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Written statement* submitted by the International NGO Forum on Indonesian Development, a non-governmental organization in special consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[17 May 2010]

* This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

Women's Reproductive Health Rights*

After 26 years of CEDAW ratification by Law No. 7 of 1984, the Indonesian government has not fulfilled its obligations concerning women's health and reproductive rights. As of 2003, the Indonesian Demographic Health Survey (SDKI) recorded 307 maternal deaths per 100,000 life births. According to UNICEF report (2004), the maternal mortality rate in Indonesia is 380 per 100,000 life births. Of these, around 19,000 Indonesian women die every year, or one every half an hour because of complications related to pregnancy, delivery, and post-partum.[1]

The government's policy on pregnancy, delivery and post-partum services through *Safe Motherhood, Making Pregnancy Safer, Basic Emergency Obstetric Neonatus Care* (BEONEC) and *Comprehensive Emergency Obstetric Neonatus Care* (CEONEC) programs have not worked optimally as evidenced in their inability to reduce Maternal Mortality Rate. Reproductive health programs are not the priority and no [financial/ budgetary] allocations are made for relevant activities.

Women's reproductive health services are getting more difficult to access, particularly by the poor and women in rural areas. State-owned Local General Hospitals and public health clinics/centers are required to contribute to the government's locally generated revenue, and people who need health services are required to pay. Health insurance for the poor is not effective because of bureaucratic obstacles.

Indonesia's population of 222 million people is projected to become 250 million by 2015, making it the fourth most populous country in the world. However, in the Human Development Index, Indonesia ranks 110th out of 167 countries (HDI Report 2006). Family planning programs in Indonesia have not shown a significant progress, reflected in the rate of unmet need that remains high (9%) and the Total Fertility Rate (TFR) of 2,6%.

Factors hindering the continuation of Family Planning Programs are:

1. since the decentralization took effect in the year 2001, family planning programs have been merged into the programs of local government institutions at district/city level. The programs then become unfocused and budgetary allocations became smaller;

2. contraceptives are getting more difficult to obtain, particularly by women, either because of unavailability or lack of money to purchase;

3. Low rate of male participation in family planning: contraception service is still gender-biased, male contribution is only 2,5%. Consistent use of condoms does not work. One of the reasons is the wrong assumption that condoms are porous;

4. Lack of information and education on family planning;

5. Discriminatory family planning services, which only aimed at married couples and often provided without counseling.

* CEDAW Working Group Initiative and the Human Rights Working Group (HRWG), NGOs without consultative status, also share the views expressed in this statement.

1 Reasons for the high maternal mortality rate include bleeding (42%), eclampsia (13%), abortion (11%), infection (10%), parturition that is too long (9%) and others (15%). The abortion referred to as contributing to the maternal mortality rate here is unsafe abortion which performed by unskilled and unauthorized trained health personnel. Women who terminated their pregnancy were mostly married women (who account for 87%), and the main reasons for it were psychosocial (57,5%) and "family planning failure" (36%).

Indonesian adolescents (age 10-19) constitute 30,2% of the entire population, the largest in ASEAN. Ten percent (10%) of females aged 15-19 are already married and have at least one child. Maternal mortality rate for that group is twice or four times greater than those who are get married at over the age of 20. The age at which adolescent become sexually active for the first time is getting younger. Reproductive health education for adolescent is still considered unacceptable and has not been adopted in the national education curricula yet.

Reproductive health problems among adolescent include:

1. the increase of the dangerous practice of circumcision on female children, endorsed by the followers of a religion (Islam), despite admonitions from the Ministry of Health. Mass circumcision of female children has even been practiced in several regions (according to the 2005 study of Mitra Inti Foundation);

2. Female adolescent experiencing unwanted Pregnancy are usually expelled from school or married off by their parents despite their early age, and some of them overcome this problem by resorting to unsafe abortion;

3. In many rural areas, early marriages are still the custom and most of the women get pregnant immediately. The number of adolescent girls (15-19 years old) who get pregnant in these areas is twice than those in urban areas, 14% and 7% respectively;

4. The rate of Sexually Transmitted Diseases including HIV/ AIDS among adolescent is on the rise.

Even though there are already Guidebooks on Public Health Centers Care For adolescents, most Public Health Centers are not accustomed to accepting adolescents who come to them with reproductive health problems (such as Sexual Transmitted Diseases/ STD and HIV/AIDS). The provision of contraceptives and services limited to married couples in the national family planning program. This would increase the probability of unwanted pregnancy as well as sexual transmitted diseases (infections). Condom using are considered only for married male.

There is also a discriminatory attitude against females with HIV/ AIDS. The rate of HIV/ AIDS has increased sharply and based on the latest data on March 31, 2007, there were a total of 15,378 people living with HIV/AIDS, of whom 6,449 were HIV positive and 8,988 had AIDS. And the number of infected women is increasing. The tendency of transmission from mother to infant, too, is increasing and there are many wives who have been infected by their promiscuous husbands. Discrimination is a typical problem faced by HIV-positive women, in particular the stigma of being “immoral”.

The important role of women in the economic sector is reflected in the increasing participation of female labor force. Problems faced by female workers as far as their reproductive health is concerned are this:

1. a permanent female employee cannot will not be paid during maternity leave if unable to show her marriage certificate or official registration. This is difficult especially for couples in rural areas where 30% of officially married couples in Indonesia have marriage certificates;

2. Female workers in companies/ factories cannot take menstrual leave without producing a doctor’s note.

Special groups such as prostituted women, prostituted female children, [physically and or mentally] disabled women, female senior citizens and LBT (Lesbians, female Bisexuals and Transsexuals) difficulties to access reproductive health services.

Accordingly, we recommended the following things:

1. The government should guarantee the availability of appropriate and adequate [health] services (including in rural areas) for pregnant women, women in childbirth and post-childbirth.

2. The law should provide as to when, or in which case, abortion should be allowed. Standards of service and competence of medical officers should be set and adopted in regulations.

3. The government should provide women and girls effective and non-discriminatory access to information and services on sexual and reproductive health, family planning, contraceptive use, and HIV and AIDS.

4. The government must guarantee and provide settlement measures in the event of side effects or contraceptive failure.

5. A formal curriculum on reproductive health education for adolescents should be created and distributed to adolescents at school as a separate subject.

6. The government must make regulations to regulating [maternal] leave for pregnant female adolescent students and not expel them from school.

7. Groups of Peer Educators should be formed to reach out to all adolescents, irrespective of whether they go to school or not, and to provide them with information on reproductive health, in order for them to get the right and correct information.

8. The role of hospitals and public health centers should be optimized to enable them to provide service that cares for teenagers without stigmatizing and discriminating against them.

9. Women, particularly those infected with HIV/ AIDS or other STDs, should be involved in policy-making and program development.

10. The circular decree from the Director General for Public Health Development on the de-medicalization of Female Circumcision by Health Personnel should be made into law.

11. The government should guarantee protection and fulfilment the rights of people living with HIV and AIDS, including the availability of ARV (Anti Retro Viral) medicines without stigmatization and discrimination, and incorporate the provisions into the amendment of the Health Law currently underway.

12. The government must ensure that companies provide paid menstrual leave without a doctor's note and maternity leave without a marriage certificate.

13. The government must make available inspection personnel in a proportional number to the number of companies in order to monitor any possible violations committed by companies to women's reproductive health rights. Violations should be sanctioned.

14. The process of privatization of state-owned Local General Hospitals must be stopped. Imposition of user's fees for poor women must be prohibited.

15. There must be an inter- and cross-departmental program with the perspective of and which accommodate the need of the disabled, the elderly, and minority groups; for example, clinics and integrated health service posts for the elderly.

16. There must be guaranteed reproductive health protection for women of all sexual orientations and other minority groups such, as prostituted women, the elderly and widows free from discriminatory actions.