women – thus limiting the number of unsafe abortions which pose a risk to women’s health, and in some cases lead to death or injury. Doctors in Indonesia may be more likely to provide abortion services in the circumstances in which they are meant to provide them, but do not due to the threat of criminalization. The decriminalization of abortion does not mean that Indonesian authorities would provide abortion services in all circumstances – it simply means that abortion would not be treated as a crime in law.

The criminalization of abortion itself is a barrier to accessing legal abortion services, even in the two instances under Indonesian law where a woman is entitled to an abortion. This is because criminalization can lead to the misunderstanding that all abortions are illegal. Rather than women being given information and access where they are entitled, they end up in a situation where they need to seek information and prove their entitlement against an assumption of abortion being a criminal act. Furthermore, by criminalizing abortion, the state puts many women and girls in a situation where they may seek an unsafe illegal abortion, even though it puts their life at risk. Global studies have found that a woman who wants to seek an abortion will do it regardless of whether it is legal or illegal.¹³⁷ The state should take comprehensive measures to prevent the risk of a woman dying as a result of unsafe abortions. Among these measures should be the decriminalization of abortion.

5. THE CASE-STUDY OF DOMESTIC WORKERS AS A VULNERABLE GROUP

“Women can also face health risks from their work, often due to their perceived inferior status and limited access to education”

Speech delivered on behalf of Dr Endang Rahayu Sedyaningsih, Indonesia's Minister of Health, May 2010.¹³⁸

THE CASE OF LATIFAH

Latifah is an 18 year old unmarried baby-sitter from West Java. Her former male employer sexually harassed her, and did not allow her to communicate with the outside world freely. Latifah dropped out of school when she was 12 years old.

Latifah started working when she was 14 years old. She told Amnesty International about the sexual harassment she and another domestic worker suffered while working with her last employer:

“He asked us to massage his feet in the bedroom when his wife was not in the house... He said he could give us money... 20,000 Rp (2.20 USD) but I didn't want to... One day, he walked out of the bedroom wearing only a towel, and showed us his sexual organs. As his wife was coming home at the same time, he quickly entered the bathroom... One night he came to our bedroom (the room was not locked as the key was broken) while we were sleeping. His wife was sleeping with their child. He said he was looking for something. I woke up and felt afraid... I didn't tell his wife about the situation as I was afraid she would not believe me... that they would argue and get divorced... I only told the neighbours about the situation. They said it happens often with domestic workers in this house... We didn't have a mobile phone... I took the phone from one of the family's older children and called the recruitment agency. I asked them to take us back... I didn't want to work for this employer any longer.”¹³⁹

The previous chapters described barriers to access reproductive health information and services (for example family planning services) that are specifically related to laws, policies and practices which violate women's human rights, and in particular sexual and reproductive rights. However, sexual and reproductive rights are also affected by failures to protect human rights more broadly. One example is the treatment of domestic workers.

Women and girl domestic workers in Indonesia typically leave school early and so have limited access to information on sexuality and reproduction. Amnesty International met many adolescent domestic workers in March 2010 who stopped schooling when they were under 15. Access to government programmes on sex education is made more difficult for adolescents who have left the education system, although there are also limits to the information provided to adolescents within the education system (see Box 3: Gaps in government information programmes for unmarried adolescents). In the case of adolescent domestic workers, their access to public sources of information on sexual and reproductive issues may also be

restricted because they live at their employers' houses, and are often not married. They may not be able to move freely outside the house, or be able to freely access sources of public information within the house (for example television and radio).

In 2007 Amnesty International highlighted the extent to which domestic workers in Indonesia – the vast majority of whom are women and girls – are vulnerable to gender-based violence and violations of their rights, in part because they are not fully legally recognized as workers and their work generally takes place out of the public eye. The lack of adequate protection¹⁴⁰ impacts domestic workers' enjoyment of their sexual and reproductive rights. For example, they risk losing their job as a result of their pregnancy, without any form of compensation. They may also be forced to work in situations that are dangerous to themselves and their unborn children.

5.1 IMPACT OF THE FAILURE TO PROTECT WORKERS' SEXUAL AND REPRODUCTIVE RIGHTS

The latest census conducted by the Indonesian National Institute of Statistics (*Badan Pusat Statistik*, BPS) in 2001 places the number of domestic workers in Indonesia at 570,000. But a 2002 International Labour Organization (ILO) study concluded that there are about 2.6 million domestic workers in Indonesia, the majority of whom are women and girls.¹⁴¹ Approximately one third of domestic workers are girls (under 18).¹⁴² The vast majority of domestic workers in Indonesia come from Indonesia itself.¹⁴³

Aside from these – quite different – figures, there is very little information on domestic workers and their situation in Indonesia. The Indonesia Population and Housing nationwide census conducted in 2010 did not include any specific questions attempting to obtain data on domestic workers within each household.¹⁴⁴

BOX 5: WHAT IS A DOMESTIC WORKER?

Although there is no standard definition of a domestic worker, definitions in legislation throughout the world seem to agree that domestic service requires the following components: the workplace is a private home; the work performed has to do with servicing the household; the work is carried out on behalf of the direct employer, the householder; the domestic worker is directly under his/her authority; the work performed must be done on a regular basis and in a continuous manner; and the employer shall not derive any pecuniary gain from the activity done by the domestic worker.¹⁴⁵

A DISCRIMINATORY LEGAL FRAMEWORK

Domestic workers are at risk of a range of human rights abuses, including long hours of work without breaks, and in some cases without any pay, in part because domestic workers are not afforded the same level of protection as other workers under the Manpower Act (No. 13/2003).¹⁴⁶ The case of Lenny, a 14 year old girl, who was forced to work 19 hours a day for several months without any pay, illustrates the vulnerability of domestic workers to exploitation and abuse at work, amounting potentially to trafficking and forced labour.

THE CASE OF LENNY

In February 2010, Lenny, a 14 year old domestic worker, was abducted and then abused by her employer for three months.

Lenny, a 14 year old girl from Java agreed to become a domestic worker for a salary of 300,000 Rp (33.12 USD), per month in

part to support her mother who was ill. However, Lenny was reportedly deceived by her recruitment agent who instead of employing her as a domestic worker as he had implied, brought her to his home and “sold” her to her new employers for 100,000 Rp (11.04 USD). According to local NGOs, Lenny was drugged during her travel to Aceh, the place where her new employers were from, hundreds of kilometres away from her sick mother.

Lenny spent three months working from 4am until 11pm for her new employers. Although they told Lenny that her salary was of 200,000 Rp (22.08 USD) per month, she was never paid.

Lenny suffered multiple forms of physical and psychological abuse at the hands of her employers. For example, they often told her that she was “stupid” or that “girls from the mountains do not know anything”. Lenny told local NGOs that her new employers often beat her using a large spoon, an iron bar, or scissors. They also hit Lenny’s head against the wall. In February 2010, Lenny managed to escape from her employers.¹⁴⁷

The national Manpower Act protects fundamental workers' rights, including regulation of hours of work per week, defined rest periods, holiday and leave arrangements, and payment of the minimum wage. The Manpower Act outlines the responsibilities which “entrepreneurs” have for the health and safety of their employees. These include ensuring that employees are provided with adequate rest time (Article 79), and a healthy and safe working environment (Articles 86 and 87). The Manpower Act states that employees should be paid in cases of illness, festive occasions and death in the family (Article 93).

Specific provisions in the Manpower Act provide protection for women workers during their menstrual period,¹⁴⁸ at times of pregnancy and during night work. The Manpower Act provides that an entrepreneur is prohibited from employing or requiring a pregnant worker (*mempekerjakan pekerja/buruh perempuan*) to work at night if, according to a doctor’s certificate, the worker is at risk of damaging their health or safety and the safety of their unborn child/children (Article 76.2). An entrepreneur is also prohibited from terminating the employment of a female worker if she is absent from work because she is pregnant, giving birth, having a miscarriage, or breast-feeding her baby (Article 153.1(e)). The law also states that every worker shall receive protection as regards to occupational safety and health by preventing occupational accidents and diseases, controlling hazards in the workplace, promoting health, medical care and rehabilitation (See Article 86 and its explanatory comment).

Under the Manpower Act, female workers are also entitled to rest, starting one and a half months prior to delivery and lasting one and half months after the birth, which is a total of 12 weeks maternity leave (Article 82.1). Furthermore, a female worker who has a miscarriage is entitled to a period of rest of one and a half months or a period of rest as stated in the medical statement issued by the obstetrician or midwife (Article 82.2). A female worker who is entitled to leave under Article 82 shall receive her wage in full (Article 84).

However, these protections are only extended to the employees of “entrepreneurs” in “business” or “social or other undertakings with officials in charge” – definitions which private households and domestic workers do not meet. Only one sub-provision of one article mentions any protections applicable to other workers – obliging the employer of those workers to provide protection of their welfare and health (Article 35.3).

This sub-provision states that in employing people, employers are “*under an obligation to provide protection which shall include protection for their welfare, safety and health, both mental and physical*”. Violation of this provision does carry a specified penalty of “*a criminal sanction in jail for a minimum of one month and a maximum of four years and/or a fine of a minimum of 10 million Rp (1,104.11 USD)*”

and a maximum of 400 million Rp (44,164.73 USD)".¹⁴⁹ However, this sub-provision does not specify benchmarks by which to measure the provision of this protection. The article thus has had little impact on the daily reality of domestic workers, and certainly does not provide them with a legal means by which to claim reasonable limitation on working hours or the minimum wage, for example.¹⁵⁰

This lack of legal protection for domestic workers is in violation of international human rights law and standards pertaining to workers' rights. In particular, by excluding women and girl domestic workers from legal protection in relation to their gender-specific needs, the state is in violation of its obligations as a state party to CEDAW,¹⁵¹ CRC,¹⁵² and the ICESCR.¹⁵³



Women domestic workers demonstrating for their rights, including protection under the law, February 2010. © Rumpun Tjoek Nyak Dien

PREGNANT DOMESTIC WORKERS NOT PROTECTED IN THE WORKPLACE

“No employer wants the domestic worker to become pregnant... if she is pregnant it means that she will stop working” Ita, a 30 year old unmarried domestic worker, March 2010.¹⁵⁴

Not all domestic workers interviewed by Amnesty International in March 2010 were domestic workers when they became pregnant. Of those who became pregnant when they were working, Amnesty International found that their treatment during pregnancy and at the time of the birth depended solely on their employers' goodwill, as they had no adequate legal protection under the Manpower Act.

Domestic workers who are pregnant may be forced to work long hours without adequate time to rest, if they want to keep their job.¹⁵⁵ Some of the domestic workers interviewed by Amnesty International were forced to work even if they did not feel well or they felt the work they were doing was too heavy for their condition and put their health and pregnancy at risk.

These findings are in line with those of Amnesty International's 2007 report which found that while some domestic workers were provided adequate time to rest when they were ill, others had to continue working when they were feeling unwell.¹⁵⁶ Overall Amnesty International found that women domestic workers usually left their job early during pregnancy rather than work, sometimes in harsh conditions.

According to the ICESCR and other standards,¹⁵⁷ mothers should be given special protection before and after childbirth. During this time, they should be given paid leave or leave with adequate social security benefit (Article 10). Further, Article 12 of CEDAW requires states parties to ensure that women receive *“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.”*

Many domestic workers told Amnesty International that a domestic worker who becomes pregnant would either lose her job or no longer be paid if she decided to take maternity leave. For example, Rini, a 45 year old domestic worker from West Java, told Amnesty International that she worked until she was eight months pregnant. However, when she stopped working, her employer stopped paying her salary (see her case below).

THE CASE OF RINI

Rini is a 45 year old domestic worker from West Java. Her third child died in 2008 when he was two weeks old.¹⁵⁸

During her last pregnancy, Rini was 43 year old. She worked until she was eight months pregnant. When she stopped working, her employer stopped paying her salary. She told Amnesty International:

“When I was pregnant [in 2008]... I continued my work as usual... I [did] the laundry [manually] from 6am until 11am... I went [several times] to the health post (Posyandu)... [where] they gave me [medicine] but I don't know what it was... I gave birth at home... there was my sister... and my husband... no [there was no midwife]... Pak M [the traditional birth attendant] came to wash the baby... he was paid 50,000 Rp (5.52 USD)... no there was no [medical] examination after the birth... no midwife... my baby boy died two weeks later.”

5.2 THE DOMESTIC WORKERS' BILL

“[Employers should] treat us as human beings, not like animals” a 14 year old domestic worker, March 2010.¹⁵⁹

In a positive development, draft legislation pertaining to the protection of domestic workers was being discussed this year in the Parliamentary Committee on Health, Manpower and Population Affairs (Committee IX) at the House of People's Representatives. The draft legislation contains provisions prohibiting the employment of child domestic workers below 15 years old (Article 7), and provides for adequate pay (Articles 9 and 32); rest periods – one days' rest per week and 12 days' annual leave (Article 34); the right to form a union (Article 10); and the conditions for work termination (Article 36). Violations of certain provisions in the draft law may be subject to administrative and criminal sanctions (Articles 43–51).¹⁶⁰

Although Amnesty International welcomes discussions on the draft legislation in the House of People's Representatives, it is concerned that the draft as it stands does not meet international human rights law and standards, in particular with regard to the protection of female workers prior to and after pregnancy. The draft does not contain any provisions concerning the specific needs of women, although the overwhelming majority of domestic workers in Indonesia are women and girls.

6. EFFORTS TO MEET MDG TARGETS AND CONSISTENCY WITH HUMAN RIGHTS

“If we succeed in reaching the MDG goals by 2015, which is entirely possible, it will be the single-most important achievement of our generation. And it will be an achievement that will benefit not only your neighbour, your community, your country, but our humanity”

President Susilo

Bambang Yudhoyono.¹⁶¹

Indonesia has consistently expressed its strong commitment to achieving the Millennium Development Goals (MDGs).¹⁶² It has also set up ambitious national goals for poverty eradication as stipulated in the Medium-term Development Plan.

Gender equality and women’s empowerment are widely recognized as essential for tackling poverty and achieving the MDGs. However, women and girls continue to suffer from gender discrimination, violence and other human rights violations across all continents and in all societies. As the analysis in previous chapters highlights, women and girls experience pervasive inequality and discrimination in their access to rights, opportunities and resources. Certain groups of women and girls, such as domestic workers, face multiple forms of discrimination, which impede their access to a range of services, including sexual and reproductive health services. It is therefore striking that these concerns feature so poorly in the MDGs as a whole and that the gender-sensitive targets and indicators are both limited and inadequate.

International human rights law requires all states to guarantee equality and non-discrimination.¹⁶³ The MDGs, in contrast, contain no explicit requirement for states to comprehensively identify and redress exclusion and discrimination. While the Millennium Declaration reiterated states’ commitment to “*combat all forms of violence against women and to implement the Convention on the Elimination of All Forms of Discrimination against Women*”, gender equality and women’s rights are only partly and very poorly reflected in the MDGs. MDG 3, to promote gender equality and empower women, has been reduced to a single target – to eliminate gender disparity in education – and two complementary indicators on the percentage of women involved in paid employment and political representation. This is a long way from states’ obligations under CEDAW, which requires governments to address discrimination against women and guarantee equality in all areas.¹⁶⁴ The MDGs do not require states to take appropriate measures to eliminate such discrimination in law, in policy and in practice. As a result, women and girls continue to suffer from discrimination, violence and other human rights violations.

In its 2010 MDG Report, Indonesia identified that promoting gender equality must ensure the role of women in development; their protection against all forms of abuse; and mainstreaming gender equality in

all policies and programmes while building greater public awareness on issues of gender.¹⁶⁵ In its 2010 Roadmap Report, Indonesia retains a more narrow focus, identifying challenges to achieve gender equality primarily in the area of education, employment and female participation in political life.¹⁶⁶

However, as this report highlights, the policies and programmes formulated by the Indonesian government do not sufficiently identify and address gender discrimination or the barriers faced by women and girls in realizing their human rights, including sexual and reproductive health rights.

With only five more years to go in the MDG timeframe, little progress has been made in the daily realities of women and girls in Indonesia to address these concerns.¹⁶⁷ Certain laws, regulations or mechanisms have been put in place at the local and central levels to address gender discrimination and gender-based violence,¹⁶⁸ and some policies have aimed at disseminating gender-awareness within the administration and among health providers.¹⁶⁹ However, these measures and their impact have been counter-balanced by other pervasive discriminatory practices and attitudes, which are either embedded in laws, regulations and policies, or are part of traditional attitudes or practices which are discriminatory towards women and girls, in particular as regards to sexual and reproductive rights.



Mother and child at a community health centre, Eastern Indonesia. © AI

Tackling discrimination, marginalization and exclusion must be central to any efforts to meet the MDGs. The analysis in previous chapters on domestic workers and barriers to sexual and reproductive rights underline the challenges with the achievement of the MDGs. The failure to integrate women's human rights fully into efforts to meet all the MDG targets means that the structural inequality and discrimination experienced by women is often not addressed in states' MDG policies and programmes, which is likely to undermine achievement of all the MDGs, including MDG 5 on improving maternal health.¹⁷⁰

Over the last 20 years, the Indonesian government has adopted various health strategies and policies to improve reproductive health within poor and marginalized communities. However, maternal mortality continues to pose a big challenge to the country's achievement of MDG targets by 2015. The Indonesian government has recently acknowledged that it will be unable to achieve its MDG target of reducing the maternal mortality ratio by three quarters between 1990 and 2015 unless its efforts are intensified.¹⁷¹ In order to reach the target of 102 maternal

deaths per 100,000 live births by 2015, Indonesian authorities would have to halve the current Maternal Mortality Ratio.¹⁷²

In its 2007 MDG report Indonesia acknowledged that a reduction in the maternal mortality rate is very much determined by factors that are not all directly related to the health sector. The health of an individual is not only influenced by the health care sector, but also by physical environment, socio-economic conditions, as well as the cultural and political environment. Thus, to confront these challenges, systematic and integrated approaches are needed.¹⁷³

At the September 2010 MDGs Summit in New York world leaders committed to take steps to realize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including sexual and reproductive health. The world leaders also emphasized the commitment to build on effective, multi-sectoral and integrated approaches, for the provision of universal access to reproductive health by 2015, including integrating family planning, sexual health and health care services in national strategies and programmes.¹⁷⁴

Amnesty International's research confirms the need for the Indonesian government to continue efforts to combat gender inequalities and discrimination, in particular in the areas of family relations and access to sexual and reproductive health, to achieve MDG 3. Not only will these efforts contribute to achieving gender equality and women's empowerment, they are likely to help remove some of the barriers to achieving MDG 5 on improving maternal health.

7. INDONESIA'S HUMAN RIGHTS OBLIGATIONS

7.1 THE RIGHT TO EQUALITY AND NON-DISCRIMINATION

The right to equality before the law is provided for in the Indonesian Constitution (Article 27.1) and the Human Rights Act (Article 3.2). The right to non-discrimination is also provided for in the Constitution (Article 28.1 (2)) and the Human Rights Act (Article 3.3).



Women at a community health centre, Java. © AI

The International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) prohibit discrimination on the grounds of sex in relation to all the rights guaranteed by these treaties.¹⁷⁵ Under the ICCPR, there is also a self-standing right to equality and non-discrimination.¹⁷⁶

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) requires states parties to eliminate discrimination against women in all its forms.¹⁷⁷ As noted earlier, the CEDAW Committee has stated that *“[m]easures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women.”*¹⁷⁸

CEDAW also guarantees the right of women, on the basis of equality with men, to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.¹⁷⁹

Both the ESCR Committee and the CEDAW Committee have clarified that the realization of women's right to health requires the removal of all barriers interfering with *“access to health services, education and information, including in the area of sexual and reproductive health.”*¹⁸⁰ The CEDAW Committee has stated that:

*“Barriers include requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport.”*¹⁸¹

The CEDAW Committee has also affirmed that “*access to health care, including reproductive health is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women*”.¹⁸² The Committee said further that Article 12:

“[R]equires States to eliminate discrimination against women in their access to health care services, throughout the life cycle, particularly in the areas of family planning, pregnancy, confinement and during the [postnatal] period¹⁸³... Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women.”¹⁸⁴

According to the CEDAW Committee, certain groups of women, in addition to suffering from discrimination directed against them as women, also suffer from multiple forms of discrimination based on “*race, ethnic or religious identity, disability, age, class, caste or other factors*”.¹⁸⁵ Such cumulative discrimination impairs women’s access to sexual and reproductive health care.

According to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, marginalized women, such as women living in poverty and ethnic minority or indigenous women, are “*...more vulnerable to maternal mortality*”.¹⁸⁶ Principles of equality and non-discrimination, explains the Rapporteur, give rise to the need to “*promote more equitable distribution of health care, including provision in rural or poor areas, or areas with high indigenous or minority populations*”.¹⁸⁷ States must pay particular attention to the rates at which they have reduced maternal mortality “*in vulnerable groups, regions and communities*”.¹⁸⁸

The idea of “intersectionality” seeks to capture both the structural and dynamic consequences of the interaction between two or more forms of discrimination or systems of subordination. It specifically addresses the manner in which racism, patriarchy, economic disadvantages and other discriminatory systems, reinforced by government policies, collude to disempower women living at the intersection of multiple identities that are marginalized.¹⁸⁹

To ensure that all groups of women fully and substantively enjoy their human rights, specific measures are needed to address the ways in which women are differently affected in their enjoyment of a right as a result of intersectional discrimination.

7.2 THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The right to health is provided for under the Indonesian Constitution (Article 28H), the Human Rights Act (Articles 9, 49.2 and 62), and the Health Law (Articles 4–8).¹⁹⁰ The Human Rights Act provides that a woman has the right to receive specific protection in the context of threats to her reproductive health functions (Article 49.2 and 49.3).

The ICESCR, to which Indonesia is a state party, requires states to take steps to provide for “*the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child*”. The ESCR Committee, the body responsible for monitoring this treaty, has stated that this treaty obligation must be:

“[U]nderstood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and [postnatal] care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”¹⁹¹

Further, CEDAW requires states parties to “ensure to 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” (Article 12.2).



Mother and child waiting in a community health centre, Eastern Indonesia. © AI

While the right to health is subject to progressive realization and availability of resources, according to the ESCR Committee there are some obligations that are subject to neither resource constraints nor progressive realization, but are of immediate effect. These immediate obligations include ensuring the realization of the right to health on a non-discriminatory basis; the provision of primary health care, safe water and adequate sanitation; and equitable distribution of all health facilities, goods and services.

The ESCR Committee requires states parties to ensure that health care services, goods and facilities connected to preventing maternal mortality must be available, accessible, acceptable and of good quality.¹⁹²

Under a number of international treaties which Indonesia has ratified, women are entitled to a range of health services which play an important role in improving maternal health, including:

- Primary health care services throughout a woman's life;¹⁹³
- Education and information on sexual and reproductive health;¹⁹⁴
- Sexual and reproductive health care services, such as family planning services;¹⁹⁵
- Prenatal health services;¹⁹⁶
- Skilled medical personnel to attend the birth;¹⁹⁷

- Emergency obstetric care;¹⁹⁸ and
- Postnatal health services.¹⁹⁹

7.3 THE PROHIBITION OF TORTURE AND OTHER ILL-TREATMENT

Article 28G (2) of the Indonesian Constitution stipulates that “*each person has the right to be free from torture or inhuman and degrading treatment*”. The Human Rights Act also provides for everyone to be free from torture and other cruel, inhuman and degrading treatment or punishment (other ill-treatment) (Article 33.1); however national laws still fall short of fully protecting people in Indonesia from torture and other ill-treatment.²⁰⁰

International human rights law and standards prohibit torture in all circumstances even “*in time of emergency which threatens the life of the nation*”.²⁰¹ The right to be free from torture and cruel, inhuman, or degrading treatment or punishment is provided for in the ICCPR, and the Convention on Torture and Other Cruel, Inhuman, Degrading Treatment or Punishment, to which Indonesia is a state party.

The UN Human Rights Committee, which oversees the implementation of the ICCPR, has stated that to compel a victim of rape to carry a pregnancy to full term or seek an unsafe abortion constitutes a violation of the prohibition of torture in Article 7 of the Covenant. According to the Committee, denying women access to life-saving obstetric care, including post-abortion care, is a violation of their right to life and a form of cruel, inhuman and degrading treatment.²⁰²

7.4 THE RIGHT TO LIFE

The right to life is provided for under the Indonesian Constitution (Article 28A) and the Human Rights Act (Articles 4, 9, and 53).

The ICCPR, which Indonesia has ratified, guarantees that “[*e*]very human being has the inherent right to life”.²⁰³ The UN Human Rights Committee has emphasized that the “*inherent right to life*” should not be understood in a restrictive manner and requires states to take positive measures to ensure protection of this right.²⁰⁴ It has highlighted the obligation of states parties to take all possible measures to increase life expectancy.²⁰⁵

In its concluding observations and recommendations, while monitoring states’ implementation of the ICCPR in relation to the right to life, the UN Human Rights Committee has consistently expressed concern over high maternal mortality rates.²⁰⁶ It has recommended:

*“So as to guarantee the right to life, the State party should strengthen its efforts in that regard, in particular in ensuring the accessibility of health services, including emergency obstetric care. The State party should ensure that its health workers receive adequate training. It should help women avoid unwanted pregnancies, including by strengthening its family planning and sex education programmes, and ensure that they are not forced to undergo clandestine abortions, which endanger their lives.”*²⁰⁷

7.5 ACCOUNTABILITY AND REMEDIES

The ESCR Committee has stated that anyone who is a victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels:

“All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.”

It has also stated that:

“National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions should address violations of the right to health.”²⁰⁸

While the right to health is provided for under Indonesian law, the number of cases where courts have been used as a means of enforcing state obligations to guarantee the right to health has been very small.²⁰⁹ In practice, patients who submit a complaint, or health workers facing accusations, may not have their rights as victims, witnesses and defendants protected under Indonesia’s criminal justice system due to endemic structural weaknesses including widespread corruption.²¹⁰

The Medical Practices Law (No. 29/2004) provides for the establishment of the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Doktor Indonesia*, MKDKI).²¹¹ The responsibilities of doctors and the rights of patients are outlined in the law.²¹² Any person who feels that their interests have been harmed directly by the treatment of a doctor can make a report. The Indonesian Medical Disciplinary Board can examine a case and decide if a health worker has committed a disciplinary violation and impose sanctions.²¹³ However, the utilization of this mechanism is very limited.²¹⁴

The Indonesian Doctors Association has developed an Indonesian Doctors Ethical Code (*Kode Etika Kedokteran Indonesia*, KODEKI), which outlines responsibilities of doctors to patients, co-workers and to themselves. The Association has a Medical Ethics Board (*Majelis Kehormatan Etika Kesehatan*, MKEK), which monitors compliance with the ethical code. The Board deals with complaints from the public of violations of the code and is also empowered to impose sanctions.²¹⁵

There are other bodies in Indonesia where individuals can make complaints if they are not satisfied with the treatment they have received and believe their human rights, and in particular their right to health, have been violated. This includes the National Human Rights Commission;²¹⁶ the National Commission on the Elimination of Violence against Women;²¹⁷ and the Commission on Child Protection (*Komisi Perlindungan Anak Indonesia*, KPAI).²¹⁸ However, these commissions do not have the power to submit their findings to the Attorney General, except for the National Human Rights Commission in certain limited cases.²¹⁹ They can only conduct inquiries, publish their findings and make recommendations to relevant bodies. The Ombudsman of the Republic of Indonesia can also receive complaints of “maladministration in the provision of public services”, conduct investigations and make recommendations to the President, parliament, government officials, regional heads and public service bodies.²²⁰

8. CONCLUSIONS AND RECOMMENDATIONS

“The progress of women’s health is a challenge to human history. Therefore, there is urgent need to address it with the utmost seriousness”

Speech delivered on behalf of Dr Endang Rahayu Sedyaningsih, Indonesia’s Minister of Health, May 2010.²²¹

Certain groups, such as unmarried women and girls, victims of sexual abuse, and domestic workers, face multiple forms of discrimination, which undermine their ability to realize their sexual and reproductive rights, and ultimately constitute barriers to their access to reproductive health information and services. Such barriers leave women and girls, especially if they are from poor and marginalized communities, at risk of ill-health and even death.

The Indonesian authorities should continue their efforts to combat gender inequalities and discrimination, in particular in the areas of family relations and access to sexual and reproductive health. Not only will these efforts contribute to achieving MDG 3 on gender equality and women’s empowerment, but they will help remove some of the barriers which are likely to compromise Indonesia’s ability to meet MDG 5 on improving maternal health.

In this chapter, Amnesty International provides a series of key recommendations to Indonesian authorities. They are addressed in particular to the Indonesian President; the Coordinating Minister for People’s Welfare; and relevant Ministers or Head of Departments including the Minister of Health, the Head of the Department of Population and Family Planning, the National Development Coordination Agency Minister, the Minister of National Education, the Minister of Religious Affairs, the Minister of Justice and Human Rights, the Minister of Home Affairs, the Minister of Social Affairs, the Minister for Manpower and Transmigration, the Minister for Women’s Empowerment, and the Head of the Central Bureau of Statistics.

These ministers and departments all have specific responsibilities in the areas of gender equality, labour issues, family planning, law, maternal health, and education. Certain recommendations pertaining to law reform are also geared towards members of the national legislative body, the House of People’s Representatives, and especially Parliamentary Commission III, specialized in human rights, law and security reform; Commission VIII, specialized in religion, social affairs and women’s empowerment; and Commission IX specialized in manpower, population affairs, and health.

8.1 COMBAT GENDER DISCRIMINATION IN ALL ITS FORMS

The Indonesian government has an obligation to take all appropriate measures to end discrimination against women in all its forms. This includes the repeal of all laws, regulations and policies which constitute discrimination against women as defined in CEDAW, to which Indonesia is a state party. This also includes the elimination of practices which are harmful to women, or which are based on stereotyped roles for women, and ensuring that women and girls can enjoy their sexual and reproductive rights in Indonesia free from discrimination, coercion and the threat of criminalization.

This requires that Indonesian authorities, and in particular the Minister for Women's Empowerment, the Minister of Home Affairs, the Minister of Justice and Human Rights, and the Minister of Health to work in collaboration with the House of People's Representatives, and in particular Parliamentary Commissions III, VIII and IX:

- Undertake a review of all the laws, regulations and policies which are discriminatory towards women and girls to bring them in line with international human rights law and standards, and in particular CEDAW. Particular attention must be paid to local regulations that have been enacted in the last decade as part of the decentralization process, and which discriminate against women in law or through their implementation; and
- Conduct awareness-raising campaigns to explain that sexual and reproductive rights are human rights and that they should be provided free from discrimination, coercion and the threat of criminalization.

This requires that the House of People's Representatives, and in particular Commission III and VIII:

- Review and amend the Marriage Law to bring it in line with international human rights law and standards. In particular legal provisions which discriminate against women (for example in respect of age of marriage, and polygamy), and which stereotype the roles of men and women should be repealed;
- Review and amend the Criminal Code to bring it into line with international human rights law and standards. In particular legal provisions which criminalize extramarital consensual sexual relationships and the dissemination of information on sexual and reproductive health and rights should be repealed. Furthermore, the Criminal Code should explicitly criminalize rape in the context of marriage; and
- Enact specific legislation with appropriate penalties prohibiting Female Genital Mutilation (FGM).

8.2 REMOVE BARRIERS TO REPRODUCTIVE HEALTH INFORMATION AND SERVICES

The Indonesian government has an obligation to take all appropriate measures to guarantee the right to health in accordance with international human rights law and standards. This requires that Indonesian authorities ensure that women and girls can fully access education – including sexuality education – and age-appropriate information on sexuality and reproduction. It also requires that Indonesian authorities ensure that women and girls can freely access services on sexual and reproductive health, free from discrimination, coercion and the threat of criminalization.

This requires that the Indonesian authorities, and in particular the Minister of Health, the Head of the Department for Population and Family Planning, the Minister for Women's Empowerment and the Minister

of Education:

- Publicly support the work of human rights activists, who are promoting and providing sexual and reproductive health information and services (for example contraceptives). Ensure that all those who intimidate them through violence or any other unlawful means are brought to justice and that victims receive reparations;
- Conduct targeted campaigns to highlight the impact on women's and girls' health and human rights of policies, laws and practices, at the central and local levels, which are stereotyping the roles of women and girls. These campaigns should be conducted in particular in rural areas and among the least educated. They should highlight the link between discriminatory practices and reproductive health;
- Ensure that a comprehensive reproductive health education programme is included in the national school curriculum, and that students who are pregnant are not dismissed from school. Materials should be developed in a way so that adolescents, regardless of their level of education or marital status, can fully access information on the prevention of unwanted early pregnancies and sexually transmitted diseases, including HIV/AIDS. Materials should be developed in a way which is non-discriminatory and which do not reinforce the stereotyping of women's and men's roles;
- Take measures to ensure that state officials, health workers and other service providers provide women and girls, regardless of their marital status, age-appropriate information and services on reproductive health programmes. Monitoring mechanisms should be in place to ensure that reproductive health programmes are implemented free from discrimination;
- Ensure that programmes on emergency contraception (including the morning after pill) are implemented throughout Indonesia, and promoted by health workers, as a way to combat unwanted pregnancies; and
- Ensure that vulnerable groups such as victims of sexual abuse can access reproductive health care services and information without delay and in privacy. They should be able to receive counselling wherever appropriate; and access comprehensive information on reproductive health services they are legally entitled to, including emergency contraception and abortion services.

This requires that the House of People's Representatives, and in particular Commissions VIII and IX:

- Review and amend the Population and Family Development Law to bring it in line with international human rights law and standards. In particular legal provisions which discriminate on the grounds of marital status (for example access to family planning services) should be amended; and
- Review and amend the Health Law to bring it in line with international human rights law and standards. In particular legal provisions which discriminate on the grounds of marital status (for example access to reproductive health services) and legal requirements for husband's consent should be amended.

8.3 DECRIMINALIZE ABORTION TO GUARANTEE ACCESS TO SAFE SERVICES

An important element in protecting the rights of women and girls is to ensure that they can access the abortion services to which they are legally entitled. Given that unsafe abortion is a significant cause of maternal deaths in Indonesia, decriminalizing abortion would also be a positive step towards combating

maternal mortality.

This requires that Indonesian authorities, in particular the Minister of Health, the Minister of Justice and Human Rights, and the Head of the Department of Education and Family Planning:

- Ensure that women and girls have access to information about legal abortion services. Health workers should provide age-appropriate information on legal safe abortion services regardless of their personal or religious convictions. Monitoring mechanisms should be in place to ensure health workers provide these services in practice;
- Minimize requirements, and develop and use clear protocols to facilitate prompt referral and access to appropriate care for victims of gender-based violence, in particular sexual violence. Police officials, court officials and health care providers must be trained to understand the need for prompt and compassionate action, as well as the need to coordinate their services. They should be made aware of the full range of comprehensive sexual and reproductive health care available to victims, including on legal abortion services;
- Ensure health workers are trained in safe abortion and post-abortion care. Enact relevant protocols, establishing the circumstances under which they are obliged to offer a woman abortion access as one option within a comprehensive range of reproductive health services tailored to pregnant women and/or rape victims; and
- Ensure that any woman who has a complication related to an abortion procedure receives timely emergency care.

Amnesty International also recommends that the House of People's Representatives, and in particular Commission IX:

- Repeal legal provisions criminalizing abortion in both the Criminal Code and Health Law;
- Repeal legal provisions criminalizing the dissemination of information on the prevention of pregnancy in the Criminal code; and
- Revise the Health Law, and in particular:
 1. Repeal legal provisions pertaining to a husband's consent;
 2. Review the time limit regarding access to legal abortion services for rape victims; and
 3. Revise legal provisions in the Health Law to ensure that women who suffer from complications arising from an abortion have the explicit right to receive post-abortion care regardless of whether the abortion was legal or not.

8.4 ENSURING STATE ACCOUNTABILITY TO PROTECT REPRODUCTIVE HEALTH RIGHTS

An important element in improving sexual and reproductive rights is to ensure that the state is accountable in its delivery of information and services on reproductive health. In particular, there should be systems in place to allow individual complaints, and where appropriate, individuals should be able to

bring those responsible for a violation of their right to health to a court, and receive reparations. Furthermore, there should be monitoring mechanisms in place to ensure that health workers provide sexual and reproductive health care in accordance with international human rights law and standards, including in reference to non-discrimination and gender equality.

This requires that Indonesian authorities, and in particular the Minister of Justice and Human Rights, and the Minister of Health:

- Ensure effective remedies to all victims, including access to justice and the right to reparations, including restitution, rehabilitation, compensation, satisfaction and guarantees of non-repetition; and
- Encourage the National Human Rights Commission and other monitoring bodies to address violations of reproductive health rights as part of their work and ensure that systems to submit information about violations are accessible and well publicized.

8.5 GUARANTEE DOMESTIC WORKERS FULL PROTECTION AS WORKERS

As a group particularly at risk of domestic violence and exploitation, domestic workers require high levels of protection and support from the state and associated institutions. However, their work is rarely regulated by a contract, and they are excluded from legal protections of basic workers' rights. The government should ensure that women and girl domestic workers can fully enjoy their sexual and reproductive rights, without coercion, discrimination and the threat of criminalization.

This requires that the House of People's Representatives, and in particular Commission IX:

- Pass specific legislation regulating the labour rights of domestic workers in accordance with international law and standards, including the ICESCR and relevant ILO Conventions,²²² and in particular:
 1. Provisions contained in the legislation should not be less favourable than what is provided for in the Manpower Act;²²³
 2. The new Domestic Workers Law should explicitly prohibit the employment of children below the age of 15 as domestic workers, and children under the age of 18 shall not be engaged in the worst forms of child labour, as provided in CRC and ILO Conventions No. 138 and 182, which Indonesia has ratified;²²⁴ and
 3. The law should explicitly include legal provisions pertaining to the specific needs of women, in particular during and after pregnancy.
- Ratify the ILO Maternity Protection Convention (No.183), which provides provisions on maternity leave, employment protection, and non-discrimination.

Furthermore, this requires that Indonesian authorities, in particular the Minister of Manpower and Transmigration, the Central Bureau of Statistics, the Minister for Women's Empowerment, the Minister of Health, the Minister of Home Affairs, the Minister of National Education, and relevant local authorities:

- Immediately undertake a thorough survey assessing the number of domestic workers in every

Indonesian province. This survey should gather data on their gender, age, origin, socio-economic background and conditions of living and employment;

- Ensure that domestic workers are recognized and treated legally as workers and enjoy all the rights that are provided in international law and standards;
- Publicize the Domestic Violence Law and relevant services, such as the gender desks in police stations and the Centres for Integrated Services for Women's and Children's Empowerment, among domestic workers, their employers and recruitment agents, including through the media;
- Conduct training to ensure that legal practitioners, including judges and prosecutors and police are fully briefed about the content and applicability of the Domestic Violence Law;
- Ensure that medical responses to violence against women are integrated into all areas of care (for example emergency services, reproductive health services, mental health services, and HIV/AIDS related services);
- Take measures to ensure that domestic workers enjoy freedom of movement and of communication;
- Take measures to ensure that education is free and compulsory for all until the age of 15 years old; and
- Devise an education programme on sexual and reproductive rights to provide domestic workers with access to information on family planning and contraceptives, early marriage and pregnancy, and the prevention of HIV/AIDS and other sexually transmitted diseases.

ENDNOTES

- 1 It was formerly known as *Badan "Koordinasi" Keluarga Berencana Nasional*. The name has been changed since the Law on Family Planning and Development (No. 52/2009) came into effect.
- 2 Amnesty International focus group discussion, Jakarta, 12 March 2010. Not her real name. All the names of those interviewed have been changed for security reasons.
- 3 The Indonesian government has estimated that there are 70 million people who are poor or near poor in Indonesia. These figures are based on an estimate provided in Ministry of Health, *Pedoman Pelaksanaan: Jaminan kesehatan Masyarakat (Jamkesmas) 2008*, 2008. Jakarta, p84. A higher definition of poverty (those earning less than 2 USD per day) brings the total of poor in Indonesia to an estimated 100 million people. In Claudia Rokx, George Schieber, Pandu Harimurti, Ajay Tandon, and Aparna Somanathan, *Health Financing in Indonesia: A Reform Road Map*, The World Bank, 2009, p46.
- 4 For the purpose of this report, a health worker refers to all paid workers employed in organizations or institutions whose primary intent is to improve health (for example doctors, midwives, etc).
- 5 Amnesty International focus group discussion, Banten, 13 March 2010.
- 6 It is estimated that globally unsafe abortions cause 13 per cent of maternal deaths. Website: http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html, accessed on 7 October 2010.
- 7 The study was conducted in six regions of Indonesia: Sumatra; Java; Kalimantan; Bali; North and South Sulawesi; and Eastern Islands (West and East Nusa Tenggara). The study also selected 10 major cities. It used a comprehensive social mapping of abortion service delivery points to directly estimate the average number of abortion cases per month. In B Utomo, V Hakim, Attas Hendartini Habsjah et al, *Incidence and Socio-Psychological Aspects of Abortion in Indonesia: A Community Based Survey in 10 Major Cities and 6 Districts*, Centre for Health Research, University of Indonesia, 2001, Jakarta, p8, (B Utomo et al, *Incidence and Socio-Psychological Aspects of Abortion in Indonesia*).
- 8 Official government figures vary. Recent figures indicate that abortion accounts for five per cent of maternal deaths in Indonesia, see Ministry of National Development Planning (BAPPENAS), *A roadmap to accelerate achievement of the MDGs in Indonesia*, 2010, p123, (*2010 MDG Roadmap Report*). Website: <http://www.bappenas.go.id/node/118/2767/a-roadmap-to-accelerate-achievement-of-the-mdgs-in-indonesia/>, accessed on 7 October 2010. However, previous figures indicate that abortion accounts for 11 per cent of maternal deaths in the country, see National Development Planning Agency, *Report on the Achievement of Millennium Development Goals Indonesia 2007, 2007, (2007 MDG Report)*, p52. Website: <http://www.undp.or.id/pubs/docs/MDG%20Report%202007.pdf>, accessed on 8 October 2010. According to the National Strategic Plan on Making Pregnancy Safer from the Ministry of Health, which was published in 2001, the estimated abortion rate in Indonesia is 18 per cent, p9.
- 9 Article 1.
- 10 Article 2, CEDAW. See also website: <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>, accessed on 7 October 2010.
- 11 Amnesty International, *Exploitation and Abuse: the plight of women domestic workers*, (AI Index: ASA 21/001/2007), February 2007.
- 12 Amnesty International, *Briefing to the UN Committee on the Elimination of Discrimination against Women: women and girl domestic workers*, (AI Index: 21/007/2007), July 2007.
- 13 Amnesty International, *Unfinished Business – Police accountability in Indonesia*, (AI Index: ASA 21/013/2009), June 2009. See especially Chapter 3.3 "Women at particular risk".
- 14 Recent Amnesty International's legal commentaries include Amnesty International's Joint Open Letter with LBH Masyarakat to the House of People's Representatives on the review and passing of a new Criminal Code, (AI Index: ASA 21/022/2009), November 2009; Amnesty International's Open Letter to the Minister for Home Affairs on the passing of the Aceh Criminal Code, (AI Index: ASA 21/021/2009), November 2009; and Amnesty International's Joint Open Letter with Federasi Apik to the Minister of Health on the Health Law (No. 36/2009), (AI Index: 21/001/2010), February 2010.
- 15 See, for example, World Health Organization (WHO), *Using Human Rights for Maternal and Neonatal Health – A tool for strengthening laws, policies and standards of*

care, 2006, (WHO, *Using Human Rights for Maternal and Neonatal Health*); Asian-Pacific Resource and Research Centre for Women (ARROW), *A Report of Indonesia field Test Analysis and Rights and Realities: Monitoring Reports on the Status of Indonesian women's Sexual and Reproductive Health and Rights*, 2006, (ARROW Report); Ministry of Health and local governments in Nusa Tenggara, *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health – Using WHO tools, Report on Provincial & District Laws, Regulations, Policies and Standards of Care*, November 2008.

16 For every maternal death, it is estimated that approximately 20 women suffer pregnancy-related injury, infection or disease (also called maternal morbidity). In some cases, these diseases may lead to long-term disabilities, such as uterine prolapse (fall of the uterus), infertility, obstetric fistula (hole between the rectum and vagina or between the bladder/rectum and vagina) or incontinence. See Gita Nanda, Kimberly Switlick and Elizabeth Lule, *Accelerating Progress towards Achieving the MDG to Improve Maternal Health: A Collection of Promising Approaches*, World Bank, 2005, Washington DC, p4. Website:

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/NandaAcceleratingProgresswithCover.pdf>, accessed on 7 October 2010. In Indonesia, it is unclear how many women and girls suffer from pregnancy related injuries due to the lack of data. However, a recent study suggests the problem is of large scale. See C. Ronsmans, S. Scott, P. Deviany, and F. Nandiaty, *Estimation of population-based incidence of pregnancy-related illness and mortality (PRIAM) in two districts in West Java, Indonesia*, July 2008.

17 There has been an increased privatization of health care services, including family planning provisions, since the mid-1990s, in certain parts of Indonesia (for example Bogor district). This has led to the weakening of health provisions made available by the state in some cases due to competition in terms of available human resources and a weakening of the referral system. In PowerPoint presentation "*Isu-isu kespro terkini di Indonesia*", by Atashendartini Habsjah, Amnesty International workshop, 10 March 2010, Jakarta. See also Stein Kristiansen and Purwo Santoso, *Surviving decentralisation? Impacts of regional autonomy on health service provision in Indonesia*, 2005.

18 The term "ever married", which is used in the survey, refers to women and men who are married or have been married in the past and includes widows and divorcees.

19 See *Indonesia Demographic and Health Survey – 2007* carried out by Statistics Indonesia (*Badan Pusat Statistik*, BPS), December 2008, pp129–145, (*Indonesia Demographic and Health Survey – 2007*). This survey is the sixth in a series of surveys undertaken as part of the International Demographic and Health Surveys project. It provides detailed information on population, family planning, and health for policy-makers and programme managers. It was conducted in Indonesia's 33 provinces, collecting information from over 40,000 households – over 32,000 married women and over 8,000 married men. The data excludes unmarried couples.

20 The term "never married", which is used in this survey, refers to women and men who have never been married.

21 For data on unmarried women and adolescents, see Statistics Indonesia (*Badan Pusat Statistik*, BPS), National Family Planning Coordinating Board, Ministry of Health, and Macro International, *2007 Young Adult Reproductive Health Survey*, December 2008 (*2007 Young Adult Reproductive Health Survey*). Over 8,000 unmarried women aged between 15 and 24 were interviewed for this survey. Website: <http://www.measuredhs.com/pubs/pdf/FR219/FR219.pdf>, accessed on 7 October 2010.

22 For further information, see Amnesty International's webpage on the Demand Dignity Campaign. Website: <http://www.amnesty.org/en/demand-dignity>, accessed on 7 October 2010. See also Amnesty International recent reports on Maternal Mortality, for example, *Deadly delivery: The maternal health care crisis in the USA*, (AI Index: AMR 51/007/2010), March 2010; *Giving Life: Risking Death – Maternal Mortality in Burkina-Faso*, (AI Index: 60/001/2009), December 2009; *Not even when her life is at stake: How the total abortion ban in Nicaragua criminalizes doctors and endangers women and girls* (AI Index: AMR:43/004/2009), July 2009, and *Fatal Flaws: Barriers to Maternal Health in Peru*, (AI Index: AMR 46/008/2009), July 2009.

23 This table was produced by Amnesty International.

24 In *The Jakarta Globe*, "Gender Inequality Seen as a Major Obstacle", 4 August 2010. Website: <http://www.thejakartaglobe.com/home/gender-inequality-seen-as-a-major-obstacle-in-meeting-mdgs/389465>, accessed on 7 October 2010.

25 For further information, see Iwu Dwisetyani Utomo, "Women's lives: Fifty years of change and continuity", in Terence Hull (Ed.), *People, Population, and Policy in Indonesia*, Equinox publishing, 2005; Susan Blackburn, *Women and the State in Modern Indonesia*, Cambridge University Press, 2004; and Linda Rae Bennet, *Women, Islam and modernity – Single women, sexuality and reproductive health in contemporary Indonesia*, Routledge Curzon, 2004, (Linda Rae Bennet, *Women, Islam and modernity*).

26 See *Combined fourth and fifth periodic reports of States parties: Indonesia*, UN Doc. CEDAW/C/IDN/4-5, 27 July 2005, para 163 (*Combined fourth and fifth periodic reports of States parties: Indonesia*). See also WHO, *Using Human Rights for Maternal and Neonatal Health*, p8, Supra No 15.

27 *The Jakarta Globe*, "The Thinker: Let's talk about sex", 17 May 2010. Website: <http://www.thejakartaglobe.com/columns/the-thinker-lets-talk-about-sex/375460>,

accessed on 7 October 2010. Also quoted in Primaironline, "Pernikahan dini di Indonesia capai 690 kasus per tahun", 10 September 2009. Website: <http://www.primaironline.com/berita/detail.php?catid=Sosial&artid=pernikahan-dini-di-indonesia-capai-690-kasus-per-tahun>, accessed on 7 October 2010.

28 The Convention on the Rights of the Child defines as a child "every human being below the age of eighteen years" (Article 1).

29 Amnesty International interview with Susun, West Java, 22 March 2010.

30 *We the Children: End-Decade Review of the Follow-up to the World Summit for Children: Report of the Secretary-General*, 4 May 2001, p50, para 181. Website: <http://www.unicef.org/specialsession/documentation/documents/a-s-27-3e.pdf>, accessed on 11 October 2010.

31 Polygamy is also referred to in other legal provisions. See for example government regulation No. 10/1983, which was later revised with government regulation No. 45/1990, which stipulates that a male state official can marry more than one woman only after receiving permission from his superiors. The regulation also stipulates that permission can only be granted if a state official's wife fulfils one of three criteria – namely she is incapable to serve in her duty as a wife; has an incurable disease; or is incapable of giving birth to a child. In The Jakarta Post, "Police Chief Responds To Polygamy Claims", 12 May 2010. Website: <http://www.thejakartapost.com/news/2010/05/12/police-chief-responds-polygamy-claims.html>, accessed on 11 October 2010.

32 Amnesty International interview with Siri, West Java, 14 March 2010.

33 See, for example, Linda Rae Bennet, *Women, Islam and modernity*, Supra No 25, pp23–27.

34 There have been "mistaken" arrests of women based on the assumption that "they were sex workers, or on the accusation that they use codes signifying the provision of sexual services" as a result of local regulations criminalizing prostitution. See National Commission on the Elimination of Violence against Women (*Komnas Perempuan*) report, *In the Name of Regional Autonomy: the Institutionalization of Discrimination in Indonesia*, 2009, p33, (*Komnas Perempuan, In the Name of Regional Autonomy*).

35 See Linda Rae Bennet, *Women, Islam and modernity*, Supra No 25, p29.

36 *Indonesia Demographic and Health Survey – 2007*, Supra No 19, p43.

37 In March 2010, a regional LGBT conference due to be held in Surabaya was cancelled as a result in part of violence led by Islamic Defender Front (*Front Pembela Islam*, FPI) members. See Antara News, "Gays Forced To Cancel Regional Conference", 25 March 2010. In April 2010, a human rights training for transvestites was cancelled as a result of violence conducted by FPI members. See The Jakarta Post, "Indonesian police said 'powerless' against radical Islamist assaults", 4 May 2010. See also The Jakarta Globe, "Acehnese Gays Face a Climate of Fear and Abuse", 19 August 2010.

38 The Jakarta Post, "Nursyahbani Katjasungkana: A new perspective on sex", 16 August 2008. Website: <http://www.thejakartapost.com/news/2010/08/16/nursyahbani-katjasungkana-a-new-perspective-sex.html>, accessed on 7 October 2010.

39 Amnesty International interview with Lila, West Java, 17 March 2010.

40 See Amnesty International, *Ending Female Genital Mutilation to promote the achievement of the Millennium Development Goals*, p3. Website: <http://www.amnesty-eu.org/static/documents/2010/FGMCampDigest.pdf>, accessed on 7 October 2010.

41 The study was conducted in Banten, East Java, West Sumatra, Gorontalo, South Sulawesi, East Kalimantan and West Java. It is based on a household survey with a sample of 1,694 mothers of girls under the age of 19. See Population Council, *Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights*, Jakarta, September 2003 (Population Council, *Female Circumcision in Indonesia*). Website: http://www.popcouncil.org/pdfs/frontiers/reports/Indonesia_FGM.pdf, accessed on 7 October 2010. See also Basilica Dyah Putranti, Faturochman, Muhadjir Darwin, and Sri Purwatiningsih, *Male and Female Genital Cutting among Javanese and Madurese*, Centre for Population and Policy Studies, Gadjah Mada University, 2003. And see IRIN, "Female genital mutilation persists despite ban", 2 September 2010.

42 Domestic violence is recognized as one of the manifestations of gender-based violence against women that violate women's and girls' human rights. The UN Declaration on the Elimination of Violence against Women defines violence against women as "physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation" (Article 2 (a)).

43 Circular for Health Personnel on Prevention and Prohibition on Medicalization of Female Circumcision, Ministry of Health, Director General of Community Health, 20 April

2006, cited in WHO, *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*, 2006. The standards for midwifery service adopted by the Ministry of Health in 2001 states that midwives should avoid harmful practices and support good practices. See “Standard Pelayanan Kebidanan, Departemen Kesehatan Republik Indonesia”, 2001, Buku 1, quoted in WHO, *Using Human Rights for Maternal and Neonatal Health*, Supra No 15, p34.

44 Amnesty International interview with midwife, Jakarta, 12 March 2010.

45 Amnesty International interview with midwife, West Java, 11 March 2010.

46 See for example Dr Amal Abd El-Hadi, “Islam, Law and Reproductive Health in Egypt”, in Zainah Anwar and Rashidah Abdullah (Eds), *Islam, Reproductive Health and Women’s Rights*, Sisters in Islam, 2001, pp167–168.

47 In Population Council, *Female Circumcision in Indonesia*, Supra No 41, pp3–4.

48 Among the perceived beliefs are “that reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, can attenuate sexual desire in the female, maintain chastity and virginity before marriage and fidelity during marriage, and increase male sexual pleasure.” Other reasons range from sociological reasons (initiation of girls into womanhood and the maintenance of social cohesion); Hygiene and aesthetic reasons; maternal myths (for example that it can enhance fertility and promotion of child survival); and religious reasons within Muslim communities. In Population Council, *Female Circumcision in Indonesia*, Supra No 41, pp3–4.

49 CEDAW Committee, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Indonesia*, UN Doc. CEDAW/IDN/CO/5, 10 August 2007, (CEDAW Committee, *Concluding comments:Indonesia*), para 21.

50 Amnesty International interview with Lila, West Java, 17 March 2010.

51 There are still some shortcomings in the protection of victims and witnesses. See for example, Asian Legal Resource Centre, *Witness Protection Lacking in Indonesia and Nepal*, 24 August 2010. See also Rifka Annisa Study, *Pemantauan Implementasi Undang-Undang Penghapusan Dalam Rumah Tangga di enam Propinsi Di Indonesia*, 2009, pp 42–49, (Rifka Annisa Study).

52 Although the 2004 Domestic Violence Law criminalizes sexual violence in the context of home, and provides for up to 12 years jail sentences in cases where a husband uses sexual violence on this wife – or vice versa (Articles 46 and 53), the definition adopted is not sufficiently comprehensive. In the Domestic Violence Law, sexual violence is defined as “forcing sexual intercourse carried out against an individual living within the scope of the household” and “forcing sexual intercourse against one of the individuals within the scope of the household for commercial purpose and/or a certain purpose” (Article 8). International human rights law requires that definitions of rape should not just focus on force or threat of force, but also breaches of the right to sexual autonomy. The Criminal Code adopts a similar definition of rape, which is defined as any person using force or threat of force on a woman to have sexual intercourse with him out of marriage (Article 285). A person guilty of violating this Article may face up to 12 years’ imprisonment. Amnesty International recommends that the Domestic Violence Law and the Criminal Code be amended to be consistent with international human rights law and standards, as is, for example, the definition used in the Elements of Crimes of the Rome Statute of the International Criminal Court. The definition of rape in the Elements of Crimes contain the following aspects: (1) “The perpetrator invaded the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body”, and (2) “The invasion was committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or another person, or by taking advantage of a coercive environment, or the invasion was committed against a person incapable of giving genuine consent”. In *Report of the Preparatory Commission for the International Criminal Court* Elements of Crimes Article 8 (2) (e) (vi)–1, UN Doc. PCNICC/2000/1/Add.2, 2 November 2000.

53 Deficiencies remain within criminal law in Indonesia in addressing the particular challenges of investigating offences which involve sexual violence. For example, the Criminal Procedure Code provides that a judge can only impose a criminal sentence on someone if s/he has two elements of proof. These can either be a testimony from the victim; the defendant; an expert; a letter; or a sign (Articles 183–184). The Domestic Violence Law also requires two elements of proof in cases of sexual violence (Articles 54 and 55).

54 See Rifka Annisa Study, Supra No 51, pp 27–29.

55 Nikah Siri refers to unofficial marriages, which are conducted at the community level.

56 See National Commission on the Elimination of Violence against Women (*Komnas Perempuan*) Annual Report 2009, *Tak Hanya di Rumah: Pengalaman Perempuan akan Kekerasan di Pusaran Relasi Kekuasaan yang Timpang*, (Komnas Perempuan, *Tak Hanya di Rumah*). Website: <http://www.komnasperempuan.or.id/wp->

content/uploads/2010/03/Catatan-Tahuhan-Kekerasan-terhadap-Perempuan-tahun-2009-edisi-Launching.pdf, accessed on 7 October 2010.

57 The Jakarta Post, "Councilors mull virginity as criteria for enrollment", 22 September 2010. A Jambi provincial legislator suggested that women and girls enrolling into state schools should undergo virginity tests. If they fail, they would be excluded from the school. The idea has been criticized by government officials, and has reportedly been dropped. See Agence France Presse, "Indonesia Rejects Proposal to Subject Girls to Virginity Tests", 28 September 2010.

58 Amnesty International interview with non-governmental organizations, Aceh, 22 March 2010.

59 See the full transcript of the interview with Ramli Mansur, in the Jakarta Globe, "West Aceh District Chief Says Shariah Law Needed or There Will Be Hell to Pay", 18 August 2010. See also The Jakarta Globe, "Outrage, Ridicule leveled at West Aceh Politician After Rape Comment", 19 August 2010.

60 See Law No. 22/1999 which provided for decentralization, deconcentration and local autonomy and Law No. 25/1999 which provided for fiscal balance between the central government and local administration. See also the Regional Government Act (No. 32/2004).

61 Komnas Perempuan, *In the Name of Regional Autonomy*, Supra No 34.

62 Although these bylaws should not longer be applicable since the passing of the Law on the Governing of Aceh (LoGA) in 2006, the National Commission on the Elimination of Violence against Women (Komnas Perempuan) has documented that some Islamic bylaws which were passed in the early 2000 are still in application. "Although later the Law No. 18 Year 2001 [on the Special Autonomy for the Aceh Special Region] was declared naught (after the enactment of Law No.11 Year 2006), the *qanuns* [bylaws] issued on the basis of Law No.18 continue to be in effect till the present day", in Komnas Perempuan, *In the Name of Regional Autonomy*, Supra No 34.

63 In the bylaw on *khalwat*, *khalwat* is defined as: "the conduct of being together in isolation between two *mukallaf* [adults] or more of different sex who are not *muhrim* [a close relative] or without marriage ties". Any Muslim in Aceh who is found guilty of *khalwat* may be sentenced to three to nine lashes or a fine of between 2.5 to 10 million Rp (between 276 and 1,159.20 USD).

64 Komnas Perempuan, *In the Name of Regional Autonomy*, Supra No 34, p40.

65 See Komnas Perempuan, *In the Name of Regional Autonomy*, Supra No 34, p41.

66 See Komnas Perempuan, *In the Name of Regional Autonomy*, Supra No 34, pp41–42.

67 Amnesty International interview with non-governmental organization, Aceh, 24 March 2010; and Amnesty International email correspondence, 22 September 2010.

68 See Amnesty International Press Release, *Indonesia must repeal "cruel" new stoning and caning law*, 17 September 2009. Website: <http://www.amnesty.org/en/news-and-updates/news/indonesia-must-repeal-cruel-new-stoning-caning-law-20090917>, accessed on 7 October 2010.

69 National Development Planning Agency, *Report on the Achievement of Millennium Development Goals Indonesia 2007*, 2007, p6. Website: <http://www.bappenas.go.id>, accessed on 11 October 2010.

70 "The HIV epidemic in Indonesia is among the fastest growing in Asia. At the end of 2009, it was estimated that there were 333,200 people living with HIV (PLHIV) in Indonesia. The cumulative number of reported AIDS cases has risen sharply from 2,682 cases in 2004 to 19,973 by December 2009. Among the cases 25 [per cent] are women. The AIDS epidemic now affects almost all parts of Indonesia... In 2004 only 16 out of 33 provinces had reported HIV. However, by the end of 2009, AIDS cases were reported in 32 provinces of Indonesia's 33 provinces. These increases reflect both the spread of infection as well as better reporting as a result of growing availability and utilization of counsel[ing] and testing". In National Aids Commission, *Republic of Indonesia Country Report on the Follow up to the Declaration of Commitment On HIV/AIDS (UNGASS), Reporting Period 2008-2009*, 2009, p8. Website: http://data.unaids.org/pub/Report/2010/indonesia_2010_country_progress_report_en.pdf, accessed on 7 October 2010.

71 This law replaces the Law on Population (No. 10/1992).

72 Articles 1.11 and 1.12.

73 See also Articles 2 and 23 of the ICCPR; Article 2 of the ICESCR; and Article 1 of CEDAW.

74 In 1996, the Ministry for Health issued the Essential Reproductive Health Services (*Pelayanan Kesehatan Reproduksi Esensial*, PKRE) in order to prepare adolescent reproductive health services, which includes services on reproductive health, including family planning, maternal health, adolescent health and HIV/AIDS within community

health centres (*Puskesmas, Pusat Kesehatan Masyarakat*). In 1998, the Ministry of Health issued a management guideline on essential reproductive health services for the Community Health Centres and a policy to extend information and reproductive health education to adolescents. From 2000, the National Family Planning Coordination Board was in charge of the Protecting Adolescent Couples Programme (BKR), the Centre of Reproductive Health Information and Counselling for Adolescents (Pusat Informasi & Konselling Kesehatan Reproduksi Remaja, PIK – KRR), and Family AIDS Awareness. From 2001, the Ministry of Education introduced reproductive health education in schools. See ARROW Report, Supra No 15, p136. See also *Combined fourth and fifth periodic reports of States parties: Indonesia*, Supra No 26, paras 129, 135 and 139, p44, p46 and p47 respectively; Ministry of Health, Ministry for Women's Empowerment, Ministry of Education, Ministry of Social Affairs, National Family Planning Coordination Board, UNFPA, WHO, *Kebijakan dan Strategi Nasional Kesehatan Reproduksi di Indonesia* [Policy and National Strategy on Reproductive Health], Jakarta, 2005, (*Kebijakan dan Strategi Nasional Kesehatan Reproduksi di Indonesia* [Policy and National Strategy on Reproductive Health]); and Bab 2 A.2 "Panduan Pengelolaan Pusat Informasi & Konseling Kesehatan Reproduksi Remaja (PIK-KRR)", Badan Koordinasi Keluarga Berencana Nasional, Jakarta, 2008, p12.

75 The World Health Organization and the Ministry for Health in Indonesia define "adolescents" as those between the age of 10 and 19 years old. However, the Department of Population and Family Planning in Indonesia defines adolescents as those aged between 10 and 24 years. Furthermore, the *2007 Young Adult Reproductive Health Survey* relies on interviews with "never married" adolescents between 10 and 24 years old, with a focus on 15-24 year olds, Supra No 21.

76 *2007 Young Adult Reproductive Health Survey*, Supra No 21, p31.

77 Amnesty International interview with non-governmental organization, Yogyakarta, 5 March 2010.

78 Amnesty International workshop on sexual and reproductive rights, Lombok, 18 March 2010.

79 Amnesty International interview with Lila, West Java, 17 March 2010.

80 Amnesty International interviews, March 2010.

81 Committee on Economic, Social and Cultural Rights, *General Comment No. 14 (The right to the highest attainable standard of health)*, 11 August 2000, UN Doc. E/C.12/2000/4, para 34 (ESCR Committee, *General Comment No. 14*).

82 Local NGOs confirmed that unmarried girls who become pregnant are usually forced to leave school. One explanation offered by a High School teacher was that allowing a pregnant girl to continue in school could encourage other students to do the same. Although it does not appear to be a central government policy, it is left for the school to decide what to do in case a student is pregnant.

83 Amnesty International interview with non-governmental organization, Aceh, 24 March 2010.

84 Amnesty International interview with midwives, Lombok, 20 March 2010.

85 See also Linda Rae Bennet, *Women, Islam and modernity*, Supra No 25.

86 Amnesty International interviews in Lombok and Aceh, 20 and 24 March 2010.

87 The Ministry of Health, Provincial Government of West Nusa Tenggara and Provincial Government of East Nusa Tenggara, *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health in 2 cities and 2 districts in West and East Nusa Tenggara, Indonesia*, 2009, p70, (*Measuring the fulfilment of Human Rights in Maternal and Neonatal Health*).

88 Amnesty International interview with local NGO, Lombok, 19 March 2010.

89 Amnesty International email correspondence with local NGO, 14 July 2010.

90 Amnesty International interview with legal aid organization, Jakarta, March 2006.

91 According to *Indonesia Demographic and Health Survey – 2007*, 12.7 per cent of married women from the lowest wealth quintile had an unmet need for family planning (both for spacing and for limiting) against between 7.3 per cent and 8.9 per cent for the other wealth quintiles, supra No 19, p93.

92 Amnesty International interview with a domestic worker recruitment agent, Jakarta, 22 March 2010.

93 It was already the case in the former Population Law (No. 10/1992). The explanatory comments of Article 19 stated that the husband and wife have a common

responsibility to negotiate an agreement about timing and spacing of children and the choices they will make.

94 Amnesty International interview with health workers, Aceh, 24 March 2010.

95 Amnesty International interview with midwife, West Java, 11 March 2010.

96 Amnesty International focus group discussion, Jakarta, 12 March 2010.

97 Amnesty International interview with a health worker, West Java, 11 March 2010.

98 Amnesty International interview with midwives, Aceh, 24 March 2010.

99 The practice of requiring husband's authorization for sterilization is mentioned in *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health*, Supra No 87, p30.

100 See *Kebijakan dan Strategi Nasional Kesehatan Reproduksi di Indonesia* [Policy and National Strategy on Reproductive Health], Supra No 74.

101 See WHO and John Hopkins, *Family Planning: A Handbook for Providers, 2007*. Website: <http://www.infoforhealth.org/globalhandbook/handbook.pdf>, accessed on 11 October 2010. See also the International Planned Parenthood Federation about contraception myths. Website: <http://www.ippf.org/Templates/Myths.aspx?NRMODE=Published&NRNODEGUID={476CAE21-4E6C-4CDF-8C04-EB3A0EE218DF}&NRORIGINALURL=%2fen%2fResources%2fContraception%2fdefault.htm&NRCACHEHINT=Guest>, accessed on 11 October 2010.

102 Article 16 (1) (e) of CEDAW.

103 Article 534 states that "[a]ny person who either openly exhibits means for preventing pregnancy, or without being requested offers, by disseminating in writing, shows where such means or services for the prevention of pregnancy are available, shall be punished by a maximum light imprisonment of two months". Article 535 states that "[a]ny person who either openly exhibits means for the termination (*menggugurkan*) of pregnancy, or openly or without being requested offers or shows where such means or services for the disturbance of pregnancy are available, shall be punished by a maximum light imprisonment of three months". Article 283 states that any person who offers, hands over permanently or temporarily shows to a minor who he knows or reasonably suspects not yet to have reached the age of seventeen years, either a piece of writing, a portrait or an article offending against decency, or a means to prevent or to terminate (*mencegah atau menggugurkan*) pregnancy, shall be sentenced to a maximum of 9 months' imprisonment.

104 See Articles 17 and 24 of CRC, and Committee on the Rights of the Child, *General Comment 4 (Adolescent health and development in the context of the Convention on the Rights of the Child)*, 1 July 2003 UN Doc. CRC/GC/2003/4, (CRC Committee, *General Comment 4 (Adolescent health and development in the context of the Convention on the Rights of the Child)*), paras 26 and 28. See also ESCR Committee, *General Comment No. 14 – the right to health* is interpreted by the Committee "as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as... access to health-related education and information, including on sexual and reproductive health", Supra No 81, para 11. Furthermore, CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, 1999, (CEDAW Committee, *General Recommendation No. 24 (Women and Health)*) provides that "States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their rights to privacy and confidentiality", para 18. Website: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>, accessed on 11 October.

105 Amnesty International interview with human rights defender, Yogyakarta, 5 March 2010.

106 The Pornography Law (No. 44/2008) defines pornography as "picture, sketch, illustration, photo, writings, vocalizations, sounds, moving picture, animations, cartoon, conversation, body movements or other form of messages that are communicated or transmitted via media communications and/or public shows that is indecent or sexually exploitative or contravenes norms of community morality".

107 Amnesty International interview with human rights defender, Yogyakarta, 5 March 2010.

108 See Ministry for Health and WHO, *Pedoman pelayanan kontrasepsi darurat* [Guidelines on emergency contraception], 2004, (*Pedoman pelayanan kontrasepsi darurat* [Guidelines on emergency contraception]).

109 *Pedoman pelayanan kontrasepsi darurat* [Guidelines on emergency contraception], Supra No 108.

110 See also WHO, *Using Human Rights for Maternal and Neonatal Health*, Supra No 15, p14.

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- 111 Amnesty International interview with health local government officials, Jakarta, 19 March 2010.
- 112 Amnesty International interview with health workers, Lombok, 20 March 2010. See also *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health*, Supra No 87, p26.
- 113 See *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health*, Supra No 87, p30.
- 114 See Law on Children's Court (No. 3/1997), Article 1.
- 115 2007 MDG Report, Supra No 8, p52.
- 116 2010 MDG Roadmap Report, Supra No 8, p123.
- 117 Although there is a total of six criteria, some of them only apply to rape victims; and others only apply to cases that are life-threatening to the foetus or the mother.
- 118 CEDAW Committee, *Concluding comments:Indonesia*, Supra No 49, para 16.
- 119 ARROW Report, Supra No 15, p75.
- 120 See also Amnesty International report, *Not even when her life is at stake: How the total abortion ban in Nicaragua criminalizes doctors and endangers women and girls*, Supra No 22, p30.
- 121 Amnesty International interview with a doctor, Jakarta, 15 March 2010.
- 122 A 2005 religious edict by the Council of Indonesian Ulama also provides that abortion is allowed for up to 40 days gestation in case the pregnancy is the result of a rape (Fatwa No.4/2005). The religious edict is not legally binding.
- 123 Amnesty International meeting with non governmental organization, Surabaya, 24 March 2010.
- 124 Article 346 of the Criminal Code which provides that "any woman who with deliberate intent causes or lets another cause the drifting off or the death of the fruit of her womb, shall be punished by a maximum imprisonment of four years".
- 125 Article 349 of the Criminal Code provides that "If a physician, midwife or pharmacist is an accomplice to the crime in Article 346, or is guilty or is an accomplice to one of the crimes described in Articles 347 and 348, the sentences laid down in said articles may be enhanced with one third, and he may be deprived of the exercise of the profession in which he commits the crime". Further, Article 348 of the Criminal Code provides that (1) "Any person who with deliberate intent causes the drifting off or the death of the fruit of the womb of a woman with her consent, shall be punished by a maximum imprisonment of five years and six months", and (2) "If the act results in the death of the woman, he shall be punished by a maximum imprisonment of seven years".
- 126 Amnesty International interview with health worker, Yogyakarta, 5 March 2010.
- 127 Amnesty International phone interview with reproductive health expert, July 2010.
- 128 Amnesty International interview with health worker, 19 March 2010.
- 129 See ARROW Report, Supra No 15, pp76–77.
- 130 Tempo Interaktif, "Polisi Jember Perdalam Penanganan Kasus Aborsi Ilegal", 15 August 2010. See also Tempo Interaktif, "Polisi Tuban Tangkap Dukun Aborsi", 27 July 2010.
- 131 Amnesty International interview with traditional birth attendant, West Java, 14 March 2010.
- 132 See B. Utomo et al, *Incidence and Socio-Psychological Aspects of Abortion in Indonesia*, Supra No 7, p8.
- 133 See Supra No 8.
- 134 Linda Rae Bennet, *Women, Islam and modernity*, Supra No 25, pp113–114.
- 135 Amnesty International interview with Detty, Jakarta, 17 March 2010.

136 See *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt*, UN Doc. E/CN.4/2004/49, 16 February 2004, (Report of the Special Rapporteur on the right to health), para 30.

137 See International Planned Parenthood Federation, *Death and Denial: Unsafe Abortion and Poverty*, January 2006, p1.

138 Speech delivered on behalf of the Minister of Health of the Republic of Indonesia at the Annual IFPMA Reception on the occasion of the 63rd World Health Assembly. Theme: Meeting UN MDG 5: the challenges of improving women's health. Geneva, May 19th 2010. Website: http://www.ifpma.org/fileadmin/templates/Events/2010/pdfs/20100519_WHA_Reception_Engko_Indonesia_19May2010.pdf, accessed on 11 October 2010.

139 Amnesty International interview with Latifah, West Java, 15 March 2010.

140 In a positive step, domestic workers were specifically included in the 2004 Domestic Violence Law. They are referred to as "the individual working to assist the household and living in the household" (Article 2.1 (c)). See Amnesty International 2007 report on domestic workers, Supra No 11.

141 The percentage of male domestic workers remains marginal. According to the ILO estimate, they comprise less than five percent of the total number of domestic workers. The ILO survey was conducted in 2002 by the University of Indonesia and the ILO International Programme on the Elimination of Child Labour (IPEC). The ILO estimates are based on an extrapolation method, in ILO, *Bunga-bunga di Atas Padas: Fenomena Pekerja Rumah Tangga Anak Di Indonesia*, [Flowers on the Rock: Phenomenon of Child Domestic Workers in Indonesia], (ILO, *Bunga-bunga di Atas Padas: Fenomena Pekerja Rumah Tangga Anak Di Indonesia* [Flowers on the Rock: Phenomenon of Child Domestic Workers in Indonesia]) 2004.

142 See ILO, *Bunga-bunga di Atas Padas: Fenomena Pekerja Rumah Tangga Anak Di Indonesia*, [Flowers on the Rock: Phenomenon of Child Domestic Workers in Indonesia]e Supra No 141, p20.

143 See Amnesty International 2007 report on domestic workers, Supra No 11

144 Email correspondence, 8 July 2010; and Amnesty International interviews, Jakarta, 9 and 12 March 2010.

145 See Ramirez-Machado, José Maria, *Domestic work, conditions of work and employment: A legal perspective*, ILO, Conditions of Work and Employment Series No. 7, 2003, pp9-15.

146 It is worth noting that a recent government study had found that unmarried female workers are also at risk of discrimination by their employers as they may ask for a marriage certificate from women to grant them access to maternity leave although no national level regulation requires it. In *Measuring the fulfilment of Human Rights in Maternal and Neonatal Health*, Supra No 87.

147 Amnesty International interview with human rights worker, Aceh, 22 March 2010; and email correspondence, August/September 2010.

148 The Manpower Act contains provisions allowing women to rest on the first and second day of their menstruation period if they feel pain and notify the entrepreneur about this (Article 81). Furthermore, entrepreneurs are required to provide a place or room to a woman who needs to breastfeed during working hours (Article 83).

149 Article 186.1.

150 See Amnesty International 2007 report on women domestic workers, Supra No 11.

151 Article 11.

152 Article 24 (2) (d).

153 Article 10 (2).

154 Amnesty International interview with Ita, Jakarta, 17 March 2010.

155 Amnesty International 2007 report on domestic workers documented how domestic workers often work very long hours and are allowed little or no rest. Those interviewed in 2006 worked an average of 70 hours a week, but many worked a lot more. Over the course of the research conducted in March 2010, Amnesty International also met domestic workers who worked very long hours with no break. Domestic workers who look after young children are particularly vulnerable to working long hours as they are asked to look after children at night, especially if they are sick, despite working long hours during the day. See Amnesty International 2007 report on domestic workers, Supra No 11.

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- 156 Some felt that they were viewed with suspicion when they were sick and although they wanted to rest they were obliged to continue working. In addition, very few domestic workers were trained on how to use potentially hazardous materials despite reports indicating that domestic workers are at serious risk of injuries in the household. In Amnesty International 2007 report on domestic workers, *Supra* No 11, p72.
- 157 See Article 24 (2) (d) of CRC to which Indonesia is a state party. This provides that states shall take appropriate measures to ensure appropriate prenatal and postnatal health care for mothers. See also ILO Conventions on Maternity Protection (183), which Indonesia has yet to ratify.
- 158 Amnesty International interview with Rini, West Java, 11 March 2010.
- 159 Amnesty International focus group discussion, Banten, 13 March 2010.
- 160 The commentary is based on a copy of the draft from April 2010.
- 161 Dr Susilo Bambang Yudhoyono, President of the Republic of Indonesia at the Sixth Annual Conference of the Parliamentary Network on the World Bank, Helsinki, Finland, 23 October 2005. Website: http://www.kbri-canberra.org.au/speeches/2005/051023_PresRI.htm, accessed on 7 October 2010.
- 162 Apart from being a signatory to the Millennium Declaration, Indonesia shows its commitment to the MDGs in the *State Policy Guidelines (Garis Besar Haluan Negara, GBHN)* and the *Five-Year National Development Plan*, p23. Website: http://www.undp.or.id/pubs/imdg2004/English/MDG-IDN_English_Complete.pdf, accessed on 7 October 2010. See also *2010 MDG Roadmap*, *Supra* No 8.
- 163 See for example Article 2(1) ICCPR; and Article 2 CEDAW.
- 164 Article 1, CEDAW.
- 165 Ministry of National Development Planning (BAPPENAS)/ National Development Planning Agency, Report on the Achievement of Millennium Development Goals Indonesia 2010, (*2010 MDG Report*), p6.
- 166 In its 2010 MDG Roadmap Report, the government highlights the following challenges: improving gender equality at all levels of education in all provinces; implementing law enforcement to ensure equal opportunities without discrimination for women and men in employment and in the job place; providing protection for women workers to ensure the fulfilment of their rights; and improving women's participation in legislative and political institutions. See *Supra* No 8, pp94–95.
- 167 See Komnas Perempuan, *Tak Hanya di Rumah*, *Supra* No 56.
- 168 See the Domestic Violence Law (2004); and the Anti-Trafficking Legislation (2007). At the local level, see for example, *Qanun Aceh No.6/2009 Tentang Pemberdayaan dan Perlindungan Perempuan* [Aceh Bylaw No. 6/2009 on the protection of women], 2009. See also *Combined fourth and fifth periodic reports of State parties: Indonesia*, *Supra* No 26, para 21 and paras 25-28. For further information on gender mainstreaming implementation in Indonesia, see *2010 MDG Report*, *Supra* No 165, p55.
- 169 See for example the President Decree No. 9/2000 on *Pengarusutamaan Gender dalam Pembangunan Nasional* [Gender Mainstreaming in National Development]; The National Plan of Action of Human Rights 2004-2009, Presidential Decree; *Pengarus-utamaan Gender dalam Bidang Kesehatan* [Gender mainstreaming in the area of Health], Ministry of Health, 2002; and the Strategic Plan for Family Planning by the National Family Planning Coordination Board 2004–2009, Indicator 1.5.
- 170 On the occasion of the 15th anniversary of the Beijing Platform for Action, the Commission on the Status of Women stated that “gender equality perspectives are not well reflected in the current formulation of many of the Millennium Development Goals and their targets and indicators, and are often not explicitly integrated in strategies and plans to achieve the Goals. There is insufficient coherence between efforts to implement the Platform for Action and the strategies and actions to achieve the Goals and this lack of coherence is a contributing factor in the uneven and slow performance towards realizing many of the Goals”, *Linkages between implementation of the Beijing Platform for Action and the achievement of the Millennium Development Goals: Moderator’s Summary*, UN Doc. E/CN.6/2010/CRP.7, 10 March 2010, para 2.
- 171 In *2010 MDG Report*, *Supra* No 165, p67.
- 172 In *2010 MDG Roadmap Report*, *Supra* 8, p122.
- 173 In *2007 MDG Report*, *Supra* No 8, p53.
- 174 Draft resolution referred to the High-level Plenary Meeting of the General Assembly by the General Assembly at its sixty-fourth session, *Keeping the promise: united to achieve the Millennium Development Goals*, UN Doc. A/65/L.1, 17 September 2010, para 75 (b) and (c).

175 Article 2, ICCPR; Article 2, ICESCR.

176 Article 26, ICCPR.

177 Article 2, CEDAW.

178 CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 11.

179 Article 16 (1) (e).

180 See ESCR Committee, *General Comment No. 14*, Supra No 81, para 21; CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 31 (b).

181 CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 21.

182 CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 1.

183 CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 2.

184 CEDAW Committee, *General Recommendation No. 24 (Women and Health)*, Supra No 104, para 11.

185 See CEDAW Committee, *General Recommendation No. 25*, 2004, para 12. Website: <http://www.un.org/womenwatch/daw/cedaw/recommendations/General%20recommendation%2025%20%28English%29.pdf>, accessed on 11 October 2010. See also ESCR Committee, *General Comment No. 16* (The equal right of men and women to the enjoyment of all economic, social and cultural rights), UN Doc. E/C.12/2005/4, 2005, para 3.

186 Report of the Special Rapporteur on the right to health, Supra No 136, para 10.

187 Report of the Special Rapporteur on the right to health, Supra No 136, para 28(b).

188 CEDAW Committee, *General Recommendation No. 24*, Supra No 104, para. 26. See also, the commitment of States enshrined in the Beijing Platform for Action, para. 32, to "intensify efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of such factors as their race, age, language, ethnicity, culture, religion, or disability, or because they are indigenous people."

189 CEDAW, OHCHR, UNIFEM, *Gender and Racial Discrimination; Report of the Expert Group Meeting*, 2000, p11.

190 See also the preamble of the Health Law.

191 ESCR Committee, *General Comment No. 14*, Supra No 81, para 14.

192 ESCR Committee, *General Comment No. 14*, Supra No 81, para 11.

193 ESCR Committee, *General Comment No. 14*, Supra No 81, para 21; and CEDAW Committee, *General Recommendation No. 24*, Supra No 104, para 8.

194 See Articles 17 and 24 of CRC; CRC Committee, *General Comment 4 (Adolescent health and development in the context of the Convention on the Rights of the Child)*, Supra No 104, paras 26 and 28; ESCR Committee, *General Comment No. 14*, Supra No 81, para 11; and CEDAW Committee, *General Recommendation No. 24*, Supra No 104, para 18.

195 Article 12, CEDAW; ESCR Committee, *General Comment No. 14*, Supra No 81, para 14.

196 ESCR Committee, *General Comment No. 14*, Supra No 81, para 14; Article 12, CEDAW; Article 24 (2) (b), CRC.

197 ESCR Committee, *General Comment No. 14*, Supra No 81, para 12 (d) and para 36. These paragraphs refer to "skilled medical personnel" in a general sense (para 14) and then "sexual and reproductive health", among other things (para 36).

198 ESCR Committee, *General Comment No. 14*, Supra No 81, para 14.

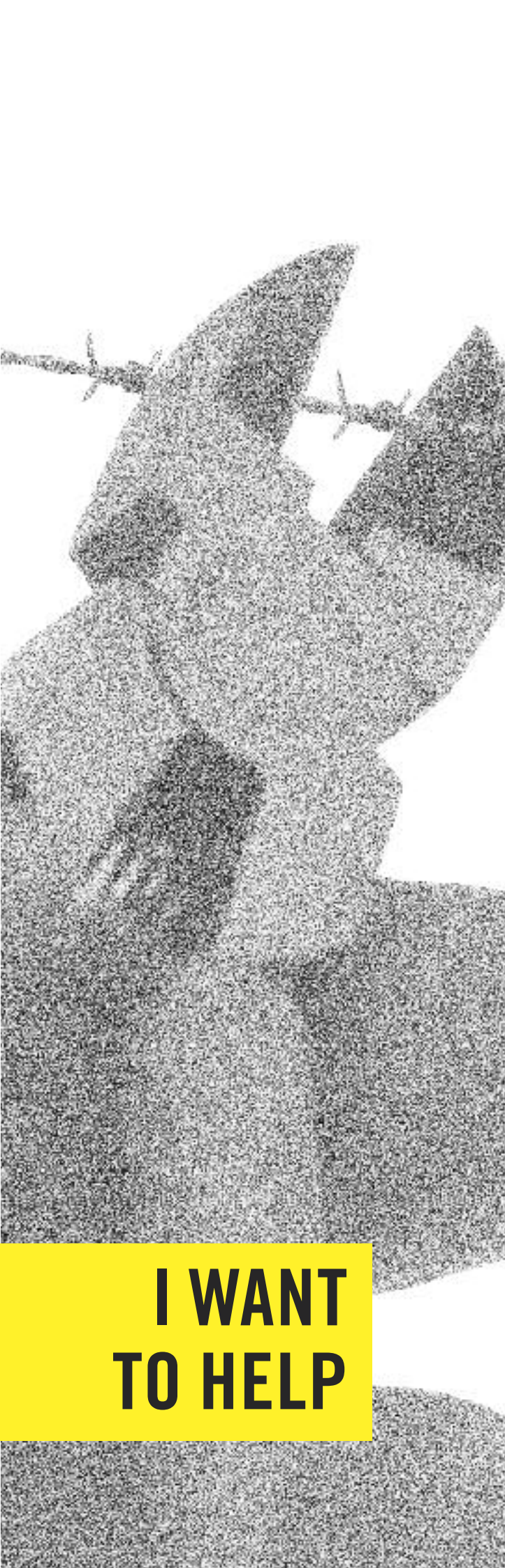
199 ESCR Committee, *General Comment No. 14*, Supra No 81; Article 12, CEDAW; Article 24.2(b), CRC.

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- 200 See Amnesty International, *Briefing to the UN Committee Against Torture* (AI Index: ASA21/003/2008), 15 April 2008. See also Amnesty International 2009 report on police accountability, Supra No 13.
- 201 Articles 4 (1) and 4 (2) of the ICCPR.
- 202 See *Final Conclusions of the UN Human Rights Committee*, UN Doc. CCPR/C/NIC/CO/3, 2008, para13.
- 203 Article 6, ICCPR.
- 204 *Human Rights Committee General Comment No. 6 (The right to life)*, April 1982, (*Human Rights Committee General Comment No. 6 (The right to life)*), para 5. Website: <http://www.unhcr.ch/tbs/doc.nsf/%28Symbol%2984ab9690ccd81fc7c12563ed0046fae3?Opendocument>, accessed on 11 October.
- 205 *Human Rights Committee General Comment No. 6 (The right to life)*, Supra 204, para 5.
- 206 See for example, *Concluding Observations of the Human Rights Committee on Zambia*, UN Doc. CCPR/C/ZMB/CO/3/CRP.1, July 2007, para 18. For other examples see Centre for Reproductive Rights, *Bringing Rights to Bear: Preventing Maternal Mortality and Ensuring Safe Pregnancy*, October 2008.
- 207 *Concluding Observations of the Human Rights Committee on Mali*, UN Doc. CCPR/CO/77/MLI, 16 April 2003, para 14.
- 208 ESCR Committee, *General Comment No. 14*, Supra No 81, para 59.
- 209 See Bivitri Susanti, "The Implementation of the Rights to Health Care and Education in Indonesia", in Varun Gauri (Ed.), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World*, The World Bank, September 2008, p229.
- 210 See for example, Amnesty International 2009 report on police accountability, Supra No 13.
- 211 See Article 55 of the Law on Medical Practices.
- 212 See Article 51 of the Law on Medical Practices.
- 213 See Articles 66-69 of the Law on Medical Practices.
- 214 The Indonesian Medical Disciplinary Board only received 19 complaints in 2008 and 36 in 2009. In *Tempo Interaktif*, "Belajar dari Kasus Budi", 31 May 2010.
- 215 See The Medical Ethics Board, "*Kode Etik Kedokteran Indonesia dan Pedoman Pelaksanaan Kode Etik Kedokteran Indonesia*", Indonesian Doctors Association, 2006. Website: <http://repository.usu.ac.id/bitstream/123456789/652/1/Kode%20Etik%20Kedokteran.pdf>, accessed on 11 October 2010.
- 216 The National Human Rights Commission is able to receive complaints on a range of human rights violations as outlined in the Law on Human Rights (No.39/1999). Article 49.2 and 49.3 of the Human Rights Act specifically relates to the reproductive health rights of women.
- 217 The National Commission on the Elimination of Violence against Women has a system to receive complaints on cases of violence against women. Website: <http://www.komnasperempuan.or.id/alur-pengaduan/>, accessed on 31 July 2010.
- 218 The Commission on Child Protection is able to receive complaints of violations of the Child Protection Law (Law No. 23/2002). Part 2 of the law is related to the health of a child.
- 219 See Amnesty International report on police accountability, Chapter 6.3.2 "The National Human Rights Commission – Komnas HAM", Supra No 13 pp56–57.
- 220 See Website: <http://www.ombudsman.go.id/Website/archive/Prosedur/1/id>, accessed on 11 October 2010; and Law No.37/2008, the Ombudsman of Indonesia. See also Amnesty International report on police accountability, Chapter 6.3.3. "The National Ombudsman", Supra No 13, pp58–59.
- 221 Speech delivered on behalf of Minister of Health of the Republic of Indonesia at the Annual IFPMA Reception on the occasion of the 63rd World Health Assembly. Supra No 138.
- 222 Indonesia has ratified the following ILO Conventions: Convention No. 19 on Equality of Treatment (Accident Compensation); Convention No. 27 on Marking of Weight (Packages Transported by Vessels); Convention No. 29 on Forced Labour; Convention No. 45 on Underground Work (Women); Convention No. 69 on Certification of Ships' Cooks; Convention No. 81 on Labour Inspection; Convention No. 87 on Freedom of Association and Protection of the Right to Organise; Convention No. 88 on Employment

Service; Convention No. 98 on the Right to Organise and Collective Bargaining; Convention No. 100 on Equal Remuneration; Convention No. 105 on the Abolition of Forced Labour; Convention No. 106 on Weekly Rest (Commerce and Offices); Convention No. 111 on Discrimination (Employment and Occupation); Convention No. 120 on Hygiene (Commerce and Offices); Convention No. 138 on Minimum Age; Convention No. 144 on Tripartite Consultation (International Labour Standards); Convention No. 182 on the Worst Forms of Child Labour; and Convention No. 185 on Seafarers' Identity Documents Convention (Revised). Website: <http://www.ilo.org/ilolex/cgi-lex/ratifce.pl?Indonesia>, accessed on 11 October 2010.

223 For further details, see Amnesty International 2007 report on domestic workers, *Supra* No 11.

224 Convention No. 138 was ratified in 1999, and Convention No.182 in 2000.



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LEFT WITHOUT A CHOICE

BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA

Women and girls face multiple barriers in fulfilling their sexual and reproductive rights in Indonesia – barriers which are rooted in gender discrimination.

A range of laws, policies and practices are discriminatory and reinforce gender stereotyping. Unmarried women and girls are denied full access to reproductive health services, while those who are married must seek their husband's consent to access some of these services. Such restrictions expose women and girls to unwanted pregnancies and other health risks.

These laws, policies and practices restrict women and girls from making decisions freely about their lives. And they can leave women and girls from poor and marginalized communities at an even greater disadvantage. Such barriers violate Indonesia's international human rights obligations to protect women and girls from discrimination. They also block the realization of the right to health, in particular sexual, reproductive and maternal health.

The Indonesian government has pledged to uphold the UN Millennium Development Goals. But if it is going to reduce gender inequality and improve maternal health in the country, then it must ensure that women and girls can enjoy their sexual and reproductive rights free from coercion, discrimination and the threat of criminalization.

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HEALTH IS A
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