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Совет по правам человека
Тридцать восьмая сессия
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Поощрение и защита всех прав человека, гражданских, политических, экономических, социальных и культурных прав, включая право на развитие

Доклад Специального докладчика по вопросу о праве каждого человека на наивысший достижимый уровень физического и психического здоровья о посещении им Индонезии

Записка секретариата

Секретариат имеет честь препроводить Совету по правам человека доклад Специального докладчика по вопросу о праве каждого человека на наивысший достижимый уровень физического и психического здоровья Дайнюса Пураса о посещении им Индонезии с 22 марта по 3 апреля 2017 года.

Индонезия добилась значительного прогресса в отношении осуществления права на здоровье, особенно за счет расширения всеобщего охвата здравоохранения. Специальный докладчик призывает правительство рассмотреть ряд серьезных проблем, которые по-прежнему связаны с существующей нормативно-правовой и политической основой и порядком ее функционирования. Он проводит оценку национальной системы здравоохранения и предупреждает о повсеместном неравенстве и дискриминации в отношении определенных групп населения, в частности женщин, лиц, живущих с ВИЧ/СПИДом, и лиц, употребляющих наркотики. Специальный докладчик предлагает ряд ориентированных на конкретные действия рекомендаций.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to Indonesia*

Contents

* Circulated in the language of submission only.

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, visited Indonesia from 22 March to 3 April 2017 at the invitation of the Government. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country implements the right to health.

2. During his visit, he met with high-ranking Government officials, members of the parliament and staff of relevant health-related institutions at the central, provincial and local levels. He had meetings with the *Komnas HAM* (National Human Rights Commission), the *Komnas Perenpuan* (National Commission on Violence against Women) and the *Komisi Perlindungan Anak Indonesia* (Indonesia Child Protection Commission). He also met with representatives of international organizations, the diplomatic corps and a wide range of civil society actors, including health-care professionals.

3. The Special Rapporteur visited health facilities at different levels in Jakarta, Padang, Labuan Bajo and Jayapura, including health posts, *puskesmas* (primary health-care centres), general hospitals and psychiatric units, a mental-health hospital, HIV/AIDS clinics and a drug rehabilitation clinic. He also visited two education centres for health workers.

4. The Special Rapporteur is grateful to the Government of Indonesia for its invitation and full cooperation during his visit. He appreciates the important support provided by the United Nations country team, including the Joint United Nations Programme on HIV/AIDS, the United Nations Population Fund, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO).

II. Right to health framework

A. Background

5. Indonesia gained independence from the Netherlands in 1945, bringing most of territories of the former Dutch East Indies under its sovereignty. Following independence, the country was ruled by a succession of authoritarian regimes that exercised centralized control. The collapse of military rule in 1998, during the Asian financial crisis, triggered important reforms at various levels, including a decentralization process.

6. Indonesia is a diverse archipelago nation spread over a territory of nearly 2 million km², with a population of over 250 million drawn from more than 300 ethnic groups. Its distinct geographical condition and vast cultural diversity are important factors that must be taken into account when designing and delivering public policies and services.

7. Since the 1990s, the country has achieved impressive economic growth, with gross domestic product (GDP) per capita rising steadily, from $857 in 2000 to $3,603 in 2016,[1] and has become the largest economy in South-East Asia. Today, it is the fourth most populous nation in the world and an emerging middle-income economy that has managed to halve poverty over the past two decades, to 10.9 per cent in 2016.[2]

8. Indonesia has concentrated its efforts in the fields of economic growth and development on infrastructure development and social assistance, including programmes related to health care and education, with a particular focus on persons living in poverty. With a strong commitment to public health, the country has made significant progress in improving the health status of its population, including life expectancy and the incidence of communicable diseases, such as malaria and tuberculosis.

9. The health sector has developed with a strong focus on primary care and universal access for the poorer sectors of the population. Considerable sums have been invested in efforts to develop health infrastructure, make services available and accessible and address

[1] See www.worldbank.org/en/country/indonesia/overview.
[2] Ibid.

the underlying determinants of health, including poverty, education and food and nutrition, through different policies and programmes.

10. Since the 1990s, there has been considerable improvement regarding most of the targets of the Millennium Development Goals, with Indonesia achieving 49 out of 67. However, target 5.A of the Millennium Development Goals was not among those achieved and neonatal, infant and under-5 mortality rates remain high.

11. In recent years, the continued decline of the global demand for commodities has led to moderate economic growth. During this time, job creation and poverty reduction have slowed down, contributing to the reinforcement of inequalities and compounded forms of discrimination, particularly among groups in vulnerable situations.

12. More than 28 million Indonesians still live below the poverty line and around 40 per cent of the population is at risk of falling into poverty. The gap between rich and poor has increased in recent years and may further widen. At 0.40, the Gini coefficient of Indonesia, a measure of inequality, is higher than that of neighbouring countries.[3]

13. Despite commendable efforts and sustained investment, availability, access to, and quality of health services remain a challenge in a country where the population is spread across thousands of islands, some located in remote and hard-to-reach areas. The Government has launched an agenda for developing Indonesia from the periphery that focuses on advancing the rights and welfare of persons living in remote and border regions.[4]

14. Indonesia has been actively involved in the 2030 Agenda for Sustainable Development and the Sustainable Development Goals since their inception and took part in the 2017 high-level political forum on sustainable development voluntary national review process. The National Medium-Term Development Plan 2015–2019 has been aligned with the targets of the Sustainable Development Goals and contains three development dimensions, including a human-development dimension comprising education, health and housing.[5]

15. Nonetheless, Indonesia must effectively address high maternal, infant and under-5 mortality and morbidity rates, inequalities, poverty and significant disparities between urban and rural areas. It is essential in this regard to improve integrated data management, institutional coordination and the availability and quality of health-related data.

B. Normative and institutional framework

16. Indonesia joined the United Nations in September 1950 and has ratified and acceded to almost all the international human rights treaties, except for the International Convention for the Protection of All Persons from Enforced Disappearance and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The country has ratified the two Optional Protocols to the Convention on the Rights of the Child on the involvement of children in armed conflict and on the sale of children, child prostitution and child pornography.

17. Indonesia has not accepted the complaints procedures under any of the international human rights treaties, a situation which seriously undermines access to remedies for victims and accountability with regard to respect, protection and fulfilment of the right to health.[6] Between 2015 and 2017, Indonesia was a member of the Human Rights Council.

18. The country has received visits by the Special Representative of the Secretary-General on human rights defenders, in 2007, the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-

[3] Ibid.

[4] See A/HRC/36/7, para. 11.

[5] Indonesia, “Voluntary national review (VNR): eradicating poverty and promoting prosperity in a changing world”, 2017, p. 1. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

[6] Indonesia has yet to ratify the Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty.

discrimination in this context, in 2013, and the United Nations High Commissioner for Human Rights, in February 2018. At present, Indonesia has 20 outstanding visit requests from different mandate holders and is yet to issue a standing invitation to the special procedures of the Human Rights Council.

19. Indonesia has not ratified the WHO Framework Convention on Tobacco Control or the Indigenous and Tribal Peoples Convention, 1989 (No. 169) and the Domestic Workers Convention, 2011 (No. 189) of the International Labour Organization.

20. In May 2017, the human rights situation in Indonesia was considered as a part of the third cycle of the universal periodic review. Prior to this process, the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women had both reiterated their concerns about a lack of clear definition and of a normative framework to prohibit and combat discrimination on all grounds. Both Committees highlighted the existence of deeply discriminatory by-laws, including in Aceh, restricting women's rights in the conduct of their daily life but also the rights of other sectors of the population, such as children, sex workers and lesbian, gay, bisexual and transgender persons.[7]

21. The report of the Working Group on the Universal Periodic Review (A/HRC/36/7) contained a number of health-related observations and recommendations that enjoyed the support of Indonesia, including a number related to: enhancing the coverage of and access to health services, particularly in rural and remote areas; adopting legislative and policy measures to ensure that women and adolescents have access to sex education and reproductive health services; expediting the adoption of the draft law on gender equality; strengthening measures to protect and promote the rights of persons with disabilities; and promoting the rights of women and children and the need to continue the fight against domestic violence.

22. Indonesia will examine a number of health-related universal periodic review recommendations with a view to providing responses in due time, including recommendations related to: drug policy and the imposition of the death penalty for drug offences; access to sexual and reproductive health services, including contraception and family planning, for women regardless of their marital status; and the prohibition of all forms of female genital mutilation.

23. At the regional level, Indonesia has launched important health-related initiatives, particularly with regard to the eradication of malaria and the fight against HIV/AIDS.

24. Pursuant to article 28 (h) of the Indonesian Constitution (1945), last amended in 2002, every person has the right to physical and spiritual prosperity, to have a home, to enjoy a good and healthy environment and to obtain medical care. Article 34 establishes the right to have access to a social security system, particularly for those in most need.[8]

25. Law No. 36 on health (2009) contains general provisions, principles and objectives relating to health and the rights and obligations of all persons with regard to health care. It establishes that the Government has a responsibility to provide health care, ensure resources for the health sector and strive to realize the highest possible level of health for the population.

26. The *Komnas HAM* was established in 1993 through a presidential decree that was superseded by law No. 39 (1999), which set out its functions and provided for its funding, membership and powers. Law No. 26 on human rights (2000) granted the *Komnas HAM* the power to investigate alleged human rights abuses. In 2008, law No. 40 gave the *Komnas HAM* additional responsibilities concerning the prevention of racial and ethnic discrimination. The body has been accredited with A status by the Global Alliance of National Human Rights Institutions ever since 2000 and is active in the field of health-related issues.

[7] See E/C.12/IDN/CO/1, para. 6 and CEDAW/C/IDN/CO/6-7, para. 17.

[8] See www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174556.pdf.

27. Several public policies, programmes and initiatives stem from this normative and institutional framework, including the Healthy Indonesia and Nusantara programmes and the health components of the National Action Plan on Human Rights 2015–2019. In line with the national development plan, Indonesia has developed its health strategy for the period 2005–2025, which prioritizes maternal health and the prevention of non-communicable diseases.

C. National health-care system

28. The current national health system stemmed from the previous *Jamkesmas* system, established in 2007 and directed at those segments of the population living in or at risk of poverty and lacking health insurance. The system is fully financed out of central Government revenues, administered by the Ministry of Health and regulated by law No. 40 on the national social security system (2004) and law No. 24 on social security agencies (2011).

29. Indonesia has mixed public-private provision of health-care services, with the public sector playing the dominant role, especially in rural areas and for secondary levels of care. Public health-care provision is decentralized to the district level within the framework of law No. 23 (2014), which established that both central and regional governments must allocate funding for the provision of health services.[9] Nonetheless, the central Government remains the dominant source of overall financing of the health sector, but district governments have discretion over how budgets are allocated and how much gets spent on health.[10] Physical access to health services in Indonesia is considered adequate, although there are shortages in the number of, and uneven distribution of, health professionals.

30. In the context of South-East Asia, Indonesia spends relatively little on health services. In 2014, the regional average for total expenditure on health as a percentage of GDP was 4 per cent. In Indonesia, it was 2.85 per cent of GDP, compared to 4.17 per cent in Malaysia, 4.7 per cent in the Philippines and 4.1 per cent in Thailand. Out-of-pocket expenditure as a percentage of private expenditure on health remains high in Indonesia: in 2014, it comprised around 75 per cent of private expenditure on health, compared to 78 per cent in Malaysia, 81 per cent in the Philippines and 53 per cent in Thailand. Per capita expenditure on health in 2015 (at average exchange rate) was $111.8, compared to $385.6 in Malaysia, $126.9 in the Philippines and $217.1 in Thailand.[11]

The path to universal health coverage

31. The *Jamkesmas* programme had a number of successes, including providing coverage for over 40 per cent of poor and near-poor households; increasing outpatient and inpatient utilization rates among *Jamkesmas* programme cardholders; reducing levels of catastrophic expenditure; and increasing the participation of private providers. However, the system was reviewed as a result of significant shortcomings,[12] including: the lack of coverage for nearly 60 per cent of the population, including in the informal sector; high out-of-pocket expenditure, even among persons enjoying coverage; the lack of equitable access to good quality health services in remote rural areas; low levels of awareness of benefits; and a low

[9] See www.indolaw.org/UU/Law%20No.%2023%20of%202014%20on%20Local%20Government.pdf.

[10] Peter Heywood and Nida P. Harahap, “Public funding of health at the district level in Indonesia after decentralization — sources, flows and contradictions”, Australia and New Zealand Health Policy, vol. 6, No. 13 (April 2009). Available from www.researchgate.net/publication/24282382_Public_funding_of_health_at_the_district_level_in_Indonesia_after_decentralization_-_Sources_flows_and_contradictions.

[11] World Health Organization (WHO) Global Health Observatory data repository, health financing. Available from http://apps.who.int/gho/data/node.main.GHEDCHEpcUSSHA2011?lang=en.

[12] The World Bank, “Key lessons learned from Jamkesmas to achieve universal health care in Indonesia”, 30 January 2014. Available from www.worldbank.org/en/news/feature/2014/01/30/improving-jamkesmas-to-achieve-universal-health-care-in-indonesia.

rate of utilization of health services. Additionally, the programme was known for its poor accountability mechanisms.[13]

32. Indonesia has made a bold, ambitious and commendable commitment to develop a universal health-care insurance system and to achieve universal health coverage by 2019. Health sector interventions designed to support poverty alleviation efforts and improve welfare have been conducted with a view to improving the health status of the population, focusing on, among other things: maternal, infant and under-5 mortality rates; coverage regarding reproductive health services; the control of communicable and non-communicable diseases; the expansion of the national social security system; equal distribution of health personnel; and provision of medicines and vaccines at the community level.[14]

33. Efforts to implement universal health coverage began in January 2014, through a system managed by the Social Insurance Administration Organization — (Healthcare). The national health insurance system uses a single-payer system, with the Social Insurance Administration Organization as the sole mechanism, known as the *Jaminan Kesehatan Nasional* (national health insurance system). The national social security system was implemented through the issuing, by the *Jaminan Kesehatan Nasional*, of the Healthy Indonesia Card. By the end of 2016, 66.4 per cent of the total population, including 40 per cent of those persons in the lowest income bracket, had been covered.[15]

34. Private health practitioners' engagement with the public sector through universal health coverage is being promoted by the Government in order to improve access to health-care services. However, there is a need to define roles and functions within the health system at the different levels of Government in the areas of human resources for health and sector performance, as well as to increase and redirect health-sector financing and determine how health institutions could develop to foster effective community and service users' participation.[16]

Primary care as a priority in strengthening the health-care system

35. Basic primary health care in Indonesia is provided by a public network of *puskesmas*, each serving a catchment area of about 25,000–30,000 individuals: a level of provision which is regarded as being relatively adequate. According to official information, there are 9,767 *puskesmas* and each one is supposed to be staffed by a minimum of nine different types of health professional, namely: doctor, dentist, nurse, midwife, public health official, environmental health official, nutritionist, pharmacist and health analyst. However, by 2016, only about 1,200 *puskesmas* met the above-mentioned health personnel standard.[17] About a third of *puskesmas* also provide inpatient services. Significant discrepancies in geographic accessibility remain a challenge, with persons living in remote inland areas or on small islands having particularly poor access to health-care services.

36. In principle, *puskesmas* should provide referrals to secondary and tertiary public hospitals. However, in practice, the gatekeeping and referral functions of *puskesmas* are weak. There are no effective mechanisms for dissuading patients from self-referring to a higher-level facility: patients can go directly to secondary or tertiary hospitals without referrals or simply obtain a referral letter from the *puskesmas*.

[13] Pandu Harimurti and others, "The nuts & bolts of Jamkesmas: Indonesia's Government-financed health coverage program", Universal Health Coverage (UNICO) Studies Series 8 (World Bank, Washington, D.C., January 2013), pp. 8–9 and 20–22. Available from http://documents.worldbank.org/curated/en/430821468044119982/pdf/749960REVISED0000PUBLIC00Indonesia1.pdf.

[14] Indonesia, "Voluntary national review, p. ix. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

[15] Ibid, p. viii.

[16] WHO Country Cooperation Strategy 2011–2017. Available from http://apps.who.int/iris/bitstream/handle/10665/136896/ccsbrief_idn_en.pdf;jsessionid=E2C142557D58D951BBBDBCFB20A2F176?sequence=1.

[17] Indonesia, "Voluntary national review, p. 38. Available from https://sustainabledevelopment.un.org/content/documents/15705Indonesia.pdf.

37. The existing primary health-care system is an impressive network of infrastructure that needs to be supported and improved so that most health conditions are effectively managed at the primary care level and only complicated cases are referred to specialists and hospitals. Moreover, the primary health-care system and the Social Insurance Administration Organization should not only serve the poor but should also win the trust of the more affluent sectors of society. This is an important precondition for the sustainability of any universal health-care system.

38. Consolidating primary care is a good basis for achieving full coverage. However, significant challenges remain regarding equitable access to and the quality of services throughout the country, as well as a lack of good governance and incentives for managing the different levels of care in such a way as to encourage the use of primary care.

39. The roles of general practitioners, nurses, social workers and health assistants should be strengthened by building their capacities and competencies through continuous-learning programmes. Innovative incentives to consolidate the position of general practitioners as health-care system "gatekeepers" should be considered.

Regional inequities in access to good-quality health care

40. A particular challenge faced by the Indonesian health-care system is linked to the distinct and complex geographical and regional disparities in terms of socioeconomic indicators and infrastructure, which particularly affect persons living in the eastern part of the country and on remote islands.

41. Availability of and access to health-care services have improved over the past decades with the extension of health coverage through increased infrastructure, staffing and financing. The Special Rapporteur visited the eastern part of the country, including Labuan Bajo and Papua, and noted some of the public initiatives to address the above-mentioned disparities. The Nusantara programme is aimed at developing primary health-care services in border and underserved areas and a scheme has been drawn up under which specialist doctors complete a period of compulsory service in such areas.

42. However, the Special Rapporteur was apprised of some of the challenges to ensuring access to good-quality health-care services for the population in the eastern provinces of the country, particularly for those living on the Lesser Sunda Islands and Papuans living in remote regencies (administrative subdivisions) in the highlands. He noted with concern that preventable and treatable diseases (respiratory-tract infections, measles, diarrhoea and dysentery) claim a high number of victims and affect the most vulnerable members of communities, particularly children.

43. With regard to Papua, the Special Rapporteur was informed that, pursuant to the special autonomy framework (laws No. 21 on special autonomy for Papua Province (2001) and No. 35 amending law No. 21 on special autonomy for Papua Province to include West Papua Province (2008)), Papua and West Papua Provinces receive larger health-budget allocations than any other province. Nonetheless, he expresses regret at the roseola epidemic that affected nine villages in Deiyai Regency between April and July 2017 and the outbreak of pertussis (whooping cough) in Nduga Regency in November 2015.[18] While in Jayapura, the Special Rapporteur met with representatives of local communities and ethnic Papuans and gathered information and testimonies on the main challenges to accessing good-quality health care. Most villages in remote regencies in the highlands suffer from a lack of health centres, medical equipment and qualified medical personnel. General vaccination and immunization services are not consistently provided, there are no adequate monitoring mechanisms and public health services are not delivered in an equitable manner. It is reported that military personnel have been deployed in the context of outbreaks of disease. Overall, there is a lack of trust in the health services available and ethnic Papuans experience stigmatization and discrimination in health-care settings.

44. The authorities should continue to improve access to good-quality health care and to build the capacity of health structures in remote regions. Members of *Adat* (customary)

[18] See A/HRC/33/32, p. 61.

communities, including indigenous Papuans, should have full access to public health facilities, goods and services, as well as to facilities, goods and services relating to the underlying determinants of health, such as safe and potable water and adequate food and sanitation. The collection and use of disaggregated data are crucial to efforts to achieve this goal. Culturally appropriate health-promotion tools and information should be developed and disseminated to prevent communicable and non-communicable diseases, particularly in remote areas. Members of *Adat* communities, including ethnic Papuans, should be trained as health-care workers, accredited as medical practitioners and integrated into the health-care system at all levels. Health-care curricula should include the training of health-care workers to deliver culturally appropriate services.

Current challenges facing the system

45. While there are important managerial and economic issues to be addressed concerning the current system, the Special Rapporteur wishes to highlight other important issues which should not be ignored by policymakers in the health and related sectors. These concern the principles of non-discrimination, accountability, participation, empowerment and informed consent and the need to go beyond the narrow biomedical model so that Social Insurance Administration Organization participants are provided with holistic, equitable and ethical care.

46. The focus on reaching the poor, addressing financial exclusion and mitigating catastrophic expenditures should not undermine the attention given to structural and systemic challenges stemming from deeply entrenched patterns of discrimination on other grounds, such as ethnicity, sex, religion, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, gender identity and legal status.

47. Mutual trust among all participants in the universal health-care insurance system is a decisive element of success. It is the best remedy against fraud, corruption, discrimination and stigmatization and disparities and imbalances within the health-care system.

48. In Indonesia, regional disparities should be addressed to avoid disproportionate allocation of Social Insurance Administration Organization health funds to urban areas and the eastern regions of the country. Mental health should be addressed as an important part of general health through the development and reimbursement of modern mental health services under basic primary care schemes. Reproductive health services need to be scaled up, with particular focus on adolescents and youth. Current trends relating to morbidity and mortality, with rates of non-communicable diseases rising and those of communicable diseases remaining high, need to be addressed in a creative manner.

49. These and other challenges can only be effectively addressed if all elements and principles of the right to health framework are mainstreamed into health policy formulation and implementation, including non-discrimination, equality, participation and accountability.

50. National budget allocations for health should be increased and out-of-pocket payments reduced. However, increased investments in the health-care system only make sense if the system is efficient, transparent, user-friendly and -responsive. For health-care systems to be efficient, sustainable investment in primary care must be given top priority.

51. While the Special Rapporteur commended the efforts made to invest in training of front line health-care workers, he wishes to underline that substantial investment is needed to improve the quality and increase the number of health-care workers. Skills training for and geographical deployment, with innovative incentives, of doctors and other health-care workers remain a challenge.

III. Mental health

52. A number of major initiatives have been launched regarding mental health care, including provisions for the integration of basic mental health into general health services, the building of human-resources capacity, ensuring the availability of affordable drugs and

accessible community-based services.[19] The Special Rapporteur visited Suharto mental health hospital and familiarized himself with the approach and level of public sector mental health professionals.

53. Specific guidelines have been developed by health officials for the implementation of rights-based mental health services and programmes, including training programmes for primary care physicians on the management and development of health-care facilities and services. However, as at 2011, most primary care doctors and nurses had not received updated official in-service training on mental health.[20] Additionally, there are stark disparities regarding different geographical access and availability of mental health services and facilities, particularly affecting persons living in rural and remote areas.

54. There are an estimated 600–800 trained psychiatrists in Indonesia, or 1 per 300,000–400,000 inhabitants. The country has 51 mental hospitals, serving 16,056 islands, including 32 public hospitals and 19 private hospitals located across 4 of the 34 provinces. Out of the 51 mental hospitals, an estimated 22 provide specialized services such as child psychiatry.[21] Moreover, only 249 of a total of 445 general health-care institutions offer any form of mental health-care services.[22]

55. The Special Rapporteur is extremely concerned about information received regarding living conditions in most health centres and social care institutions indicating overcrowding, involuntary treatment and the use of forced seclusion as a form of punishment or discipline.[23] Involuntary treatment and other psychiatric interventions in health-care facilities may constitute torture and ill-treatment.[24]

56. Law No. 18 on mental health (2014) mandates every province to have its own mental hospital (art. 52) and every district and municipality to build or support the establishment of at least one community-based service facility outside the mental health care sector (art. 58).[25] However, law No. 18 on mental health is problematic in its definition and application of the principle of informed consent and coercion, which perpetuates power imbalances in care relationships.

57. Law No. 18 justifies using coercion based on the principles of medical necessity, the fact that the person concerned may be incompetent or dangerous and the need to help that person overcome obstacles in carrying out functions as a human being. In such conditions of "incompetency", law No. 18 authorizes family members or guardians to take medical decisions on behalf of the person concerned without judicial review, including regarding admission to a mental health facility and the administering of treatment without consent.[26] The person admitted cannot appeal against his or her admission or leave the facility in question until he or she has been administratively discharged.

58. Informed consent is a core element of the right to health, both as a freedom and as an integral safeguard to the enjoyment of that right (A/64/272). The right to provide informed consent to treatment and hospitalization includes the right to refuse treatment (see E/CN.4/2006/120, para. 82).

59. States should fully integrate a human rights perspective into mental health and community services and adopt, implement and monitor all existing laws, policies and practices with a view to eliminating all forms of discrimination, stigma, violence and social exclusion within that context (Human Rights Council resolution 36/13 on mental health and human rights).

[19] Law No. 18 on mental health (2014), arts. 7, 25, 26, 34–35, 40 and 79.

[20] See www.who.int/mental_health/evidence/atlas/profiles/idn_mh_profile.pdf.

[21] ASEAN Secretariat, *ASEAN Mental Health Systems* (Jakarta, 2016), p. 43. Available from http://asean.org/storage/2017/02/55.-December-2016-ASEAN-Mental-Health-System.pdf.

[22] Human Rights Watch "Living in hell: abuses against people with psychosocial disabilities in Indonesia" (March 2016). Available from www.hrw.org/report/2016/03/20/living-hell/abuses-against-people-psychosocial-disabilities-indonesia.

[23] Ibid.

[24] See A/HRC/22/53, para. 64 and A/63/175, para. 50.

[25] See http://jakartaglobe.id/news/indonesian-mental-health-law-passed-five-years/.

[26] Law No. 18 on mental health (2014), art. 21.

Persons with intellectual and psychosocial disabilities

60. The right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities. Immediate action is therefore required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement.

61. The Special Rapporteur acknowledges the significant progress made with regard to legislative provisions that uphold the rights of persons with disabilities in the form of law No. 8 on persons with disabilities (2016). The law provides for the strengthening of legal frameworks and institutional capacity and the development of monitoring and evaluation mechanisms that affect the daily lives of persons with disabilities. It also outlines provisions on the formulation of follow-up laws and implementing regulations at the provincial and local levels, including Presidential and Ministry of Social Affairs regulations.[27]

62. However, this law is not in full conformity with the Convention on the Rights of Persons with Disabilities as, for example, it fails to recognize the legal capacity of persons with disabilities. Furthermore, while the law contains provisions on the reproductive health rights of persons with disabilities, including specific provisions on the protection of women and girls with disabilities who are victims of sexual violence,[28] it is silent on the subject of law No. 1 on marriage (1974), pursuant to which uncured illness and a wife's disability are legitimate grounds for divorce and polygamy.[29]

63. In 2011, the Government launched a campaign to end the degrading and violent practice of shackling that led to clear policies, guidelines and efforts in that regard. Initiatives in that field have focused on raising awareness about mental health, integrating mental health care into primary health care, providing mental health medication at the public health centre level and training health staff to identify and diagnose basic mental health conditions. Community mental health teams have been created by the Government to conduct community outreach activities, including identifying and rescuing persons held in shackles. As of 2015, some 8,690 persons with mental disabilities across 19 provinces were found to be shackled: of those cases, 7,961 have been addressed, with medical treatment being provided.[30]

64. The capacity of health structures in remote regions should be strengthened and they should be oriented towards community-based services and supported through substantial budget allocations, the adequate training of their staff and the empowerment of persons with psychosocial disabilities. The role played by primary health structures and general practitioners and their teams is essential. An integrated approach is required to prevent shackling being replaced with other forms of restraint and confinement which violate human rights.

IV. Key populations and groups

65. Inequalities in the enjoyment of the right to health in Indonesia are experienced in the form of barriers hindering access to and affecting the quality of essential services. This situation disproportionally affects groups in situations of poverty and persons living on small, remote islands and in the eastern provinces.

66. Additionally, certain population groups face discrimination and specific challenges in realizing their right to health, such as women and girls, persons who use drugs and persons living with HIV/AIDS.

[27] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCRPD%2fICO%2fIDN%2f27065&Lang=en.

[28] Law No. 8 on persons with disabilities (2016), arts. 5 (2) and 125–127.

[29] See www.cambridge.org/core/books/sharia-and-politics-in-modern-indonesia/the-law-of-the-republic-of-indonesia-number-1-of-the-year-1974-on-marriage/C93550E393785DF11BA9FA3385C34F90.

[30] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fIDN%2f1&Lang=en.

A. Women and girls

Maternal mortality and morbidity

67. The country has significantly raised the life expectancy of certain sectors of the population and reduced child mortality rates over the past decades. The completion of the maternal and neonatal tetanus immunization programme in May 2016 is commendable.[31]

68. Government regulation No. 61 on reproductive health (2014) represented a step forward regarding efforts to address reproductive health issues. In 2015, the Ministry of Health endorsed a national action plan on maternal health for the period 2016–2030. However, while under-5 mortality has been halved since the 1990s, the maternal mortality rate has remained among the highest in the region, at 305 deaths per 100,000 live births in 2015,[32] with maternal health in Papua, Sulawesi, Maluku and Nusa Tengarra Provinces lagging behind other parts of Indonesia.[33] Reports indicate that most maternal deaths are the result of complications during pregnancy, unsafe delivery practices, early pregnancies and poor childbirth and postnatal care, including low levels of competence of birth attendants and poor access to family planning services. Other underlying causes include variations in the availability of and access to good quality referral systems for obstetric care in emergencies, particularly in remote areas.

69. The situation is aggravated by an extremely restrictive normative framework for the interruption of pregnancies, which criminalizes abortion and the provision of information on or advice specific to abortion in all circumstances. Women and girls who undergo an abortion face imprisonment. According to article 346 of the Penal Code, health professionals can be penalized for performing illegal abortions, with sentences of up to 10 years' imprisonment. Women and girls seeking an abortion may be imprisoned for up to 4 years.[34]

70. Under law No. 52 on population growth and family development (2009) and articles 299 and 346–349 of the Penal Code, abortion is permitted only where the life of the mother or of the fetus is at risk or where pregnancy is the result of rape. However, the laws infringe on dignity and autonomy by restricting decision-making by women and girls in respect of their sexual and reproductive health. Legal requirements such as the obtaining of consent from the husband or, in the case of rape, a doctor's letter and an official statement from a police investigator, psychologist or other expert regarding the alleged rape and documents relating to the counselling process, have made medical coercion common.[35] Paternalistic legislation and a lack of alternatives mean that access to safe abortion and post-abortion care is extremely limited, especially for poor and young women.[36] As a result, abortions are performed in clandestine locations, causing grave health complications that lead to the deaths of many girls and young women every year.[37]

71. The strong social stigma attached to premarital sex further discourages unmarried women and girls from seeking to obtain access to antenatal and postnatal services and leaves them at risk of unwanted pregnancies, sexually transmitted diseases, unsafe abortion and exploitation.

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[31] See http://indonesia.unfpa.org/en/news/indonesia-has-eliminated-maternal-and-neonatal-tetanus.

[32] See http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/IDN/INT_CEDAW_IFN_IDN_26445_E.pdf.

[33] Wide disparities exist regarding the under-5 mortality rate, which, in 2012, stood at 115 deaths per 1,000 live births in Papua and 28 per 1,000 in Riau. See https://pdf.usaid.gov/pdf_docs/pnaea447.pdf; see also, Country Programme Action Plan 2016–2020: Government of Indonesia/United Nations Population Fund, *Programme of cooperation between the Government of Indonesia and the United Nations Population Fund*, (Jakarta, 2016).

[34] Amnesty International, *Left without a choice. Barriers to reproductive health in Indonesia* (2010), p. 33. Available from www.amnesty.org/download/Documents/36000/asa210132010en.pdf.

[35] Law No. 36 on health (2009), arts. 75–76.

[36] Amnesty International, *Left without a choice. Barriers to reproductive health in Indonesia (2010)*, pp. 35–36. Available from www.amnesty.org/download/Documents/36000/asa210132010en.pdf.

[37] See Ministry of National Development Planning, *The Roadmap to Accelerate Achievement of the MDGs in Indonesia* (2010), p. 123. See also National Development Planning Agency, *Report on the Achievement of Millennium Development Goals: Indonesia, 2007* (2007), p. 52.

72. Law No. 36 on health (2009) provides that the Government shall issue specific guidelines for doctors and health professionals on the provision of abortion services in the event of pregnancies that are life-threatening or in cases of rape, without discrimination against and fully respecting the right to privacy of victims of rape. Despite the authorities' efforts, awareness regarding the legal status of abortion is not yet widespread, either among women or among health professionals.

Sexual and reproductive health and rights

73. According to reports, there are more than 65 million young persons aged between 10 and 24 years in Indonesia, representing about 28 per cent of the population.[38] Approximately 5 per cent of adolescents aged between 12 and 19 years report having had sexual relations, of which 83 per cent did so before the age of 14 years. More than half of those relations occurred without planning, with 34 per cent reporting having using modern contraceptive methods, such as condoms.[39]

74. Positive initiatives have been launched to create a supportive environment for young persons' sexual and reproductive health, such as the incorporation of adolescent sexual and reproductive health in the National Action Plan on School Aged Child and Adolescent Health 2017–2019. National health and family planning policies and programmes have incorporated adolescent sexual and reproductive health in order to promote the coordinated delivery of adolescent-friendly health services in public health centres to protect young persons from and prevent risks related to their sexual and reproductive health.[40] However, punitive laws and restrictive interpretations of religious and cultural values and beliefs limit the delivery of comprehensive sexual and reproductive health services, including family planning and contraceptive methods, to young persons, adolescents and unmarried adults, and those population groups' access to such services (law No. 52 on population growth and family development (2009) and law No. 36 on health (2009)).[41]

75. Many adolescents, particularly girls and those identifying as lesbian, gay, bisexual and transgender, are deterred from approaching health professionals for fear of being judged according to social norms or laws that stigmatize or criminalize their sexual behaviour.

76. Comprehensive sexuality education is not properly integrated into school curricula in Indonesia. Related educational programmes are often limited to biology, physical education and procreation, and do not address human rights concepts, sexuality, gender identity or sex characteristics, including non-conforming gender identities. Educational programmes also have a stronger emphasis on abstinence as a means of avoiding sexually transmitted infections and unintended pregnancies than on the provision of comprehensive and evidence-based information to young persons and adolescents.

77. There is a need to expand the coverage and improve the quality of age-appropriate, comprehensive sexuality education, and to include therein the promotion of gender equality and respect for human rights, in order to better address the needs of all children and young persons, prevent early pregnancy and sexually transmitted infections and cater for the needs of persons living with HIV/AIDS, minors who may not be in education and persons who do not conform to gender norms.

78. The sexual and reproductive health services most needed, particularly among girls and young women, include: access to safe, reliable, affordable and good-quality contraception; comprehensive maternal health services; safe abortion and treatment for complications arising from unsafe abortion; and prevention and treatment of sexually transmitted infections and HIV/AIDS (see E/CN.9/2014/4, paras. 68–77). These services should be provided irrespective of age, marital status, sexual orientation or gender identity. Evidence shows that

[38] See www.unicef.org/indonesia/children_2834.html.

[39] See www.who.int/ncds/surveillance/gshs/GSHS_Country_Report_Indonesia_2007.pdf?ua=1 and www.who.int/ncds/surveillance/gshs/UNICEF-GSHC-Report-Oct-07.pdf.

[40] Statistics Indonesia, *Indonesia Demographic and Health Survey: 2012: Adolescent Reproductive Health* (2013). Available from: https://dhsprogram.com/pubs/pdf/FR281/FR281.pdf.

[41] United Nations, "United Nations country team Indonesia: report for the universal periodic review of Indonesia, twenty-seventh session", April–May 2017.

access to comprehensive sexuality education has a positive impact on the knowledge and health-related behaviours of adolescents and youth, and on their attitudes towards gender equality (see E/CN.9/2014/4, para. 68).

Gender-based violence

79. Gender-based violence, including violence against girls, women and transgender persons, was flagged as being an issue of grave concern. Reports indicate widespread prevalence of physical, sexual, emotional and economic violence (not allowing a person to work or confiscating a person's money), with 2 in 5 Indonesian women (or over 41 per cent) having experienced at least one of these four types of violence in her lifetime.[42]

80. Domestic violence at home and in the context of personal relationships constitutes an overwhelming majority of the reported cases involving sexual violence, including rape, with over 33 per cent of women aged between 15 and 64 years having reportedly experienced intimate partner violence or non-partner sexual violence.[43] However, it is estimated that the figures reported represent only the tip of the iceberg, as violence remains widely underreported, owing to prevailing patriarchal gender norms and associated stigma, and that the scope and enforcement of the existing legal provisions remains unsatisfactory.

81. Several laws and policies have been adopted to strengthen the legal framework on the protection of children from violence, including presidential instruction No. 5 on the national movement to eliminate sexual crimes against children (2014) and the national child-protection strategy for the period 2015–2019. The Special Rapporteur welcomes the inclusion of the bill on the elimination of sexual violence on the priority list of the 2017 national legislation programme for discussion in the parliament. He trusts that the bill will be passed as a matter of priority, in order to further advance the right to health, in line with the Sustainable Development Goals relating to women and girls.

82. While the country is taking important steps to strengthen data-collection and statistical systems to meet international standards, there is a need to improve the availability of high-quality data on violence against women to better inform public policies and action. The first nationally led survey on violence against women, conducted in 2016, constitutes a significant step in this direction.

83. The Special Rapporteur was apprised of the deeply entrenched discriminatory and violent attitudes towards individuals and groups based on their sexual orientation and gender identity or gender expression. The situation of lesbian, gay, bisexual and transgender persons is of particular concern, as they remain isolated from the main support networks, live and work in very difficult environments and face violence from the community. There have been commendable attempts to address discrimination against and social exclusion of lesbian, gay, bisexual and transgender persons in the form of a number of scattered technical and welfare regulations and initiatives. These include: circular No. 6/X/2015 issued by the head of the national police and stipulating that sexual orientation is one of the main issues related to hate speech; Ministry of Home Affairs regulation No. 27/2017 including transgender persons in the provision of social services; and Ministry of Social Affairs regulation No. 6 (2012) and the Ministry of Culture "Peduli" programme, both of which incorporate lesbian, gay, bisexual and transgender persons as beneficiaries.

84. Discriminatory attitudes and increasingly restrictive laws and regulations relating to expression of sexual orientation and gender identity have contributed to increased stigma and harassment in health-care settings for lesbian, gay, bisexual and transgender persons seeking sexual health care and services, including refusal of admission or services and a lack of comprehensive health services tailored to their needs. Regulations at the national and subnational levels create barriers to access to these services. Moreover, confidentiality is not always guaranteed.

[42] See www.unfpa.org/news/new-survey-shows-violence-against-women-widespread-indonesia.

[43] See http://indonesia.unfpa.org/sites/default/files/pub-pdf/2016_SPHPN_%28VAW_Survey%29_Key_Findings1_0.pdf.

85. Many lesbian, gay, bisexual and transgender persons do not use health services for fear of stigma and rejection, particularly if they fear arrest or breach of privacy and disclosure of their sexuality or gender identity to their family and community. To address this issue, the Ministry of Health has developed training modules and education materials for health personnel.

86. However, the Special Rapporteur heard testimonies and was presented with evidence of violence and discrimination against transgender women, who face extreme forms of violence based on their sexual orientation and gender identity and expression. Transgender women also suffer from harassment under laws relating to public order or immoral conduct, including from law enforcement officials, and legal uncertainty when attempting to obtain identity documents. In health-care settings, such women are forcibly tested for HIV/AIDS, are identified on the basis of their identity papers, which do not reflect their current sex status, and are placed in male wards, where they are exposed to serious violence and abuse.

87. The situation in Aceh Province is particularly alarming, in that a 2014 by-law amended the Penal Code to incorporate certain principles of sharia law, applicable to Muslims and, in certain cases, to non-Muslims. The by-law contains provisions criminalizing consensual, same-sex sexual acts and all sexual relations outside of marriage, and providing for sanctions of up to 100 lashes and up to 100 months' imprisonment for consensual, same-sex sexual acts. Punishments are also imposed against persons who are viewed as not behaving in accordance with such moral principles as dressing in conformity with one's biological sex.

88. The pathologizing of persons based on their sexual orientation and gender identity is extremely worrying, as are the practice of labelling them as mentally ill or as suffering from "psychiatric disorders" that require treatment and statements comparing the "fight" against homosexuality to modern warfare. Such classifications perpetuate prejudice and discrimination and have been used as a pretext for abusive forced treatment, psychiatric evaluation and procedures to change the sexual orientation of individuals, so-called corrective therapies. Such therapies are unacceptable from a human rights perspective, are unscientific and unethical and have serious negative impacts on the mental health and well-being of the persons concerned.

89. The Constitutional Court is currently examining a petition seeking to criminalize consensual, same-sex behaviour and increase penalties for sexual activity out of wedlock. Proposed amendments to the Penal Code include limits on the distribution of contraceptive supplies and on the provision of information about contraception. The amendments, if approved, risk creating additional barriers for women and certain key populations in the realization of their right to health and will be counterproductive from a public health perspective.

Harmful practices: child marriage and female genital mutilation

90. The situation of women and girls, who face compounded forms of discrimination due to their social, cultural and religious backgrounds, is of particular concern. This group includes women and girls who are exposed to harmful traditional practices, such as child marriage and female genital mutilation.

91. In Indonesia, the prevalence of child marriage remains alarmingly high: an estimated 3,500 girls are married every day, with 1 in 7 girls being married before the age of 18 years, with rates as high as 35 per cent in some provinces.[44]

92. Girls living in rural areas, from poorer households and those with limited or no access to education are more likely to be married early. Legislation sets the age for marriage at 21 years for both men and women. There are exceptions to the age limit: girls aged 16 years and boys aged 19 years can marry with their parents' permission. The law includes a clause that allows girls aged under 16 years to marry if their parents obtain a dispensation from local

[44] United Nations Children's Fund (UNICEF), *The State of the World's Children 2016: A fair chance for every child* (2016).

religious or district-level courts.[45] Every year, an estimated 300,000 girls are reported to marry before the age of 16 years.[46]

93. In an attempt to reduce the incidence of premarital sex and alleviate the perceived shame of having an unmarried pregnant daughter and children born out of wedlock, certain authorities are extending dispensations, thereby encouraging underage marriage.

94. Child marriage is not only a violation of girls' basic rights but also has significant health, gender and socioeconomic consequences. Early marriage is often associated with an increased risk of early and frequent pregnancies, with married girls often unable to effectively negotiate safer sex, leaving them vulnerable to sexually transmitted infections, including HIV.[47]

95. The inclusion of child marriage as a priority in the national midterm development plan for the period 2015–2019, and the adoption of several regulations to protect girls from child marriage are commendable. It is important that these measures are effectively implemented, in line with the targets and indicators of the Sustainable Development Goals relating to the elimination of child marriage.

96. Female genital mutilation/cutting, which, according to various definitions, including that used by WHO, includes female circumcision under types I and IV, is widely practised across Indonesia. In the 2013 Ministry of Health basic health survey, it was found that 51 per cent of girls aged between 0 and 11 years had been circumcised.

97. The prevalence of this practice is alarming and the health authorities have issued a regulation barring health professionals from performing the procedure, Ministry of Health regulation No. 1636 (2010). However, this policy development has yet to be widely disseminated. Reports indicate that the medicalization of this harmful practice is extended in the interests of "safer and hygienic" procedure, contrary to WHO regulations.[48] In rural communities, in the past, the procedure was performed by traditional birth attendants, but, more recently, they have been replaced by midwives in this regard.

98. Ministry of Health regulation No. 1636 (2010) contains a number of legal contradictions that risk supporting female genital mutilation. Article 1 of the regulation, for example, discourages the practice, affirming that it has no medical benefit. However, article 2 accepts the practice, outlining that it may be carried out subject to guidelines issued by the council for health and religious consideration. In order to avoid inconsistencies in law and in practice, and to safeguard the rights of women and girls, effective and appropriate measures, complemented by culturally sensitive education and public awareness campaigns, should be taken to abolish female genital mutilation.

99. The practice constitutes a denial of the dignity and integrity of those affected, is based on unacceptable discrimination and violence based on sex, gender, age and other grounds and often causes severe physical and psychological harm or suffering.[49] The partial or complete removal of the external female genitalia, or the injury of female genital organs, for non-medical or non-health reasons, can lead to multiple immediate and long-term health consequences. The practice denies girls and women the opportunity to make an independent decision about an intervention that has a lasting effect on their bodies and that infringes on their autonomy and control over their lives.

[45] Law No. 1 on marriage (1974).

[46] See www.girlsnotbrides.org/wp-content/uploads/2016/11/UNICEF-Indonesia-Child-Marriage-Factsheet-1.pdf.

[47] UNICEF, "Child marriage in Indonesia: progress on pause". Available from https://www.unicef.org/indonesia/UNICEF_Indonesia_Child_Marriage_Reserach_Brief_.pdf.

[48] World Health Organization (WHO), "Global strategy to stop health-care providers from performing female genital mutilation" (2010).

[49] Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health, para. 9; Committee on the Elimination of Discrimination against Women, general recommendation 19 (1992) on violence against women, para. 20; joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2014) on harmful practices.

B. Persons living with HIV/AIDS

100. Indonesia has a relatively low prevalence of HIV/AIDS, which, in 2016, affected about 0.4 per cent of the population in the 15–45-years age bracket. However, prevalence remains quite high among certain key populations, particularly men who have sex with men (25.8 per cent), injecting persons who use drugs (28.7 per cent) and transgender persons (24.8 per cent). Over the past few years, the nature of the epidemic has been changing and most new cases of infection are sexually transmitted. According to available data, only 35 per cent of persons living with HIV/AIDS know their status, the coverage of adults and children receiving antiretroviral treatment is quite low (about 13 per cent), and knowledge of HIV prevention among young persons should be improved.[50]

101. An analysis of the epidemic shows that most cases are concentrated in a few provinces, mainly Jakarta, Papua and West Papua Provinces, which are experiencing a generalized epidemic.[51] It is estimated that 2.4 per cent of the general population in Papua Province is living with HIV: the prevalence of HIV is reportedly higher among young persons aged 15–20 years.

102. Over the past decades, there has been serious commitment on the part of the authorities to fight the spread of the infection and to provide access to testing and treatment for persons living with HIV/AIDS, including by addressing mother-to-child transmission through targeted prevention and treatment programmes. However, while HIV testing in Indonesia has substantially increased overall, numbers are still low and coverage for antiretroviral treatment is among the lowest in the region.[52]

103. Since 2009, total government expenditure on HIV/AIDS has been increasing: a situation which should be commended. However, a large portion of that funding still comes from international partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, raising concerns about the sustainability of HIV/AIDS policies and programmes. Funding at the district level is deemed to be insufficient, restricting access to treatment and services.[53]

104. The Special Rapporteur was informed that the National AIDS Commission will cease to exist as of 2018 and that its functions and responsibilities will be absorbed by the Ministry of Health. The authorities should set up an independent body to monitor the situation, implement and coordinate programmes, and engage with key populations. The body should be provided with sufficient resources to effectively combat the spread of AIDS and achieve the goal of its elimination by 2030.

105. Existing normative, policy and institutional frameworks act as serious barriers to access to treatment and services, hindering the effectiveness of the HIV response. Homosexuality and sex work are criminalized at the national and provincial levels, and most by-laws and local regulations contain provisions that criminalize non-disclosure, exposure and transmission, and that impose mandatory testing. This situation is incompatible with the obligations arising from the right to health and other human rights, as it is discriminatory on the basis of health status and infringes upon the rights to privacy, to autonomy and to refuse treatment.

106. The Special Rapporteur was informed about ongoing discussions in the context of article 481 of the draft revised Penal Code reform criminalizing the distribution of contraceptives, including condoms, unless it is done by qualified health officials. This measure would have a negative impact on prevention programmes, since outreach workers, many of whom are not qualified health officers, would no longer be able to perform this important task.

[50] See www.unaids.org/en/regionscountries/countries/indonesia/.

[51] National AIDS Commission, 2014 Report, p. 16. Available from www.unaids.org/sites/default/files/country/documents/IDN_narrative_report_2014.pdf.

[52] United Nations Office on Drugs and Crime (UNODC), *Country Programme 2017–2020: Indonesia*, p. 22.

[53] UNAIDS, “Indonesia report NCPI”, 2013.

107. Reports and testimonies gathered during the visit indicate that stigmatization and discrimination, particularly in health-care settings, are major barriers preventing key populations from obtaining access to treatment and services. Consequently, such populations tend to avoid health services. While the adoption of health-related policies and programmes targeting key populations is commendable, it does not offset the impact of criminalization, which is a serious barrier to the enjoyment, by those at risk, of the right to health, and which drives them away from the services they need and increases health-related risks for society as a whole.

108. Moreover, there is a societal misconception associating HIV/AIDS with immoral behaviours, which suggest low levels of understanding among the general public of HIV/AIDS risk behaviours. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has criticized the way HIV transmission is depicted in some school textbooks based on myths and widespread misconceptions.[54]

109. More effort is needed to effectively reach out to those most at risk and to ensure access to good quality, evidence-based services, including by working in close partnership with key affected populations. Evidence-based public awareness, education and information campaigns are necessary to address widespread misconceptions about HIV/AIDS.

110. The situation in Papua, where there is a generalized epidemic and infection rates are the highest at the national level, is of particular concern. The Special Rapporteur notes specific HIV/AIDS policies in Papua, where HIV tests are offered to all users of health services, regardless of their symptoms, while in other provinces, they are only offered to members of high-risk populations. Despite these and other commendable attempts, ethnic Papuans are currently twice as likely to have HIV/AIDS than the rest of the population, and rates of infection are on the rise in this part of the country. The situation in Wamena, Timika and Nabire Regencies shows that the epidemic is moving from coastal areas to the highlands, where most ethnic Papuans live, often in remote areas.

111. Ethnic Papuans face important challenges when it comes to awareness, testing, treatment and health-related services, both in terms of access but also of effectiveness of the response, given adverse historical, socioeconomic and cultural factors. Women are at particular risk in this context, where new infections are mostly sexually transmitted. This critical situation deserves special attention and efforts from all stakeholders to build trust among service providers and users, but also to scale up investment in the health sector and to enhance access to treatment and services in a culturally sensitive manner.

112. More effort is required to actively reach out to those populations, both as a preventive measure and also to ensure effective access to health services. Age-appropriate, evidence-based, educational modules on HIV/AIDS transmission and prevention should be included in the school curricula.

113. Target 3.3 of the Sustainable Development Goals is aimed, among other things, at ending the AIDS epidemic by 2030. In order to achieve this target and to continue leading efforts in the region, Indonesia needs to promote the necessary normative and societal changes to achieve zero discrimination, particularly in health-care services.

C. Persons who use drugs

114. Indonesia has not traditionally been a major producer of illicit drugs but has become a key transit country for the trafficking of such substances.[55] Drug use has steadily increased in recent years, with synthetic drugs, including methamphetamine, ecstasy and, to a lesser extent, amphetamine, becoming increasingly available.

[54] See http://unesdoc.unesco.org/images/0024/002473/247396E.pdf.

[55] UNODC, *Country Programme 2017–2020: Indonesia*, pp. 12–14. Available from www.unodc.org/documents/indonesia/publication/2017/UNODC_Country_Programme_2017_-_2020.pdf.

115. National data show that, in 2015, more than 4 million persons (about 2.2 per cent of the population) used drugs.[56] Moreover, HIV prevalence among persons who inject drugs is currently alarmingly high. Between 2009 and 2014, HIV prevalence among persons who inject drugs rose from 27 per cent to 39.7 per cent, making Indonesia the country in the region with the second highest HIV rate among this population group.[57]

116. Indonesia is party to the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, and has adopted a punitive approach towards drug use and supply in an attempt to deter use and curb trafficking. Penalties for drug-related offences are quite severe, including the death penalty, which is employed as a last resort in cases of drug trafficking and after domestic remedies have been exhausted and has been used on several occasions since 2013. Overuse of incarceration for drug-related offences leads to overcrowding in prisons and to a consequent deterioration of the conditions of detention.

117. Article 127 of law No. 35 (2009) criminalizes drug use and the possession of small quantities of illicit drugs for personal use and fails to make a distinction between casual users and those who may have dependency problems. In a positive step, law No. 35 provided for mechanisms to divert persons who use drugs away from the prison system and towards treatment. However, articles 55 and 128 of the law also established the compulsory registration, self-reporting and reporting of persons who use drugs.

118. The criminalization of drug use, together with compulsory reporting and rehabilitation, only generate more discrimination, violence and exclusion. Criminalization has not proved to be an effective way of curbing drug abuse or drug trafficking: it drives individuals away from the health services that they need, seriously undermining public health efforts.

119. While the efforts made to address drug use through non-custodial measures should be recognized, granting criminal courts jurisdiction over a public health issue can lead to forms of coercive treatment. Drug use should not be a criminal offence and restorative measures should be put in place to address such behaviours outside the criminal justice system, particularly for adolescents and young persons.

120. Drug-abuse services and treatment are mostly provided by the public sector but the relevant authorities have acknowledged challenges in providing adequate and good quality services. Since 2002, Indonesia has implemented a basic harm-reduction policy, including needle-syringe exchange programmes and opioid substitution treatment. Additionally, public, community-based, rehabilitation programmes have been established and are available in priority areas that are considered to be at risk based on HIV infection rates and the number of persons who inject drugs reported therein.

121. The Special Rapporteur visited health centres with specific programmes and services for persons who use drugs. Such structures provide counselling and harm-reduction services but are few in number and do not cater for the needs of specific populations, such as adolescents and young persons. Reportedly, social discrimination is an important barrier for many persons who use drugs wishing to access drug-dependency treatment and services and HIV prevention, treatment, and care. Drug use is an illegal activity, therefore, a positive drug test and/or possession of needles and syringes can attract attention from law enforcement officials.[58]

122. The interaction of health services with persons who use drugs in Indonesia is mostly based on law enforcement and does not respect some of the basic elements of the right to health, including informed consent and the right to refuse treatment. Adequate health services

[56] See http://www.iosrjournals.org/iosr-jhss/papers/Vol20-issue4/Version-5/H020454246.pdf; http://iosrjournals.org/iosr-jhss/papers/Vol20-issue8/Version-2/A020820103.pdf and http://bnn.go.id/_multimedia/document/20161208/survei_2015_-_english_version_isbn_final_cetak.pdf.

[57] UNODC, *Country Programme 2017–2020: Indonesia*, p. 21. Available from www.unodc.org/documents/indonesia/publication/2017/UNODC_Country_Programme_2017_-_2020.pdf.

[58] Ibid., p. 22.

should be put in place based on informed consent and the right to refuse treatment, a key element of the dignity and autonomy of those individuals affected. More investment in prevention, education and information programmes on drug use is needed.

V. Conclusions and recommendations

123. **There are real opportunities and a genuine commitment to achieve the progressive realization of the right to health in Indonesia. The country has been at the forefront of the global movement towards the Sustainable Development Goals and the 2030 Agenda, and it is now leading the way towards universal health coverage, a key element in developing an equitable and sustainable health-care system.**

124. **This is an illustration of political will and a sign that the Indonesian leadership understands the intrinsic link between sustainable and inclusive development and the need to invest in the right to health, including in an equitable health system. For this ambitious goal to be reached, gaps and challenges relating to the enjoyment of the right to health need to be identified and addressed in a comprehensive way.**

125. **The public authorities need to step up efforts to address structural and systemic issues, both in law and in practice, to make sure that they are not tempted merely to address issues that can be resolved easily and to make sure that no one is left behind.**

126. **The right to health can only be fully realized through the enjoyment of the underlying and social determinants of health, which requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving and other biomedical interventions but also on broader socioeconomic, cultural and environmental factors.**

127. **Health policies, programmes and services should be guided by a human rights-based approach, with strong emphasis on the principles of equality, non-discrimination, transparency, participation and accountability.**

128. **The Special Rapporteur recommends that the authorities of Indonesia:**

(a) **Consider ratifying the Optional Protocols concerning individual communications procedures of the international human rights treaties, and extending a standing invitation to the special procedures of the Human Rights Council;**

(b) **Promote the adoption of a law against all forms of discrimination, and introduce public awareness-raising campaigns and education programmes to combat discrimination;**

(c) **Strengthen the health-care system and guarantee adequate, equitable and sustainable financing by increasing national budget allocations for health, and continue improving the availability and accessibility of health services in remote regions, with particular focus on primary care, the role of general practitioners, and the situation of *Adat* communities, including ethnic Papuans;**

(d) **Ensure that a solid health information system is in place to generate quality national data and statistics for the analysis of gaps in and for the design, implementation, monitoring and review of health-related policies and services;**

(e) **Address maternal and under-5 mortality, including by referring to the WHO Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and the technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable maternal and under-5 mortality and morbidity (A/HRC/21/22 and Corrs. 1–2 and A/HRC/27/31);**

(f) **Respect, protect and fulfil the right to health of women and girls by removing barriers to their sexual and reproductive rights, ending the criminalization of abortion and ensuring access to abortion services, and providing sexual and reproductive health information, services and goods, particularly comprehensive, age-sensitive and inclusive sexual education in secondary schools;**

(g) **Ensure comprehensive protection for women against all forms of gender-based violence by addressing, without delay, the remaining gaps in legislation and in practice, in order to ensure substantive equality and women's enjoyment of the right to health and related rights;**

(h) **Establish an independent national body for HIV/AIDS monitoring and prevention, with a strong mandate and the resources necessary to enable it to perform its functions, in consultation with key stakeholders;**

(i) **Remove all legal provisions criminalizing and stigmatizing persons living with HIV/AIDS, including those that criminalize homosexuality, sex work, and HIV/AIDS non-disclosure, exposure and transmission;**

(j) **Guarantee non-discrimination against persons living with HIV/AIDS in the health-care sector by ensuring that health services, materials and information are available, accessible, acceptable and of good quality for all key populations, and that health workers are properly trained and equipped;**

(k) **Address without delay the HIV/AIDS situation in Papua by guaranteeing access to testing, treatment and culturally sensitive health-related services, particularly for young persons and women, and build trust among service providers and users;**

(l) **Abolish the death penalty for drug-use offences, promote a non-punitive approach to drug-use policies and programmes outside the criminal justice system and expand services for persons who use drugs, particularly adolescents and young persons, based on scientific evidence and with full respect for their dignity, autonomy and basic rights;**

(m) **Adopt modern mental health policies and services with a view to mainstreaming them into the general health system and community support services, and launch a comprehensive reform of the mental health-care system in order to optimize investments and move towards community-oriented services based on the principles of non-discrimination, participation and respect for the dignity and rights of users.**