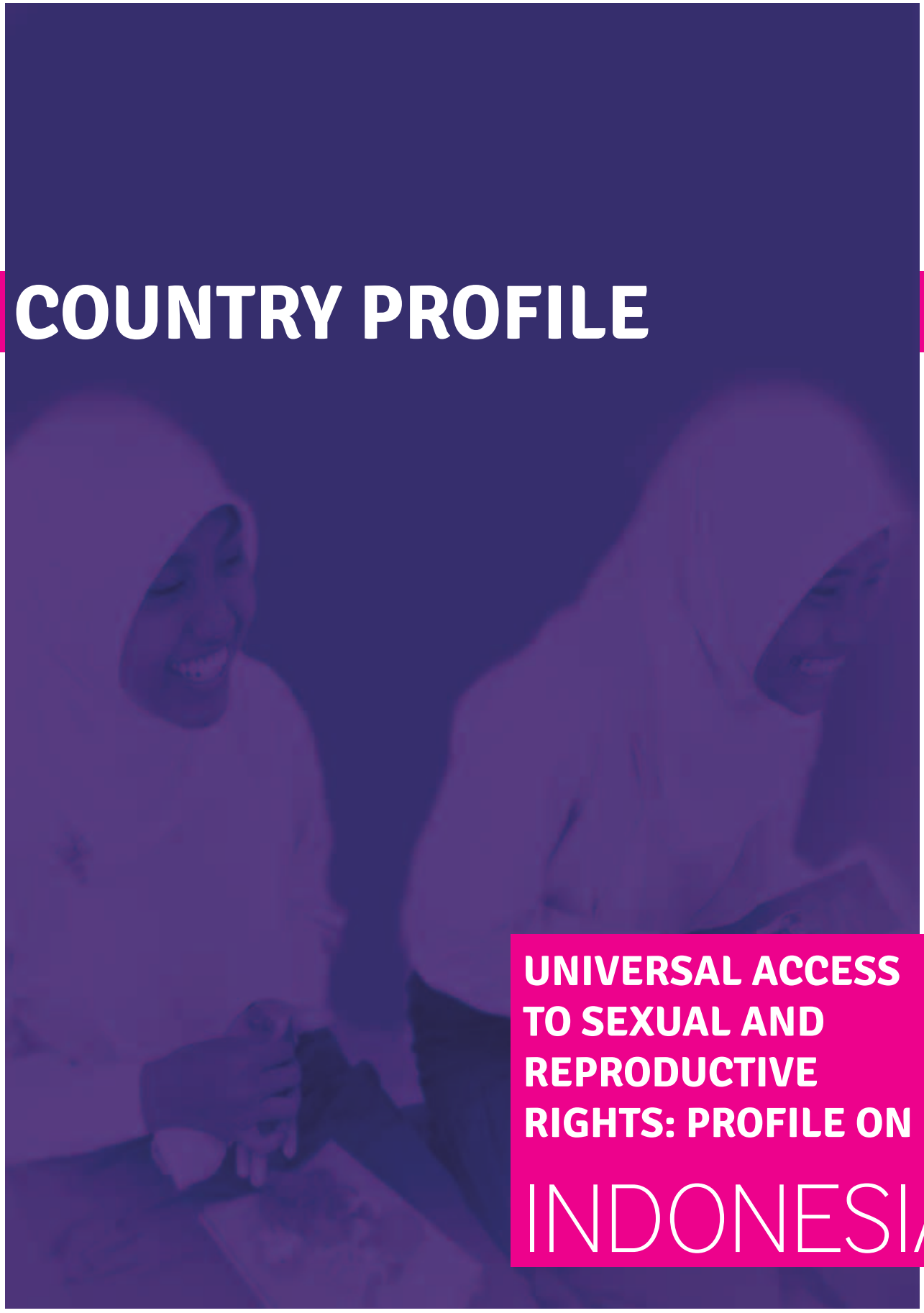
COUNTRY PROFILE



UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS: PROFILE ON

INDONESIA

1. Introduction

Indonesia is an archipelago of approximately 17,000 islands with a total population of 239 million people (2010 Census). The country is home to about 1340 ethnicities with different views on gender and sexuality issues and varying degrees of access to sexual and reproductive health and rights (SRHR), including relevant healthcare services (see Table 1).

Table 1. Basic demographic indicators

Population	2010
Total population	239,871,000
Population density (per km)	126,000
Child dependency ratio	40%
Old age dependency ratio	8%
Proportion of youth (%)	18 %
Life expectancy:	
▪ **Male**	68.7
▪ **Female**	72.6

Source: Indonesia DHS 2012

Access to SRH services varies from one area to another, subject to socio-economic conditions, geographic distance, and cultural beliefs. The country's reports on the International Convention on Population and Development (ICPD) Programme of Action have documented the interlink ages between poverty and health as obstacles to improving sexuality and reproductive health services, as well as other obstacles related to ethnicity, differences in perceiving socio-cultural beliefs, and gender inequality. Besides these, attempts to reduce the high maternal mortality ratio (MMR) remain unsuccessful and still pose problems to improving women's quality of life. These obstacles create difficulties for NGOs to engage in advocacies for SRHR regulation and policy reforms after the downfall of the Soeharto government in 1998.

The lack of a favourable environment for NGO participation in policy reforms affected progress in addressing universal access to SRHR for women and young people.

Enabling environment for NGOs in SRHR progress: 1994 – 2000

Indonesia was one of the 179 countries represented at the ICPD in Cairo in 1994. The Indonesian delegates at that time were the biggest in number, attended by high ranking government officers who were also the front liners of the Family Planning Bureau, aside from women's rights activists and scholars. Since then, the ICPD Programme of Action has been agreed to be the universal guide in formulating SRHR policies.

Several ICPD components, such as maternal and child health, family planning, adolescent reproductive health, male participation in reproductive health, HIV and AIDS, and violence against women have been put as specific programs in the Ministry of Health (MoH), National Family Planning Coordinating Board or BKKBN, and the Ministry of Women Empowerment (presently, the Ministry of Women Empowerment and Children Protection or KPPA).

In 1996, the Mother Friendly Movement (*Gerakan SayangIbu*) was officially launched by the Ministry of Women Empowerment. As part of the implementation of the ICPD Programme of Action, a national workshop on maternal mortality reduction was launched to support the Mother Friendly Movement, which promoted the importance of a multi-sector approach in reducing maternal mortality and improving women's quality of life. In the same year, the Commission on Reproductive Health was established where the relevant ministries MOH, BKKBN, KPPA, and Ministry of Manpower (*Kemenakertrans*) actively worked on maternal protection for female workers.

In 1998, after the fall of the Soeharto regime, the new environment provided for increased NGO engagement in the formulation of SRHR regulation and policies.

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Increasing NGOs participation in SRHR policy reforms: 2000 – present

After the downfall of the Soeharto government, Indonesia's newfound democracy and political system gave the opportunity to rights-based organisations to get more involved in SRHR policy reforms. They were able to provide input to the draft of a new Health Law introduced to the parliament in the early 2000s. The law was intended to replace the previous Health Law (No. 23/1992) which barely mentioned reproductive health and rights, prohibited all kinds of abortion, and imposed heavy penalty on abortion practices.

After more than 9 years of advocacy, the new Law on Health (No. 36/2009) was enacted and it contained for the first time a specific chapter that comprises of reproductive health components. Abortion, however, remained illegal. Unfortunately, the new law could not be immediately implemented because of the lack of Implementing Regulations for Operational Guidance.

As a way to address the lack of Implementation Regulation of the new law, another Law on Labour was drafted in the early 2000, which successfully incorporated several articles for maternal protection among female workers, with help from advocacies of women activists and unionists. In 2003, the Law on Manpower (No. 13/2003) was enacted. Article 82 (1) of this law stipulates that female workers are entitled to three months maternity leave that can be taken 6 weeks before and after delivery. In addition, Article 83 stipulates that "the company must provide facility and opportunity to breastfeed during working hours for female workers who are under breastfeeding period."

In 2000, the MoH launched the revitalization of its Maternal New Born and Child Health Program (MNCH), renamed Making Pregnancy Safer (MPS). Through this program, about 100,000 village midwives were re-trained using the new curricula at provincial health polytechnics. Those who finished the training received a Midwifery Diploma. Budget was provided by the provincial and/or district government.

After 5 years of advocating for a domestic violence law, the Law on the Elimination of Domestic Violence (No. 23/2004) was enacted in 2004. To implement this law, the Ministry of Women Empowerment issued an accompanying Implementing Regulations for Operational Guidance (No. 4/2006).

The regulation invites the involvement and cooperation of stakeholders in implementing the new law. In response, women's crisis centres that have been working on domestic violence issues (led by NGOs established in the 1990s) expanded its services to include hospitals and police offices. Hospital and police involvement are necessary to help survivors obtain legal and forensic evidence to support cases of domestic violence and bring such cases to criminal courts. For this purpose, special counselling desks with trained counsellors were established in hospitals and police offices.

Meanwhile, the Ministry of Women's Empowerment developed the National Strategic Plan 2005-2009 to further eliminate all forms of violence against women through a multi-sector approach involving law enforcement institutions, educational institutions, religious and cultural groups, faith-based organisations, healthcare institutions, the private sector, mass media, and other stakeholders.

In 2004, after many years of advocacy by civil society organisations to influence policy makers, the Law on the National Social Security System (SJSN) was enacted. This law provides universal access to healthcare for every citizen. It allowed for the setting up of a social insurance scheme that will cover all types of healthcare for citizens. A mandatory premium payment was to be implemented for social needs and risk sharing to cover healthcare costs. It was anticipated that it would take around ten (10) years for this law to be implemented, started from 1 January 2014. Under the scheme, SRH services will be covered, with the exception of health screening and chemotherapy. With the launching of this law, poor citizens from

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urban and rural areas will be guaranteed healthcare access by 2030, including family planning services. Strong political commitment by local governments is being encouraged to establish healthcare facilities, especially for the poor in urban and rural areas.

The MoH also implemented an adolescent reproductive health program in 2005. This program focuses on providing information and counselling for adolescents on reproductive health issues. Unfortunately, the capacity of *Puskesmas* or Community Health Centresin implementing the program is limited.

While the launching of the Millennium Development Goals (MDGs) in 2000 was met with positive response by the Indonesian government and NGO community, work on achieving the MDG targets only began in 2005, which was five years late. It was a good thing that the SRHR agenda has been mainstreamed in several policies, programs, and strategies coordinated by BAPPENAS (National Development Planning Bureau).

In 2010, the Government of Indonesia set a national target to address each health-related goal to achieve the MDGs by 2015. The government acknowledged the following gaps that require a special attention:

- MDG5 to reduce MMR was not on track as MMR was still above 200 in 2010. The target was to reduce MMR to 102 by 2015, but MMR increased dramatically to 359, placing Indonesia behind neighbouring countries, such as Malaysia, Thailand, and the Philippines.
- MDG 5B to increase contraceptive use among married women (15-49 years old) was not on track in 2010.
- MDG6 was also not on track since there has been no significant progress to reduce the HIV/AIDS prevalence and HIV cases increased.

2. Sexual and Reproductive Rights Status in Indonesia

Policies on sexual and reproductive health

The Law (No. 36/2009) on Population and Family Development and the Health Law (No. 36/2009) stipulate that only married women can have access to family planning services (particularly contraceptives), excluding both adolescent and unmarried women from these services. This has caused a significant number of women and young girls at great risk of unwanted pregnancy and sexually transmitted infections.

The Health Law (No. 36/2009) prohibits abortion except for the purpose of protecting the life of the mother and the infant and in rape cases.

Table 2. Data on sexual and reproductive health in Indonesia

Maternal Mortality Ratio (maternal deaths per 100,000 live births)	359/100,000
Birth attended by skilled health personnel (percent)	83.1 %
Contraceptive prevalence rate (percent)	61.9%
Adolescent fertility rate (birth per 1,000 women ages 15-19)	48.4/1000
Antenatal care with health personnel (percent)	87.8 %
Unmet need for family planning (percent)	11.4 %

Source: Indonesia DHS 2012

In 2008, Indonesia launched a special insurance program for the poor and nearly poor called "Jaminan Kesehatan Masyarakat (Jamkesmas)." This insurance program provides financial coverage for reproductive health services such as contraceptives, antenatal care, skilled birth attendance, care for normal deliveries, complications arising in deliveries, and postnatal care.

Grounds under which abortion is legal

The Law on Health (No. 23/1992), enacted in 1992, included, for the first time, an article on abortion. This was submitted to parliament and lead to a debate among parliament members. Conservative religious leaders made strong statements against the legalisation of abortion, but a consensus was made to delete the term of abortion in the draft of Article 15 and replace it with the less objectionable: "*tindakan medi stertentu*" or "a certain medical procedure." Unfortunately, this has always been interpreted as abortion and the practice remained illegal. Moreover, menstrual regulation, which was tacitly accepted by the Indonesian society and many healthcare providers during the 1970s-1980, became a controversial issue after the enactment of the Health Law, because this has been used to legitimise abortion in early months of the foetus.

Today, abortion remains controversial in Indonesia. While the present Health Law (No. 36/2009) stipulates that abortion is allowed to save a mother's life, in rape cases, and in incestuous pregnancies within the gestation limit of not more than 6 weeks, the law cannot be implemented because the *Peraturan Pemerintah* or Government Operational Regulation by the MoH has not been released.

Without the operational guidelines, safe abortion services in public facilities remains difficult to access. Health providers tend too reluctant to provide the service, coming from a one-sided interpretation of the Hippocratic Oath (*sumpah dokter*) and religious beliefs. This situation has led to illegal abortion practices in shady clinics offering the service at high costs, thereby and putting women's lives at risk. There is great probability that unsafe abortion contributes significantly to the country's high MMR.

In Indonesian culture, pregnancy outside marriage is not acceptable, resulting in a high number of pregnancy terminations among young unmarried women. The Indonesia DHS 2012 shows that 50.7% of female and 40.3% of male respondents knew someone who has aborted a pregnancy (see Table 3 below). Many cases of pregnancy termination occur among young people ages 15-24.

Table 3.Experience of unwanted pregnancy among friends (age 15-24 years)

Knows someone who has aborted a pregnancy	
Women	50,7 %
Men	40.3 %

Source: Indonesia DHS 2012

Policies on HIV/AIDS

Every 25 minutes in Indonesia, one person is newly infected by HIV. One out of every five newly infected people is below the age of 25 years. - UNICEF, 2012

According to UNICEF, HIV/AIDS in Indonesia is primarily transmitted through is sexual intercourse, followed by illegal drugs injection (2012). The government has not had a regulation on prohibiting arbitrary discrimination on HIV status, but one chapter in Law No. 36/1999 prohibits discrimination against people living with HIV.

Unfortunately, this has always been interpreted as abortion and the practice remained illegal. Moreover, menstrual regulation, which was tacitly accepted by the Indonesian society and many healthcare providers during the 1970s-1980, became a controversial issue after the enactment of the Health Law, because this has been used to legitimise abortion in early months of the foetus.

The MoH also released a policy on the prevention of HIV/AIDS and universal access to healthcare by people living with HIV/AIDS (Regulation No 21/2013). This regulation stipulates two fundamental rights to people living HIV/AIDS: first is the right to health and second is the right to be free from service discrimination.

Indonesian culture perceives HIV/AIDS through a moral lens. People living with HIV face many complex forms of discrimination and stigma, such as rejection in the workplace, in schools, and other public facilities. There was a case involving an elementary school student that dropped out of school because her parents were HIV positive. In many companies, people living with HIV are generally not accepted as employees and can be retrenched from their jobs if they are found to be HIV positive. Stigma and discrimination remain key barriers to HIV prevention, treatment, and care. Many people still perceive people infected with HIV/AIDS as immoral, and hence are discriminated against and ostracised from society. Stigma experienced by people living with HIV/AIDS inhibits them from seeking public health services as many health providers still have misconceptions about HIV/AIDS.

Confidentiality in HIV/AIDS testing, diagnosis, treatment, care, and support are not specifically mentioned in the Health Law. In addition, most health insurances, particularly private insurances, do not cover HIV/AIDS. Poor knowledge and understanding of HIV/AIDS have resulted to poor access to health services. Indonesia DHS 2012 shows that only 11% of women aged 15-49 years and 12% of men 15-54 years have comprehensive knowledge of HIV/AIDS.

Policies on adolescent sexual and reproductive health services

Indonesia ratified key international human rights conventions, including the Convention on the Elimination of Discrimination Against Women (CEDAW), the Beijing Platform of Action (BPFA), and the ICPD. These conventions uphold universal access to SRHR and services, including for adolescents, but Indonesia has yet to adopt laws in accordance to these conventions.

The Law on Population and Family Development (No. 52/2009), mentioned earlier, includes provisions on family planning services, but only for married couples. Actually, Articles 136–137 on Adolescents' Health of the Health Law (No. 36/2009) stipulates the government's responsibility to provide information, education, and services to adolescents as long as it is not against moral and religious norms. While moral and religious norms may be open to different interpretations, the Articles actually exclude young unmarried people to access SRH information and services.

Indonesia not only ratified and signed the Convention on the Rights of the Child, but also enacted the Law on Child Protection (Law No. 23/2002) which states that every child shall have the right to health services and social security in accordance with their physical, mental, spiritual, and social needs. However, the interpretation of these "needs" is limited by other laws. The Penal Code, for instance, criminalises people who provide information related to the prevention and termination of pregnancy (Articles 283, 534, and

Table 4.HIV/AIDS Context

HIV prevalence rate (15-49):	**0.2 %**
HIV prevalence rate in young females (ages 15-24):	0.1%
HIV prevalence in young males (15-24):	0.3%
HIV prevalence in vulnerable groups:	
▪ Sex workers:	10.2%
▪ Injecting drug users:	52.4%
▪ Men who have sex with men	5.2%
Number of death due to AIDS:	8,700
Percentage of population 15-24 years with comprehensive knowledge of HIV/AIDS	10.8%

Source: Indonesia DHS 2012

535). This is further supported by the Law on Pornography (No. 44/2008) that prohibits people to distribute information on sex education. These laws do not clearly stipulate the difference between pornographic and education materials on SRHR. SRHR material may contain information on sex that can be associated with pornographic materials, and the distribution of such material is illegal and punishable by imprisonment.

Sexual activity among young people in Indonesia begins early, especially for girls. A survey among unmarried young people aged 10-24 years found that across Indonesia 1% of boys and 4 % of girls have reportedly had sexual intercourse before the age of 13 years. By the time they reach 17, about a third of them will have at least one sexual encounter (Riskesdas, 2010 in UNICEF, 2012).

Meanwhile, according to Indonesia DHS 2012, 37.7 % of women aged 15-19 reported having difficulties in accessing healthcare. There are some social and financial barriers to girls and young women to access SRH services, including the following:

- **Costs** of services
- **Fear** of stigma from families and friends
- **Waiting times** for services and results
- **Lack of privacy** and confidentiality
- Traditional **norms of gender inequality**
- **Taboo** surrounding unmarried women accessing to SRH services
- **Limited facility of transport to services and**
- **The need of accompanying during treatment**

The above problems hinder women, particularly young ages and girls living in rural areas, from seeking health services. The quality of services still does not meet between acceptable medical and ethical standards.

Early pregnancy, early marriage, and adolescents' access to sexual and reproductive health information, education, and services

According to Law on Marriage (No. 1/1974), the minimum marrying age is 16 years for women and 19 years for men. This law contradicts the Law on Child Protection (No. 23/2002) where a child is defined as someone below 18 years of age, which may imply that Law on Marriage (No. 1/1974) promotes child marriage.

In some areas in the District of Bogor and Cianjur, the number of child marriage and maternal death are high, implying a positive correlation between the two. According to the District Head of Bondowoso, the high number of child marriages in the area is due to extreme poverty.

The Women's Health Foundation (YKP) has been actively advocating against child marriage, particularly in Bondowoso. The YKP's anti-child marriage campaign is also appealing for a judicial review of the Law on Marriage (No. 1/1974) to increase the minimum marrying age. The anti-child marriage campaign also provides additional leverage to promote the government's12 years compulsory schooling program.

The Law on Marriage (No. 1/1974) not only contradicts the Child Protection Act, but also goes against international conventions that have been ratified by Indonesia such as the CEDAW and the Convention on the Rights of the Child, both of which state that early marriage and early pregnancy are harmful.

Table 5. Barriers in accessing health care by women aged 15-49

REASON	PERCENT
At least one problem accessing health care	37.7%
Not wanting to go alone	23%
Getting money needed for treatment	15%
Distance to health facility	11%
Getting permission to go for treatment	5%

Source: Indonesia DHS 2012

Moreover, in the context of equality between women and men, CEDAW calls the member-states to formulate appropriate indicators to eliminate discrimination against women, putting into question the difference between the marrying age of women and men in Indonesia. Further more, the Convention on the Rights of the Child recommends that the minimum age of marriage is at 18 years for both girls and boys. This consideration is consistent with the Child Protection Law that states anyone below 18 years is considered as a child and requires parental consent in marriage to prevent underage marriages (Article 26).

Parents reasons for pushing for early marriageof their children

The people in the District of Gunungkidul (DI Yogyakarta Province) tend to marry their pregnant girl-child primarily for the sake of family's moral status, without regard for the age of their girls. The second most common reason is to save them from poverty.

According to the Law on Marriage (No. 1/1974), the marrying age of girls is 16 years old. However, there are many cases where girls at the age of 10 to 14 years old were married as a way out of poverty. In remote villages, girls were married to older men in exchange for money, often to pay back a family loan. This is one of the main reasons for the increasing requests for marriage dispensation to the Religious Courts, (i.e., exemptions to marry underage children),thereby circumventing the Law on Marriage that already stipulates very early marrying ages. Data from the District Gunungkidul Religious Court shows that requests for marriage dispensation increased from 90 in 2009 to 145 in 2011. In the first half of 2012, there have been 79 requests (See Table 6). The Religious Court deals with brides ages between 14-years to 19-years old.

Source:Fact Sheet,Reproductive Information for Teens and Women Also Helps End Early Marriages, 2013, Women's Reserach Institute.

It appears that the Law on Marriage (No. 1/1974)is not consistent with international conventions that Indonesia has ratified. The law is also not consistent with various national laws. These inconsistencies have led to advocacies to push the minimum age of marriage to 18 years for both girls and boys.

It has been known that early child marriage leads to early childbearing. Many experiences have been recorded that this also harmful for both mother and new-born baby. In Indonesia:

- The age of first marriage has been slowly increasing within the last two decades, while educated women marry at a later age than normal. In remote conservative areas, girls marry at 15 years and even younger. Yet, the age of early childbearing varies considerably from province to province or from district to district, depending on the level of religious conservatism and cultural values.
- In 2002-2003, the percentage of women age 15-19 years that bore their first child is 10.4%.
- In rural areas, the percentage of adolescents who started bear children is twice more than the percentage in urban areas (14% and 7% respectively).
- Evidence also shows that unmarried adolescents are unable to access reproductive health services.
- Reproductive health and sexuality knowledge among adolescents is still limited. For example, more than half of adolescents know the human reproduction process, but only less than 30% of them know of HIV/AIDS prevention.

Table 6. Data of marriage dispensation requests in Gunungkidul

Year	2009	2010	2011	2012/June
Number	90	120	145	79

Source: Religious Court of Wonosari, 2012, Women Research Institute

Table 7. Legal age at marriage

Without parental consent:	
Male 21	Female 21
With parental consent:	
Male 19	Female 16

Source: Indonesia DHS 2012, Adolescent Reproductive Health

- Median age at first marriage for women (ages 15-49) : 20,4 years
- Median age at first marriage for men (ages 15-49) : 24,3 years

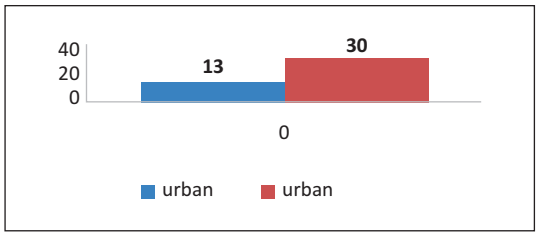
According to the Indonesia DHS 2012, urban women between 25 and 49 have their first sexual intercourse two years later than those in rural areas (21.8 years compared to 19.4 years). The median age of having first sexual experience for women between 25 and 49 who have completed secondary education is 23.1 years, and this is five years later than the median age with no education (17.5 years). The median age of women who have their first sexual experience increases according to their economic status. The median age of having first sexual experience for women age 25-49 is in the highest economic status, which is three and a half years later than the median age for women in the lowest wealth quintile (22.8 years compared with 19.3 years).

The median age of having first sexual experience for urban married men between 25 and 54 is 24.6 years, two years later than that of rural men (23.1 years). The median age of having first sexual experience for married men increases according to educational attainment. For example, the median age of married men with secondary education who had their first sexual experience is 23.2 years, two years later than among men with no education (21.4 years). Economic status is also related to age of the first sexual experience among married men. The median age of first sexual experience of men between 25 and 54 in the fourth wealth quintile is 24.1 years, one and a half years later than those in the lowest wealth quintile (22.6 years).

According to the Indonesia DHS 2012, urban women between 25 and 49 have their first sexual intercourse two years later than those in rural areas (21.8 years compared to 19.4 years). The median age of having first sexual experience for women between 25 and 49 who have completed secondary education is 23.1 years, and this is five years later than the median age with no education (17.5 years).

Table 8. Child Marriage, 2007

Proportion of females 20-24 years who were married by age 18



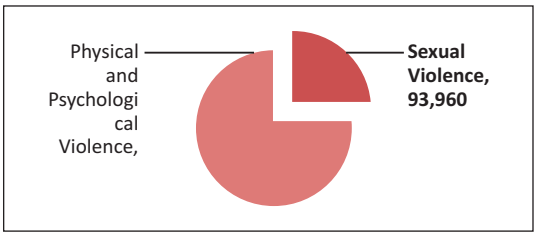
Source: Child Marriage 2007

Extent of gender-based violence

In Indonesia, the only institution which systematically collects data on violence against women is the National Committee on Violence Against Women (*Komnas Perempuan*). The process of data gathering is collected annually by involving NGOs that have been working on VAW issues. The latest report (2012) shows that there were 216,156 cases of violence against women between 25 and 40 years of age. This number has doubled from the previous year, and around 12,649 cases were gathered from NGOs. From this figure, a total of 211,822 cases are categorized as personal cases (*kekerasan di ranah personal*), meaning violence is perpetrated by a person of blood relation (father, uncle, brother, grandfather), or in a marital (husband) or intimate (boyfriend) relationship. The number includes 8,315 cases (66% or out of 12,649 cases which is collected from NGOs. Among all personal cases (8,315 cases) sent by NGOs, 42% or 4,305 cases were women assaulted by their husbands, 29% or 2,428 were other personal cases, and 13% or 1,085 were dating violence; they come from age group 25-40 years old. In the public sphere, there were 4,293 cases or 34% of the total number.

Violence occurs both in domestic and public or community spheres. The perpetrators could be anyone such as one's boss, neighbours, teachers, college professors, community leaders, or strangers. More than a half of these violence cases were sexual violence (2.521 cases or 59%) where about 840 of those cases were rape (840 cases) and molestation (780 cases).

Table 9. Gender-based violence vs. sexual violence 1998-2010 (with total cases: 400,939)



Source: Komnas Perempuan, Kekerasan Seksual- Kenali & Tangani, 2013.

Legislation related to gender-based violence

The year 2004 has been considered as a very important year for women in Indonesia. After 8 years of advocacy by women activists and scholars, Indonesia enacted Law No. 23/2004 on the Elimination of Domestic Violence, which provides legal protection to survivors, offers integrated recovery programs, and establishes measures to prevent future violence.

The Law explicitly states that any physical, psychological, and sexual violence as well as economic abandonment within domestic area are considered criminal. Also, the law provides protection from marital rape. Under the law, perpetrators could be charged of heavy penalty (minimum of five years in jail or a fine of 15 million rupiah). Furthermore, the law also enumerates the responsibilities of governments and other stakeholders, healthcare personnel, and social workers in providing integrated recovery support to survivors.

Unfortunately, the Law 23/2004 is not properly implemented. Many law enforcement officials are still unfamiliar with domestic violence issues (Jakarta Post 18 Nov, 2006). This is because information on domestic violence is not widely written in news, articles, and human right documents. Besides, domestic violence against women in Indonesia is underreported (Jakarta Post 9 Dec, 2006) and the real number can be very high. The reason why survivors reluctant to report their case is because this often jeopardises her position in the household, as she is economically dependent to her husband. Also, women are not supposed to tell of her husband's fault, as this against socio-cultural norms. Many women have limited information and understanding of the services available to them.

Although sexual violence occurs repeatedly and continuously, and thus increases in numbers, not many people understand and consider this issue, including the government. Sexual violence is often regarded as a personal issue rather than public one. In the Penal Code, sexual assault is considered an offense against decency. This shallow interpretation does not only reduce the degree of rape, but also creates the wrong opinion that sexual violence is related to women's morality, and thus, tends to blame the victims.

The legal basis for security protection from sexual violence in Indonesia include the following:

1. Penal Code Section 285, 286, 287, 290, 291
2. Law No.23 of 2004 on the Elimination of Domestic Violence Section 8 (b), 47, 48
3. Law No. 21 of 2007 on the Eradication of Trafficking in persons, Article 1 (3.7)
4. Law No.23 of 2002 on Child Protection Article 1 (15), 17 (2), 59 and 66 (1,2), 69, 78 and 88

Legislation and policies on sexual orientation

Indonesia does not have any specific law or regulation on sexual orientation. None of the existing laws mentions that homosexuality is prohibited or permitted, including the Penal Code. The Law No. 39/1999 on Human Rights stipulates that every person is equally treated and every person should not be discriminated against any treatment on any grounds.

However, there have been many cases in which homosexuals were attacked by conservative groups, especially Muslim extremists. Police protection is non-existent. Basically, if you have a different sexual orientation, you are a victim of daily violence.

Table10. Indonesia policy on sexual orientation

Same-sex sexual activity	Same-sex marriage	Anti-discrimination (Sexual orientation)	Laws concerning gender identity
Unknown	Prohibited	Every citizen should not be discriminated on any grounds	Unknown

Legislation and policies on gender identities

Similar to sexual orientation issues, there is no specific law or regulation related to gender diversity. There is no single law that prohibits or allows it. Yet, people have different sexual orientation or gender identities are more acceptable by the community or general public. Many ethnicities have their own history of homosexuality and transgender people, and some of these stories are written in legends, fables, and even on temple's relief. Some of Muslim extremists groups, however, reject the LGBT people, referring to Quranic verses and *hadits* (Muhammad practices) which states" it is a sin if a man is cross-dresser."

While there is no specific law on gender diversity issues, gender and identity can be changed easily in the civil registry by showing psychiatric diagnoses and declaration by the courts. Different gender identities are accepted in certain work environments such as beauty parlours, fashion, and entertainment, among others.

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Grievance redress mechanisms for sexual and reproductive health services

Discrimination in access to sexual and reproductive health services still exist in Indonesia, especially for the unmarried population. Unmarried people have difficulties in accessing SRH services. Young and unmarried women have difficulties in accessing contraceptive services as the Law (No. 52/2009) stipulates that contraceptive use is only for married couples. It also does not clearly state what SRH services are available for the LGBT community.

Given the fact that SRHR is not yet fully understood by many policy makers, grievance redress mechanisms are not available. When conflict occurs between homosexual groups, they solve this by themselves. For example, there was a case when a transgender was refused in entering a restaurant during New Year's Eve because of her status. The SRHR NGOs Alliance sent a condemnation letter to the Restaurant Association. Although the Health Law states that health services is provided to all citizen, transgender people are often refused health services. In hospitals where women and men have separate wards, arguments as to which rooms transgender people will be placed are very common. Since there is no grievance mechanism, they can only bring the issue to the media, which does not have any solution. This situation has brought gay and lesbian groups to set-up their own crisis centres to solve their respective problems.

3. Recommendations

Maternal health

- Monitor the implementation of the National Health Insurance scheme, introduced in January 2014, to ensure that the maternal health package is included in universal health coverage.
- Identify strategies to strengthen emergency obstetric care, including human resources, along with the availability of funding sources.
- Review the quality of services of health service providers in the community level, including regular maternal death auditing.
- Improve coordination of the work of health service providers in the services delivery system at all levels: national, provincial, district, and community levels.
- Monitor the implementation of the universal health insurance scheme particularly for the quality of services of maternal and neonatal health, including home delivery in remote areas regardless social class, religion, ethnicity, and gender identity.
- Implement Action Plan 2013-2025 for Accelerated Reduction of Maternal and Neonatal Mortality. The three key strategies identified in the action plan include (1) improve the quality and coverage of maternal health services; (2) support any attempt to change regulation in district level in order to improve access and quality of services; and (3) create enabling partnership with private sectors. Moreover, the Plan needs to be reinforced by enhancing skills of midwives, implementing quality assurance, and improving access to basic and comprehensive emergency obstetric care.

Family planning

- Revitalize family planning programs and address unmet needs of every citizen regardless of marital status.
- Ensure maternal healthcare particularly among girls and young women. This issue should be mainstreamed to relevant government policies to create a strong framework for integrated implementation.
- Build the capacity of district government to manage, implement, and monitor the family planning program. This is long-term human investment to improve health condition.
- Ensure equity access to family planning is included under the new National Health Insurance Scheme and that the services are also accessible to minority groups, regardless of marital status, ethnicity, and religion.

Adolescent reproductive health

- Address comprehensive sexuality education as major area of concern for most Indonesian adolescents. Response from the Ministry of Education and Culture is needed, particularly to connect between SRH, HIV/AIDS prevention, and anti-drug campaign in one integrated subject in the school curriculum. An integrated strategy is needed to ensure this subject is implemented. There has been an ineffective SRH textbook with messages about abstinence and relates these issues with moral values, which is far from the day-to-day reality faced by young people. This is because the response from government schools is limited. While some private schools have been responsive, comprehensive sexuality education needs to be implemented at the national scale. For this purpose, training for teachers is important to prevent judgmental attitude, stereotyping, and stigma.
- Increase awareness of the necessity of SRH services for adolescents, in face of the growing resistance from strong political and conservative opposition for providing service access for young people. The Health Law (2009) contains two articles on the rights of adolescents to access SRH education and services. However, the implementation of the law still varies from one area to another, subject to the way health providers interpret the law.

Abortion

- Increase advocacy for safe abortion services. Abortion is basically prohibited, although the Law (No. 36/2009) on Health allows the practice under certain conditions. Abortion is the leading cause of maternal death in Indonesia, although there is no exact figure, and the number of maternal deaths caused by complications during abortion is increasing, particularly among women below 20 years, majority of whom are single or divorced women. Many die in the hands of private doctors. This condition shows that most of these women went to a traditional birth attendant first and went to practitioners when complication has occurred. While the MoH has released a Government Regulation (GR) or Ministerial Decree on abortion, it limits abortion to certain preconditions. Nevertheless, this GR provides protection for some women in need of safe abortion.

HIV/AIDS

- Provide education materials to empower women and girls to have choices on reproductive health issues. This is because HIV/AIDS issues cannot be separated from reproductive health and rights issues.
- Raise public awareness, particularly among parents and religious/traditional leaders, about the right to information on HIV/AIDS. This is important to empower girls and young women to protect themselves from HIV infection.
- Ensure that every HIV positive person has access to healthcare and services without any discrimination on their HIV status, gender identity, and religion.
- Strengthen the role of the National AIDS Commission at the national, provincial, and district levels in selecting, prioritising, and scaling up effective interventions to control HIV/AIDS prevalence. As a coordinating agency, the commission will also promote and strengthen local, national, and international networks, and partnerships to achieve universal access to prevention, care, support, and treatment services.
- Strengthen the commitments and efforts to reduce HIV prevalence through sexual transmission to 50%. This is because the new HIV infected includes married women.
- Implement PPTCT (prevention of parent-to-child transmission of HIV/AIDS), by providing access to quality services for HIV positive pregnant women, and efforts should be made to reduce stigma and discrimination, particularly in accessing life-saving emergency services.
- Establish comprehensive and rights-based integrated response to HIV, where there is no discrimination and stigma by service providers, including the guarantee and fulfilment of the rights of people living with HIV/AIDS.

Child marriage

- Review and amend the Marriage Law (No. 1/1974) for discriminative articles against women, including minimum age of marriage and polygamy; and improve the language of the law to remove gender stereotypes.
- Ensure that religious courts comply with Law No. 23/2002 on Child Protection and obligations under the Convention on the Rights of the Child to prevent early marriages.
- Conduct a public education campaign to eliminate gender stereotypes and raise awareness on medical and social risks of early marriage.

Gender-based violence &sexuality

- Reform the laws related to the minimum legal age for marriage to reflect equality.
- Improve advocacy for integrated services between the police, hospitals, and crisis centres in providing psychological recovery programs for survivors.
- Provide legal aid for survivors.
- Provide training for police officers to enhance counselling skills.
- Increase the number of crisis centres for integrated recovery services for survivors and inform their service availability to the public.
- Enhance the capacity of the National Disaster Management Agency to address gender-based violence especially during emergencies.
- Expand facility services to include people of diverse sexual orientation and gender identities who are victims of domestic violence. The Law on Domestic Violence (No. 23/2004) needs to be enforced in such cases.
- Maximize the role of media to disseminate positive image of the diversity sexual orientation and gender identities, to eliminate stigma, stereotyping and discrimination.
- Conduct sensitisation training among law enforcement officers on a regular basis.

Sexual orientation

- Open more shelters for LGBT survivors, as they are often violated by the state, police, and even their immediate family.
- Recognise sensitive condition of LGBT people by law enforcement officers, and actively take action to protect them from any type of violence, including eliminating stigma and discrimination.
- Bring violence perpetrators to the courts, and take initiative or help survivors in proceeding with the lawsuit.

Non-discrimination towards SRHR as a prerequisite for Post-2015 development agenda

- Create enabling environment for people to achieve good health condition by ensuring the provision of universal access to SRHR information and services without any discrimination. Discrimination hinders access of marginalised and vulnerable people to these healthcare services.
- Enhance Gender Mainstreaming Strategies developed by the Ministry of Women Empowerment to include SRHR materials. This is an integrated step to empower and protect women from unexpected illness in more structured way.
- Enact policies to support non-discrimination and implement zero tolerance on violence against women.

4. References

Amnesty International. 2012. Indonesia: Briefing to the UN Committee on the Elimination of Discrimination Against Women.

Gender-related development index. http://hdr.undp.org/en/media/HDR_20072008_GDI.pdf.

ICPD Global Review Report. 2013. Indonesia Demographic and Health Survey 2012. HTTP://DHSPROGRAM.COM/PUBS/PDF/fr275/fr275.pdf.

Indonesia Demographic Health Survey. 2012, Adolescent Reproductive Health.

Indonesia Demographic Health Survey. 2012.

Komnas Perempuan, Kekerasan Seksual-Kenali & Tangani, 2013.

Komnas Perempuan.2012. *Lembar Fakta Catatan Tahunan (CATAHU) Komnas Perempuan Tahun. Korban Berjuang.* 2013. *Publik Bergerak: Menyoal Stagnansi Sistem Perlindungan Negara Terhadap Perempuan Korban Kekerasan.* Jakarta, 7 Maret 2013.

The World Bank. 2014. Health expenditure, total (% of GDP). Retrieved March 4, 2014, from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries?page=1&display=default

UNFPA Indonesia. 2013.Universal Access to reproductive Health in Indonesia – Progress and Challenges.

UNFPA. 2013.Indonesia: The ICPD+20 and the Unfinished Agenda.

UNICEF Indonesia.2012. "Responding to HIV and AIDS. "In *Issue Briefs*, October 2012.

UNICEF Indonesia. 2012. Issue Briefs. from Responding to HIV and AIDS: Retrieved March 10, 2014.http://www.unicef.org/indonesia/A4-_E_Issue_Brief_HIV_REV.pdf.

WHO. 2006. 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. Jakarta: WHO, Ministry of Health of the Republic of Indonesia.

WHO. Adolescent Pregnancy: Issues in adolescent health and development. Jenewa: WHO, 2013. http://www.who.int/maternal_child_adolescent

Women Research Institute. 2013. Fact sheet on March 2013. Reproductive Information for Teens and Women Also Helps End Early Marriages.

About Yayasan Kesehatan Perempuan

Women's Health Foundation (YKP) was established in Jakarta on June 19, 2001. Most of the founders YKP consisted of activists of Women's Health Forum (FKP). This forum was formed in early 1990 by a group of individuals who care about the state of women's reproductive health in Indonesia by responding directly about issues of women's reproductive health was considered controversial. In subsequent years, more systematic strategy focused on meeting the reproductive health rights of women is still neglected. Therefore, the perceived need for a non-profit foundation that regulate a variety of activities, focused to achieve a state in which every Indonesian women can enjoy their reproductive health rights and obtain legal protection

Vision: To achieve an Indonesian society which guarantees that every woman receives her rights to sexuality and reproductive health rights without discrimination, without mistreatment, and without pressure or violence from any parties whatsoever, and is therefore free from exploitation, illness, and unnecessary death.

Mission:

1. To work toward guaranteed legal protection for women, girls, the young, minority groups, and the differently-able to enjoy their sexual and reproductive rights as part of their basic human rights.
2. To realize universal access to reproductive health care that is of good quality and affordable for women and marginal groups, without discrimination.
3. To raise the public's awareness about reproductive rights and equality of women and men so that they can actively demand their reproductive health rights.
4. To urge the various authorities to reduce the maternal mortality rate.
5. To strengthen the organizational and institutional capacity of YKP to remain an effective organization in working for change in line with its vision by continuously applying the principles of good governance.

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About the Country Profile

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