# Indonesia

INDONESIA

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# EXECUTIVE SUMMARY

Indonesia's reproductive health status has been greatly affected by the social, economic and political circumstances in the country since 1999. The Government of Indonesia (GOI) cited the economic crisis as the main cause for the failure of numerous sexual and reproductive health programmes. Another oft-referred-to challenge was the frequent changes in governmental leadership (three presidents within five years). As well, the negative effects of decentralisation, a process begun in 1999, are now beginning to show.

Poverty remains a major problem in Indonesia; the number of people living in poverty has increased from 22.5 percent in 1996 to 37.15 percent in 2001. Although the Government of Indonesia has frequently attempted to increase women's access to the economy, this has been slow to happen because gender disparities have not been addressed. Consequently, programmes to enhance women's status remain ineffective.

The geographically and culturally diverse Indonesian archipelago also faces various socio-political conflicts and natural disasters. These have led to worsening poverty levels and an increase in the numbers of Internally Displaced Persons (IDPs). Both circumstances are a cause for concern for deteriorating reproductive health conditions. Also, the least accessible regions, such as East Nusa Tenggara, are often ignored and yet, these are the ones that need special attention.

There has been some progress in terms of the availability of statistical data: figures presented in the 2003 Indonesian Demographic and Health Survey (IDHS) are quite comprehensive and the quantitative data are fairly detailed. However, critical indicators on certain issues such as HIV/AIDS, violence against women and abortion are not well developed. Further, the data analysis represents a national picture and does not take into account regional and provincial variations. The broad national picture is also what enables the GOI to describe the overall situation in positive terms.

While Indonesia has ratified several international conventions, there has not been much progress in implementation. A domestic violence bill, drafted by women activists and members of parliament six years ago remains a draft. High levels of domestic violence and sexual abuse remain a problem, particularly for migrant workers, as does trafficking in women and children.

The Government declared some success in lowering of total fertility rates (TFR), increasing contraceptive prevalence rates (CPR) and launching of several Safe Motherhood programmes since Cairo 1994. However, Indonesia's maternal mortality rate (MMR) remains the highest among ASEAN countries, and research has found 11-15 percent of deaths were due to abortion. It is likely that Indonesia may not fulfil the Millennium Development Goals (MDG) objective of the reduced MMR percentage of 75 by 2015. Despite new research findings highlighting the causes, the Government has yet to consider these findings in policy-making interventions.

Challenges in assessing HIV/AIDS and STIs are further compounded by the decentralisation process, which has led to a lack of clarity about the different roles and responsibilities of the central and provincial governments.

The sexual and reproductive rights of young people and single individuals remain an area of neglect, with information being restricted and no services available.

This, in turn, contributes to rising numbers of unwanted pregnancies and the risk of HIV/AIDS and STIs. Recent amendments to the Law on Population and Prosperous Family (No.10/1992) did away with the sexual and reproductive rights of young and single individuals on the ground that they are contrary to religious and cultural values.

Donor policies, especially from the World Bank, have introduced structural adjustment programmes such as the decentralisation of authority, and health sector reforms – these latter called for the privatisation of services to reduce public spending. This resulted in pushing up the cost of services, thus taking them beyond the reach of the majority of Indonesians who live in poverty. This contradicted the 'pro-poor' policy of the Government. Although there are a number of programmes meant to subsidise costs for the poor (i.e. social safety net, healthcare security, etc.), improvement in the quality of services remains to be seen, and supervision in the social security system remains weak. This further widens the accessibility and availability gap for the poor.

There is a need to assess the role of provincial governments in the health sector, as certain tasks are still the responsibility of the centre, such as surveillance and control of sexually transmitted diseases. Moreover some provincial governments have allocated a mere three percent of their budgets to health. This is in contrast with the recently revised national budget allocation of eight percent.

## Introduction and Objectives

The objectives of this country study are:

1. To assess the progress in policies, laws, programmes and services at the local, and national levels over the last ten years, in understanding, accepting and implementing the critical ICPD gender equality and SRHR objectives

2. To assess outcomes of these changes on women's health, women's status and women's lives

3. To identify and analyse the main ICPD implementation barriers and facilitating factors for change perceived by NGOs and government in relation to:

    a. The political, economic and social context (country and global)
    b. Institutional factors (government lack of action / inertia, regulation, enforcement)
    c. Effectiveness of NGOs and civil society participation and advocacy
    d. Presence of ICPD adversaries (threats or enemies)
    e. Impact of health sector reform (e.g. decentralisation, financing, community participation, accountability)
    f. WB, IMF, ADB and other donor policies

4. To analyse the differences in the Government's assessment of ICPD progress in its country reports to the Fifth Asian and Pacific Population Conference (APPC) and UNFPA Field Inquiry 2003 Reports

5. To recommend critical actions to be taken by government, NGOs and donors at local, national and regional levels

## Methodology and Country Team

Indonesia is a large country comprising many islands and consisting of 31 provinces. Its dispersed geography makes it difficult to produce comprehensive analyses that can adequately describe the conditions in each region. Even were it possible, the exercise would be expensive and time-consuming. An attempt has been made in the design of this study to glean as comprehensive a picture as possible.

Previous to the writing of this ICPD at 10 national report, a study of seven geographical areas was conducted by NGOs working on the issue of reproductive health. This monitoring study attempts to look at each geographical area, but with different monitoring foci. An FPG (Focal Point Group) in each area was assigned to coordinate the involvement of other NGOs in the area. These seven areas then united to form IRRMA (Indonesia Sexual Reproductive Health and Rights Monitoring and Policy Advocacy). The areas covered by the study are:

1. Sumbagsel (Southern part of Sumatera): ASRH
2. Nusa Tenggara Timur (NTT): Family Planning
3. Madura: Maternal Mortality
4. DI Yogyakarta and Central Java: Sexual Violence Against the Girl Child
5. East Java (Surabaya, Malang and Sidoarjo): STI and HIV/AIDS
6. Jakarta: Unsafe Abortion
7. South Sulawesi: Health and Decentralisation

Because the two studies had broadly the same aims, it was decided to use them to draw as comprehensive a picture as possible. The present study, however, uses a wider range of indicators, and a combination of these and the data from the previous study can help to present a picture which is more complex and nuanced.

Themes and Issues:
The three indicator frameworks used are:

1. Gender equality, social equality and equity
2. Reducing maternal mortality and promoting safe motherhood and safe abortion
3. Promoting and protecting sexual health and rights: safe contraception, prevention and treatment of HIV/AIDS

Adolescent sexual and reproductive health and rights and decentralisation remain the cross-cutting issues.

Data Collection Techniques:

The following methods of data collection were used for this study:

1. Desk Research; conducted by using different documentation, whether from print documents or websites, books, international journals, documents of the World Bank, UN Bodies and donor agencies, earlier research studies and other primary and secondary data in the forms of letters or files, as well as the reports owned by the respondents. Some of the studies covered are:
    a. Population and Poverty in Indonesia; Indonesia Country Report for The Fifth Asian and Pacific Population Conference, Bangkok, 11-17 December 2002
    b. Indonesia Country Report; The Progress Made in Achieving The Goals and Objectives of The PoA of the ICPD, Jakarta 2004,

presented at the Commission on Population and Development, 22-26 March 2004, New York

c. Indonesia ICPD at Ten Field Inquiry Questionnaire, The Government of the Republic of Indonesia, April 2004
d. The Report of the Indonesian Government on the Development in the Achievement of Millennium Development Goals

2. Field-based research; conducted through FGDs and in-depth interviews. The people interviewed included policymakers and service providers at the national, provincial, or regency/municipality levels. The number of respondents in each region varied according to size and the issues of concern in that particular region. Interviews with victims, ordinary people, policymakers helped to check the claims made by policymakers against the reality on the ground.

Below are details of the FGDs conducted and the number of respondents interviewed.

| No | Area | FGDs | Interview respondents |
|---|---|---|---|
| 1 | East Nusa Tenggara | | |
| 2 | Surabaya, Malang, Sidoarjo | 3; Health personnel, Primary health care providers, hospital personnel | 600 women |
| 3 | Madura (Sampang and Bangkalan) | 8 FGDs | 200; women, policy makers, midwives, TBAs |
| 4 | Southern part of Sumatera | 6 x 10 persons Policymakers, youth, parents, teachers and health providers | Jambi: 51, Sumatra Barat 45, Lampung: 47 (total 143)<br>Youth, parents, teachers, health providers, policymakers at district and provincial levels, community leaders, religious leaders |
| 5 | Makasar and Samarinda | 2 FGDs (in Makasar and Samarinda) with policymakers | 500 primary health care visitors (both FP clients and others; male and female); 7 policymakers at the provincial level |
| 6 | Yogyakarta and Central Java | | 30 survivors, 100 other respondents from policy makers, health persons, community and religious leaders, community, police (municipal and provincial levels) |
| 7 | Jakarta | 3; women, TBAs, midwives | 50 respondents; women, health persons, TBAs, midwives |
| 8 | National level | None, but there was one FGD conducted by IPPA, with health department personnel and NFPCB, National Biro Statistic, MOWE, and NGOs | 20; policy makers from various departments. |

The indicators used in the monitoring study relate to the assessment of data and data availability, the availability, outreach, and quality of services and the implementation of policies. The final report incorporated feedback from the strategic planning meeting in Langkawi, Malaysia in June 2004 with ARROW and partners.

One of the key constraints in preparing this study was the shortage of time. All researchers and data collectors are also NGO activists and their time availability was very limited so they could not fully concentrate on this study. Moreover, the team faced continuing difficulty in contacting respondents, particularly government bureaucrats. However, the making of this study has been important and has contributed to strengthening NGO networks, especially those working for the issue of reproductive health.

# Country Context

## Population and Development

### Sexual and Reproductive Rights and Health and Population Policies

It would not be incorrect to say that there has been little change in the reproductive rights and health status in Indonesia after Cairo 1994 and even after ICPD+5 (1999). In 1994 Badan Koordinasi Keluarga Berencana Nasional or the Family Planning Board Coordination (BKKBN) issued a policy concerning Population Development and the Development of Happy and Prosperous Family (Government Regulation Number 21 and 27 of 1994). Much of the focus of this policy, however, remains administrative with not enough attention being given to guaranteeing the rights of the citizen, and rather more being given to limiting them.

The Bali Declaration 1992 (4th Population Summit), which refers to reproductive health and rights and to ending discrimination against women, was also signed by Indonesia; however, there was no subsequent change in the policy. It was another instance where the Government of Indonesia made a commitment in the international arena but then did not follow through with the necessary implementation in the country. A significant change, however, was made two years after ICPD 1994.

In 1987, the Indonesian Department of Health publicly acknowledged the first case of HIV/AIDS in the country. After the announcement, the Department of Health established the National Committee of HIV/AIDS Management under the Directorate General of P2M (Eradication of Transmitted Diseases and Healthy Environment Making) of the department. Then, in 1994 the management of HIV/AIDS changed and became the responsibility to the Coordinating Minister of Society Welfare. The Commission of HIV/AIDS Management was then established at the national and regional levels with a presidential decree. This hierarchy in the management of HIV/AIDS faced some obstacles when decentralisation was introduced in 1999.

In the same year, the Department of Health launched the Healthy Indonesia 2009 programme: Attaining Health for All by the year 2010. The year also marked a paradigm shift in the sphere of health: from rehabilitation and cure to promotion and prevention.

### ICPD Cairo and its Influence on GO Policies

Two years after the ICPD, in 1996, a national workshop on reproductive health was held in Jakarta, which agreed on the following:

1. Adoption of the definition of reproductive health as defined by WHO
2. Wider coverage of reproductive health, including: safe motherhood, family planning, prevention and management of RTIs, STD, HIV/AIDS, abortion, adolescent RH, infertility, reproductive cancer and reproductive health systems, and other RH aspects such as menopause, maternal morbidity, parenthood responsibility, the involvement of men, the elimination of female circumcision and attention to Adolescent Reproductive Health (ARH).
3. Focus on the four key issues in reproductive health in Indonesia:
    a. Safe motherhood
    b. Family planning
    c. Prevention and management of RTI, STD and HIV/ AIDS
    d. Adolescent RH
4. Clarification of the roles and functions of different stakeholders such as the Government, NGOs and others based on the mandate and responsibilities of each (eg. MOH for the supply side, BKKBN ((NFPCB)) for the demand side, and MOWE for the initiatives concerning gender issues and women's empowerment)
5. Setting up of a coordinating forum among stakeholders, in the form of a Commission for reproductive health.

The Commission was accordingly set up in 1998, with four working groups on safe motherhood, family planning, adolescent reproductive health and reproductive health for the elderly.

According to Lalu Sudarmadi, Principal Secretary of BKKBN the national family planning programme was intended to improve the quality of life in terms of human resources and health and social welfare; this could be done through birth control, postponing marriage and improving family resilience and family welfare. In terms of the future, the objective of the national family planning programme is to improve the quality of family planning and reproductive health, reproductive rights, family empowerment, poverty alleviation, child welfare, women's empowerment, and birth control to create a small, happy and prosperous family. In this analysis, the family unit is considered the smallest unit of society and therefore the individual's rights do not seem to count.[1]

Further, Lalu Sudarmadi goes on to say that the objectives of the national FP programme are to improve family and population quality by reducing the population growth rate and decreasing the total fertility rate (TFR) to 2.4 per woman by the end of 2005. To achieve this goal, couples who wish to practise FP should be able to do so by using contraceptive methods that are appropriate to community cultural and religious values. Here too, individual rights are subordinated to group rights and culture is valorised.

Although Indonesia has signed the PoA ICPD, it has done so with reservations. For example, it has only committed to implementing the PoA and guaranteeing reproductive rights if they are not contrary to cultural and religious beliefs and values in Indonesia. This reservation obviously affects the policies made by the Government. Within the MOH policy for example, it is explained that Indonesia is one of the countries that participated in the ICPD and has committed to promoting reproductive health and reproductive rights. In this context, it was agreed that Indonesia would adopt its commitment to meet the country situation. The policy and strategy on RH, therefore, were developed accordingly[2].

Indonesian NGO reports on ICPD+5 show that the Indonesian Government has not declared any explicit objection to the Cairo recommendations in its policy statements. BKKBN always affirms that the Government has never had any problem with these. Indeed they feel that in matters relating to reproductive health the Indonesian Government is ahead of many others, something that is proved by the various awards received by it in the area of birth control.

Within the body of BKKBN, there are some changes although these are not very significant. Mainly, these relate to the family planning policy; and the cafeteria system. This system was has not been conducted well in many places because of the unavailability of contraceptives (although evidence in NTT or Madura,[1] contradicts this). Male involvement in RH was also limited to the use of contraceptive methods and some attention was also given to the husband's involvement in his wife's pregnancy care and delivery.

The ARH policy has been in place since 1996 and it covers the health of the mother and baby, family planning, prevention and eradication of IMS/ISR, including HIV/AIDS, as well as adolescent reproductive health.

At the end of 1998, the Department of Health began putting together operational guidelines on the implementation of the Essential Reproductive Health Package at the basic health care service level, so that the four integrated components could be understood by medical staff at all levels. But the success of this initiative is not clear as yet. The most difficult thing to change is people's mind-set, the more so because current health services are dominated by medical specialists. In addition, in 2002, the Health Department established the Commission on Adolescent Reproductive Health, involving various concerned departments, the private sector, mass media and NGOs with the aim of improving ARH in Indonesia.

Another national policy that also concerns ARH was put in place by BKKBN. Implementation started in 2002 through Empowerment Centres for ARH in all provinces, regencies and districts. To convey the messages on ARH, BKKBN cooperates with PKBI with the support of UNFPA in the production of various books and pamphlets related to the empowerment of ARH. This programme began in schools in 2001 and is conducted by the Department of National Education by making Reproductive Health a subject in the curriculum in accordance with the policy. Although the ARH programme has been ongoing, young and single people are still to avail of the services provided; this is mainly because it is believed that cultural and religious values forbid this.

## Gender, Reproductive Health and Religion

A discussion on reproductive health cannot be separated from a discussion on gender equality. Indeed, gender equality serves as one of the necessary aspects of the achievement of good RH status for women. Thus, the change that took place in 1999, during the tenure of President Abdurrahman Wahid, was important in relation to population policy.

Today, the Ministry of Women has become the Ministry of Women's Empowerment, led by Ms. Kofifah Indarparawansa. This change is closely related to the change in the paradigm of women's development in international development discussions. Abdurrahman Wahid's tenure also saw the putting in place of a programme on Gender Mainstreaming. Through a presidential decree in 2000, all government agencies were instructed to mainstream gender in all their programmes. In the field of VAW, the programme was then followed with the Zero Tolerance Policy towards VAW. As a result, the partnership between the Government and NGOs

also began to improve. For example, in order to implement the Zero Tolerance Policy, a national team was established which comprised government officers, NGOs and others.

It was also President Wahid's decision to put BKKBN under the coordination of the Minister of Women's Empowerment. But the Government's all-too-brief tenure meant that this move could not have the desired impact.

The BKKBN has a special gender division, which conducts training programmes for BKKBN personnel and others. An international training programme within the organisation is said to be a result of ICPD and the prioritising of RH. However, if we look at the Ministry's implementation of their Small Scheme Credit for Women, it seems that they still apply the Women in Development (WID) framework instead of Gender and Development (GAD) one. Women are merely encouraged to make money to improve their family's position. There is no mention of their rights as women.[2]

The wife of former President Wahid, Ms. Sinta Nuriyah A. Wahid, played an important role in opening up the discourse on gender and religion (especially Islam). In her role as first lady her action in breaking through Islamic traditions by means of various study forums and her important work with her friends in making another version of the *ukhudulujen* book was very important. However, despite having considerable support in official circles, her ideas did not find easy acceptance.

In general, the debate on women and religion, begun in the early nineties, benefitted greatly from the works of scholars such as the Moroccan sociologist, Fatima Mernissi, the Indian writer, Asghar Ali Engineer, and Aminah Wahdud. Women's NGOs and academics helped to disseminate these ideas through seminars, discussions, and the publication of books.

The management of PMS and HIV/AIDS has not been easy. HIV/AIDS carries a lot of cultural baggage and stigma. Religious teachings sometimes reinforce this. There is a refusal to accept that now HIV/AIDS attacks heterosexual people who are not necessarily sex workers, particularly women, and this has not contributed to making people more open to discussion. Because of the moralistic approach towards HIV/AIDS and the mistaken belief that it attacks only homosexuals or sex workers, many women are not even aware of the possible threat to them.

It would not be wrong to say that not much has changed in Indonesia where RH is concerned. Indeed, it could even be said that after 1998, things have become worse, particularly regarding Indonesia's social, political and economic conditions. The long process of recovery from the economic crisis provided a convenient excuse for deflecting attention from issues of health. The rapid changes of political power in Indonesia further exacerbated this. It is ironic that the presence of a female president which is generally seen as an indicator of progress, made no difference to the position of women.

When it began its recovery from the economic crisis, Indonesia was forced to adopt certain conditionalities that usually come with IMF inputs to reform the economy. The Structural Adjustment Programme (SAP) and the process of privatisation have been accompanied by a process of decentralisation. Privatisation also meant a reform of the health sector, which in turn led to changes in health institutions, the two most affected being BKKBN and the Ministry of Health.

In early 2004, BKKBN once again went through a process of restructuring. At the provincial level in Daerah Istimewa Yogyakarta (DIY) or in the municipality

of Yogyakarta and the regency of Kulonprogo for example, BKKBN was placed under the Department of Demography, Family Planning, and Civil Registration. The reason why it was not placed under the Department of Health was that its interests were similar to those of the Department of Demography, and Civil Registration, particularly in the matter of statistics.[3] It is a matter of some concern that the demographic programme is perceived merely as a matter of statistics. The separation of these closely related sectors could be a very serious matter. Until now, the perceived gap between BKKBN and the Health Department has been one of the causes (high cost is another) for the programme not being implemented well. In addition, the separation from the Ministry of Women's Empowerment will mean that the programme will be run only partially.

The World Bank has a project on decentralisation and health sector reform in two provinces of Indonesia (DIY and Lampung). The Provincial Health Project in Yogyakarta (Project PHP-I) is a pilot project with the idea that lessons learnt in DIY can be directed at developing infrastructure in other areas going in for decentralisation. The medical charges at the Community Health Centres and the Regional Public Hospital in DIY have been raised. The formal argument for this is that performance levels will improve. Meanwhile the PHP-I policy is supposed to be pro-poor, and the raise in user fees is directed at the middle and upper classes and meant to support the poor. However, there are some important things to be kept in mind here. First, despite the increased user fees, there has been no significant change in the performance of the service providers. Second, the protection systems for the poor are not well set up. The social security systems that have been developed (JPS, JPKN, JP-BK, JP-BS to JP-Gakin) remain business-oriented and do not really side with the poor. In addition, with all the safeguards mentioned above, the PHP-I does not cover any examination or treatment related to RH for example for delivery costs or even cancer of the cervix. The availability of free contraceptives is not a priority. These conditions, therefore, can result in a baby boom.

Also, new developments in the demographic policy of 2004 are not beneficial. The amendments to the Demographic Law of 1992, close to being passed, will set RH conditions back by a decade; the Government continues to hold on to the old paradigm. The current amendment does not recognise individual rights and gives too much weight to religion and moral values. This lack of willingness to change can be very detrimental to women's reproductive health.

## The Involvement of NGOs, Universities, Donor Agencies and UN Bodies

NGO involvement in reproductive health became stronger and more central after the Beijing Conference. Various discussions were held on the rights of women in general and reproductive rights in particular and a number of research studies were carried out, with their results being disseminated widely. These have also been very useful for women's studies centres such as the one at Gadjah Mada University, or gender and sexuality centres such as the one at the University of Indonesia. Since 1993, the Ford Foundation has been active in supporting numerous NGOs and universities in the field of RH. Some of the important groups are Forum for Women and reproductive health NGO networks. Among UN bodies, there is a certain amount of specialisation. Unicef, for example, mainly supports programmes directed at children, and has only a minimal involvement in other areas. UNAIDS concentrates more on matters related to AIDS.

UNFPA, through its sixth country programme, has made some effort to develop the reproductive health programme as a whole, including reproductive health for internally displaced persons (IDPs), a serious new problem in Indonesia

that has come about as a result of the numerous conflicts in its many regions. UNFPA collaborated with International Planned Parenthood Foundation (IPPF) Indonesia as the implementing agency for ARH, and with BKKBN for the Family Planning programme. Unfortunately, and despite early NGO involvement, the implementation of the programme leaves much to be desired. UNFPA chose six target areas as the implementation areas for all spheres in RH; if UNFPA could not conduct the programme in all regions, it would perhaps have been better to choose those areas where the problems are worst, and with a different concentration of spheres in accordance with the area conditions. As an example, Papua, with an extremely high incidence of HIV/AIDS was not made a target area of UNFPA. Besides, if we look more closely, UNFPA serves as a 'broker', since many countries fund the project, including the Government of Netherlands (UNFPA Sixth Country Project document). Moreover the high salaries of UN personnel contribute to the high cost of the project.

After Suharto was forced to step down in 1998, Indonesia has had violent conflicts in different parts of the country. To add to this various natural upheavals and disasters have led to an increase in the number of IDPs in the country. Although UNFPA has a special programme for the reproductive health of IDPs, the coverage area of the UNFPA and other international NGOs is very narrow and their involvement is not long-term. The lack of nutrition, dearth of fresh water, and absence of purchasing power to buy contraceptives all affect reproductive health, both in the present and the future. In such conditions, domestic violence is also seen to increase, which then contributes to trafficking / exploitation / prostitution of girl children.

## Assessing Progress in Achieving ICPD Goals and Objectives

According to the 2000 Population Census, Indonesia's population was 205.8 million in 2000 and was projected to reach 211.1 million in 2002. This makes Indonesia the fourth most populous country in the world after the People's Republic of China, India and the United States of America. An estimated 86.5 million people (42 percent of the population) lived in urban areas in 2000, compared with 92.7 million (44 percent of the population) in 2002. In 2000, more than 88 percent of the Indonesian population was Moslem.[4]

**Table 1: Basic Demographic Indicators**

| Indicators | 1990 Census | 2000 Census | 2002 Census |
|---|---|---|---|
| **Population (millions)** | 179.4 | 206.3 | 211.1 |
| **Growth rate (GR) 2 (percent)** | 1.98 | 1.49 | 1.25 |
| **Density (pop/km2)** | 93 | 109 | 112 |
| **Percent urban** | 31 | 42 | 44 |
| | | | |
| **Reference Period** | 1986-89 | 1996-99 | 2002 |
| **CBR (crude birth rate)** | 28 | 23 | 22 |
| **CDR (crude death rate)** | 9 | 8 | 10 |
| | | | |
| **Life Expectancy** | | | |

| Indicators | 1990 Census | 2000 Census | 2002 Census |
|---|---|---|---|
| **Male** | 57.9 | 63.5 | 64.3 |
| **Female** | 61.5 | 67.3 | 68.2 |

Source: Demographic Indicators from Selected Sources, Indonesia 1990-2002

## Gender Equality, Social Equality and Equity

### Gender Mainstreaming Policy

In the year 2000, a presidential decree was issued on Gender Mainstreaming. A decade and a half before this, in 1984, Indonesia had ratified CEDAW (in Law No. 7/1984). At the time, a convention watch group was set up that periodically reports on the implementation of CEDAW in Indonesia and works to popularise its content among government personnel in universities, with NGOs etc.

At present, 40 cities / regencies have offices of Women Empowerment Agencies. In a number of provinces / cities, the agencies have been quite effective, but many others do not have a clear understanding of what is meant by gender mainstreaming. Also, they do not have any authority or functioning structures that can help them to wield more influence.

### Violence Against Women

The Jakarta riots of May 1998 that targetted Indonesian Chinese women brought the issue of violence against women to public attention. The momentum thus built up then led to setting up the National Commission Anti-VAW in October 1998. The widespread violence and conflict in different parts of the country also meant that increasing numbers of women survivors of the violence began to speak out, thus keeping public attention focussed on the issue.

There is, however, very little national data on violence against women and so far there has been no national survey to determine the incidence and prevalence of VAW. Whatever data do exist on the subject are scattered in various institutions, particularly those offering counselling for survivors of violence, police departments and different hospitals. Added to this, there are differences in the way data have been recorded and categorised which makes it difficult to get an overall comparative picture. Fortunately, the IDHS 2002-2003 contains some data on domestic violence. The accountability report of the Indonesian Government to the Demographic Assembly in New York in March 2004 also contained some information on domestic violence. According to the results of a survey (HDR 2001) 11 percent of 339 male respondents stated that they have beaten their wives, whereas 19 percent stated they have hurt their spouse psychologically. Meanwhile, 362 female respondents (16 percent) stated that they have been beaten, kicked, or burnt (usually with a cigarette or an iron).[6]

As a comparison, the following data from a Women Crisis Centre (WCC) may be useful.

**Table 2: Violence Cases handled by Rifka Annisa WCC, Year 1999-2002**

| CASE | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|
| **Wife abuse** | 225 | 225 | 234 | 250 |
| **Dating violence** | 50 | 92 | 103 | 95 |
| **Sexual abuse** | 18 | 25 | 13 | 13 |
| **Rape** | 31 | 28 | 29 | 29 |
| **Family violence (including against children)** | 12 | 12 | 16 | 14 |
| **TOTAL** | 336 | 382 | 395 | 401 |

Source: Rifka Annisa Women Crisis Centre Yogyakarta, 2003

Data recorded by the National Commission for Women, at the beginning of 2004 showed that in 2001 there were 3,169 cases of violence against women, in 2002 this figure went up to 5,163 cases and in 2003 to 5,934 cases (389 cases are those of violence against girl children).

Where service provision is concerned, a significant change has taken place. In 2003 there were 30 WCCs spread over numerous provinces in Indonesia, and also a Police Women Desk in each police office at the district and municipal level, as well as Integrated Service Centres at Indonesian Police Hospitals.

In addition, there have been some developments in legal terms. The President through presidential message has recently passed the Bill on Domestic Violence. The latest information is that the Bill is now being discussed seriously in the Legislatures in order to be issued as a permanent law. However, these changes notwithstanding, Indonesia is still putting into effect the Criminal Code (made by the Dutch, and very much out of date), the perspective of law enforcers has little or no awareness of gender and the penalties given to rapists are still relatively light. To this day, amendments to the Criminal Code have not been finalised.

### Trafficking in Women and Children

Only after considerable pressure from NGOs and other countries has the Government of Indonesia begun to pay attention to the issue of trafficking in women and children. Today, the country has an Anti-Human Trading Bill and a National Action Plan Against Trafficking. The government report presented in New York only mentions the number of Indonesian migrant workers abroad and speaks of how this number has grown as a result of the crisis at home, but it makes no mention of the terrible conditions in which they work and the violence they face.

Indonesia's report for the Special Rapporteur for Migrants' Human Rights to the UN for example, recorded 972,198 women and 383,46 migrant workers in 1999-2002. Most of them work as labour or domestic workers. The report also noted the conditions of the woman labourers, particularly domestic workers who are very susceptible to violence. The WAO (Women's Aid Organisation) Malaysia, for example, reported that out of the 19 cases of Indonesian woman labourers they handled in the year 1997-1998, 11 women had experienced physical violence, three had faced sexual abuse and rape, two were held against their will and seven others had their payments and documents withheld. Meanwhile, from 1994-1997 the Indonesian Embassy in Saudi Arabia recorded over 1000 cases of sexual violence experienced by the Indonesian migrant workers there.

In addition, research conducted by UNIFEM, quoting the report of Kobumi, shows higher figures as the table below shows.

**Table 3 : The Type and Number of IMW (Indonesian Migrant Workers) Cases Abroad**

| Case Type | Number of Cases | |
|---|---|---|
| | 2001 | 2002 |
| 1. Death | 33 | 177 |
| 2. Abuse and rape | - | 31 |
| 3. Sexual abuse - | - | 31 |
| 3. Running away | 5,598 | 313 |
| 4. Losing contact | 24,325 | 517 |
| 5. No documents | 1,563,334 | 697,000 |
| 6. Fake ID | 32,390 | 386 |
| 7. Thrown into prison | 14,222 | 749 |
| 8. Deportation | 137,866 | 505,000 |
| 9. Fired | 222,157 | 1,897 |
| 10. Put to Syariah trial | 50 | |
| 11. Arrested | 6,427 | 80,546 |
| 12. Uninsured | 65,000 | 47 |
| 13. Cuts in salary | 125,004 | |
| 14. Held/unpaid salary[1] | | 41 |
| 14. Threatened by death penalty | 2 | 10 |
| 15. Lash penalty | - | 682 |
| 16. Prostitution and trafficking | - | 2,633 |
| 17. Human trading | - | 24 |
| 18. Obstacles in prayers | - | 9 |
| 19. Conflicts | - | 871 |
| 20. Stressed, depressed, mad | - | 76 |
| 21. Handicapped/sick | - | 30 |
| 22. Held against their will | 1,101 | 470 |
| 23. Cheated | 1,820 | 1,685 |
| 24. Abandoned | 34,707 | 2,478 |
| 25. Blackmail, exchange rate mislead | - | 198 |
| 22. Others | - | 30,847 |
| Total number | 2,234,143 | 1,308,765 |

Source: NGO Data in 2001-2002

## Women and Politics

After a long struggle on the part of women's groups, Indonesia now has a 30 percent quota for women in parliament. However, there are still many obstacles to overcome, including women's own reluctance to participate in politics. Because of this, Indonesia's general election did not show any significant increase in the numbers of women entering politics. In the 1999 election, women were nine percent of the parliament, whereas in 2004 this figure went up by merely two percent, raising the overall figure to 11 percent. When Megawati was in power, the general feeling was that there should be no problems with women's leadership any more, but numerous Islamic groups opposed the entry of women in order to fulfil their political interests.[8]

## The Elderly

A National Plan of Action for the welfare of the elderly was adopted in 2000 which contains steps (1) to promote the well being of older people and the social security system, (2) to improve health services, (3) to strengthen family and community support, (4) to improve the quality of life, and (5) to develop special facilities for older persons.[9] However, the main obstacle in the efforts of improving elderly welfare remains the resource mobilisation.

## The Girl Child and Early Childhood Mortality

Early childhood mortality has tended to decrease and there is no big gap between male and female infants.

**Table 4: Trends in Mortality by Province**

*(Infant Mortality Rates (per 1,000) for the Ten-year Period Preceding the Survey, by Province, 1994-2003)*

| Province | 1994 IDHS | 1997 IDHS | 2002-2003 IDHS |
|---|---|---|---|
| **Sumatera** | | | |
| **North Sumatera** | 61 | 45 | 42 |
| **West Sumatera** | 68 | 66 | 48 |
| **Riau** | 72 | 60 | 43 |
| **Jambi** | 60 | 68 | 41 |
| **South Sumatera** | 60 | 53 | 30 |
| **Bengkulu** | 74 | 72 | 53 |
| **Lampung** | 38 | 48 | 55 |
| **Bangka Belitung na** | na | na | 43 |
| | | | |
| **Java** | | | |
| **DKI Jakarta** | 30 | 26 | 35 |
| **West Java** | 89 | 61 | 44 |
| **Central Java** | 51 | 45 | 36 |
| **DI Yogyakarta** | 30 | 23 | 20 |
| **East Java** | 62 | 36 | 43 |

| Province | 1994 IDHS | 1997 IDHS | 2002-2003 IDHS |
|---|---|---|---|
| **Banten** | na | na | 38 |
| | | | |
| **Bali and Nusa Tenggara** | | | |
| **Bali** | 58 | 58 | 14 |
| **West Nusa Tenggara** | 110 | 111 | 74 |
| **East Nusatenggara** | 71 | 60 | 59 |
| | | | |
| **Kalimantan** | | | |
| **West Kalimantan** | 97 | 70 | 47 |
| **Central Kalimanta** | 16 | 55 | 40 |
| **South Kalimantan** | 83 | 71 | 45 |
| **East Kalimantan** | 61 | 51 | 42 |
| | | | |
| **Sulawesi** | | | |
| **North Sulawesi** | 66 | 48 | 25 |
| **Central Sulawesi** | 87 | 95 | 25 |
| **South Sulawesi** | 64 | 63 | 47 |
| **South-East Sulawesi** | 79 | 78 | 67 |
| **Gorontalo** | na | na | 77 |
| | | | |
| **Total** | **66** | **52** | **35** |

Note: The 2002-2003 IDHS did not include Nangroe Aceh Darusalam, Maluku, North Maluku and Papua provinces. Previous surveys included East Timor.
na not applicable (provinces that were split from South Sumatera, West Java, and North Sulawesi provinces, respectively)

**Table 5: Early Childhood Mortality Rates by Demographic Characteristics**
*(Neonatal, post neonatal, infant, child, and under-five mortality rates for the ten-year-period preceding the survey, by demographic characteristic, Indonesia 2002-2003)*

| Demographic characteristics | Neonatal mortality | Post-neonatal mortality | Infant mortality | Child mortality | Under-five mortality |
|---|---|---|---|---|---|
| **Child's sex** | | | | | |
| Male | 24 | 21 | 46 | 13 | 58 |
| Female | 21 | 19 | 40 | 11 | 51 |
| | | | | | |
| **Mother's age at birth** | | | | | |
| < 20 | 32 | 21 | 53 | 10 | 62 |
| 20-29 | 19 | 19 | 39 | 14 | 52 |

| Demographic characteristics | Neonatal mortality | Post-neonatal mortality | Infant mortality | Child mortality | Under-five mortality |
|---|---|---|---|---|---|
| 30-39 | 24 | 22 | 46 | 10 | 56 |
| 40-49 | 36 | 14 | 50 | 8 | 58 |
| | | | | | |
| **Birth order** | | | | | |
| 1 | 22 | 15 | 36 | 8 | 44 |
| 2-3 | 20 | 18 | 37 | 12 | 48 |
| 4-6 | 26 | 29 | 55 | 15 | 69 |
| 7+ | 44 | 45 | 89 | 26 | 112 |
| | | | | | |
| **Previous birth interva 1** | | | | | |
| < 2 | 48 | 54 | 102 | 27 | 126 |
| 2 years | 22 | 25 | 47 | 19 | 65 |
| 3 years | 18 | 12 | 30 | 9 | 39 |
| 4 + years | 16 | 14 | 31 | 8 | 38 |
| | | | | | |
| **Birth size** | | | | | |
| Small / very small | 39 | 23 | 62 | Na | Na |
| Average or larger | 12 | 12 | 23 | Na | Na |
| | | | | | |
| **Antenatal care/ delivery assistant** | | | | | |
| Both ANC and DA | 10 | 6 | 16 | Na | Na |
| ANC only | 14 | 15 | 29 | Na | Na |
| DA only | 15 | 4 | 19 | Na | Na |
| Neither ANC or delivery | 29 | 28 | 57 | Na | Na |

Note:
ANC Antenatal care
DA Delivery assistance
na Not applicable
1 Computed as the difference between infant and neonatal mortality rates
2 Excludes first-order births

## Nutrition

One in three children under five is malnourished in Indonesia.[10] Despite an overall decrease in malnutrition of five percent since 1992, there are regional as well as urban-rural variations. Some remote rural districts in Sulawesi, Kalimantan, and East Nusa Tenggara report that total malnutrition has remained unchanged at 27 percent.

**Table 6: Percentage of Malnourished Under-five Population by Region**

| Under-five malnutrition (moderate and severe) by area | 1992 (%) | 1998 (%) |
|---|---|---|
| **Indonesia** | 35 | 30 |
| **Rural** | 38 | 32 |
| **Urban** | 27 | 27 |
| **Java-Bali** | 32 | 27 |
| **Jakarta** | 26 | 22 |

Source : SUSENAS, 1998

Unicef notes that there is no difference in numbers in malnutrition among male and female children. Micronutrient deficiencies are a cause of concern. Vitamin A is essential for normal vision and enhancement of immunity and Vitamin A deficiency has been known to be the main cause of childhood blindness. Several reports have shown that Vitamin A deficiency is also associated with increased mortality and increased severity of infectious diseases. [11]

### Sexual Violence Against the Girl Child

Cases of sexual violence against children vary and can be categorised as trafficking of persons (including child prostitution), and non-commercial sexual violence cases in the form of sexual abuse and rape; whether in the public sphere (including with street children) or within the domestic sphere, including cases of incest. Categorisation of such cases is made more difficult because of the variation in how different laws (such as the Criminal Code, the Child Rights Convention and the Law on Child Protection) define children (the first as below 15 and the second and third as below 18).

There are indications that the incidence of sexual violence cases (in whatever form) is much higher than what is reported. Various conflicts taking place in Indonesia (causing more poverty, separation of parents from their children, or migrant workers from their children) are thought of as one factor that makes children more vulnerable to sexual violence. The increase in poverty also pushes many girl children out onto the streets, and often families sell them into prostitution. According to Irwanto,[12] it is estimated that there are 21,000 children who have been forced into prostitution in Indonesia. The number is based on his calculation that these children constitute 30 percent of the overall number of prostitutes in Indonesia, whereas according to the Social Department, the number of sex workers in the year 2000 reached 73,990. This figure does not include the number of children trafficked abroad. Sexual violence occurring in childhood greatly affects the child's future, and obviously his/her sexual and reproductive health when the child grows older. Clearly, there is a need for urgent attention to this issue.

### Early Marriage

In general, and especially in big cities, the age of marriage has been delayed. Nevertheless, in some provinces the number of child marriages is still considered high. According to Susenas (1998) there are seven provinces in which the proportion of ever married women aged 25-34 years who were first married under the age of 16, is over 10 percent. The highest percentages were recorded for West Java (16 percent), South Kalimantan (15 percent), East Java (15 percent), Jambi (14 percent) and Bengkulu (11 percent); the phenomenon is much more prevalent in rural areas.[13]

### Male Participation

Male participation in RH is often reduced to just participation in the use of contraceptive methods (specifically condoms and vasectomy), and serves merely to mark the targets of programmes with actual participation remaining very low.

**Table 7 : Trends in Use of Specific Contraceptive Methods : Indonesia 1991-2003**

| Methods | IDHS 1991 | IDHS 1994 | IDHS 1997 | IDHS 2002-2003 |
|---|---|---|---|---|
| **Any method** | 49.7 | 54.7 | 57.4 | 60.3 |
| **Pill** | 14.8 | 17.1 | 15.4 | 13.2 |
| **IUD** | 13.3 | 10.3 | 8.1 | 6.2 |
| **Injectables** | 11.7 | 15.2 | 21.1 | 27.8 |
| **Condom** | 0.8 | 0.9 | 0.7 | 0.9 |
| **Implants** | 3.1 | 4.9 | 6.0 | 4.3 |
| **Female sterilisation** | 2.7 | 3.1 | 3.0 | 3.7 |
| **Male sterilisation** | 0.6 | 0.7 | 0.4 | 0.4 |
| **Periodic abstinence** | 1.1 | 1.1 | 1.1 | 1.6 |
| **Withdrawal** | 0.7 | 0.8 | 0.8 | 1.5 |
| **Other** | 0.9 | 0.8 | 0.8 | 0.5 |
| **Number of women** | 21,109 | 26,186 | 26,886 | 27,857 |

Note : The 2002-2003 IDHS did not include Nanggroe Aceh Darusalam, Maluku, North Maluku, and Papua provinces. Previous surveys included East Timor

Source : IDHS 2002-2003

The data demonstrate the difficulties of conducting surveys in conflict areas. The unavailability of the data in these regions makes any kind of programming and/or intervention more difficult although it is abundantly clear that the long-term impact of these conflicts will be an increase in poverty and declining health services.

Meanwhile, the struggle for gender equality and non-violence remains marginal in public discourse. There are only a few male religious leaders who actively promote women's equality. Some years ago, Jakarta saw the setting up of an unusual organisation, Cantik (Boys Against Violence) but after the initial declaration of establishment, there has not been any significant activity although male students do seem to be interested in following discussions on gender in society.

## Reducing Maternal Mortality and Promoting Safe Motherhood and Safe Abortion

The Government of Indonesia has always been proud of its Safe Motherhood Programme, but in the field - from year to year - there has not really been any significant decrease in the MMR. An analysis of the Indonesian Demographic and Health Survey in 1994 shows that five years before the survey (estimated 1990-1994) the MMR was 390 (death rate per 100,000 births). The unpublished data by IDHS in 1997 showed a slight decline to 334 for the period of 1993-1997.

However, since the MM rates and ratio have always been associated with high sampling errors, it was also believed that the interval between the two figures overlapped, and therefore it was difficult to conclude that there had been any decrease. The 2002-2003 IDHS showed a decrease to 307. However, once again, there was the issue of error sampling. Thus, it is still difficult to conclude whether a decrease of MMR ever took place in the last 10-15 years.[14]

The causes of MM still show the same pattern. There has not been any significant change in better access to health and health facilities. In Indonesia, the birth process assisted by trained medical staff is at 55.8 percent. In the rural areas, 69 percent of births are assisted by indigenous medical practitioners, 19.6 percent by midwives, 2.7 percent by doctors, and 2.3 percent by other medical officials as well as others (neighbours, relatives) and 1.4 percent are conducted by the mothers themselves (C&C 1995). Meanwhile, the check-up conducted for the foetus until the fourth month reaches 66.3 percent in the rural and 79.4 percent in the urban areas. Those still conducting check-ups until the eighth month are only 0.7 percent (rural) and 1.9 percent in the urban areas.

For MM, 56.96 percent of deaths took place at home, 28.03 percent at the doctors' clinics, and 2.46 percent at the Community Health Centres. The high MMR rate at hospitals, the one place where a mother delivering her baby should have comprehensive help, is due to the fact that most hospitals lack the necessary facilities. Besides, most of the medical staff still have not fulfilled the ideal standards of PONEK (Comprehensive Emergency Obstetric-Neonatal Service) and PONED (Basic Emergency Obstetric Neonatal Service). The Community Health Centre able to conduct PONED numbered less than 10 percent and about 40 percent of the Regional Public Hospitals in the second level regions do not have any obstetrician/ medical supports specialising in it, whereas about 65 percent do not have any blood transfusion unit since they are not able to perform Caesarean surgeries. (Indonesian Health Department, 1997). The irony here is that the Health Department has set itself a target to reach 95 percent pregnant mothers and 90 percent competence in the coverage of birth process assistance by midwives or medical staff.

Midwives and gynaecologists are not evenly distributed all over Indonesia. Most gynaecologists live in the four big cities; Yogyakarta, Surabaya, Jakarta and Semarang. Significantly, the MMR in these cities is categorised as low. The ratio of the number of medical staff compared to the number of the people is also not sufficient.

Abortion has not been really presented as a cause of maternal mortality. In data collection all cases are categorised under the general heading; pregnancies and deliveries. Meanwhile, according to the Health Department, the causes of maternal mortality can be broken down as follows:

| | |
|---|---|
| -excessive bleeding | 28 percent |
| -pre-eclampsia | 26 percent |
| -abortion | 5 percent |
| -infection | 11 percent |
| -others | 30 percent |

However, excessive bleeding and infection could also be the results of abortion.

There has also not been any significant change in matters of affordability, acceptability and accessibility in abortion services, despite the fact that maternal

deaths from abortion are put at at least 12 percent[15] of all cases of maternal mortality. Another source (Herdayati 1997) concludes that abortion contributed to 17 percent to MMR.

Even though the Government is now aware of this, there is hardly any attempt to address the problem other than explaining that abortion cannot be legalised because it is not appropriate to do so under religious law. In the year 2004, abortion remains illegal in Indonesia according to the Criminal Code and Health Law No.22/1992. The amendment to the Health Law is still caught in the legislative process, in which the unsafe abortion providers are the ones to be penalised. As a result of the efforts of NGOs some parties have agreed to accept the legalisation of abortion in cases of rape. The maximum age of the foetus to be aborted is eight weeks. Because abortion is illegal, it is also expensive. A study conducted by YKP showed that the average abortion rate is Rp 600,000 (the cheapest Rp 190,000, the most expensive Rp 2,000,000)

It is also interesting to note that it is not only single people who seek abortions. From about 2 millions cases of abortion occurring every year, in Indonesia, more than 50 percent are conducted by married women.[16] Most of these are unplanned and unwanted pregnancies that mostly happen because no contraceptives are used. Thus, the scarcity of contraceptive in a number of places is due to the changes taking place in the Coordinating Agency for National Family Planning (BKKBN), and the lessening of people's capacity to purchase contraceptives. This means that a decrease in society's capacity to have more children should be understood as a high risk for increasing the numbers of abortions. Research in the field shows that this has already happened. Our respondents in Makasar complained that after the government's decentralisation period, the costs for healthcare at hospitals and community health centres increased significantly. Even the contraceptive pills that used to be free now has to be paid for as also the once free examination card, As an example, in the suburban areas of the East Nusa Tenggara (NTT), an injection can cost as much as Rp 15,000-25,000 (transportation excluded); if at that time the village midwife happens to run out of supplies, the cost goes up to Rp 25,000-30,000. In the urban areas, one shot of an injection can cost Rp 30,000 as a minimum. In Makasar, the cost of the injection method of contraception before decentralisation was Rp 5,000, at present it is Rp 12,000, whereas the cost for contraceptive pills changed from Rp 1,000 to Rp 1,000-Rp 2,500. The delivery costs at the Community Health Centres increased from Rp 65,000 to Rp 90,000-Rp 100,000.

A similar situation obtains in Kupang (East Nusa Tenggara). Here, people's purchasing power has fallen considerably while contraceptive means cannot be freely found. If this situation continues, the nine percent of women in the category of 'unmet need' will very possibly increase, and unwanted births may also go up. According to the SDKI 1997, eight out of ten births are wanted, meaning two out of ten are unwanted.

There are a number of issues that need urgent attention, particularly in qualitative terms since on the quantitative side there seem to be fewer problems. TFR for example has decreased, and the use of contraceptive means has gone up. However, qualitatively there are many concerns. Based on the SDKI 2002-2003, there has been a decline in the TFR in the last ten years, from 3.0 children in the period of 1988-1991 to 2.6 in the years 2000-2002.[17] However, the TFR differs within different groups of women and regions. The poorest woman group rates TFR of 4.4, compared to the richest 3.4. In DIY, Central Java and Bali the rate is 2.1 children per woman, whereas 4.1 and 3.6 children per woman apply in NTT and South Sulawesi. Clearly we need to make more appropriate strategies for

all social-economic groups and regions (which is also related closely to social-economic problems).

As well, the median age of the first birth for women is getting delayed. This age for women between 25-49 has increased from 20.8 years in 1997 to 21.0 years in 2002-2003. In addition, teenage childbearing declined from 12 percent in the 1997 IDHS to 10 percent in the 2002-2003 IDHS. In a number of regions, such as Madura in East Java and West Nusa Tenggara for example, the percentage of early marriage is still high. Within this context, once again, different strategies need to be implemented. The Government cannot just make an excuse out of the local culture, but they need also to make a culture-sensitive approach to educate the people if this programme is to work in the regions.

The use of contraception shows quite a different tendency from the previous years in terms of the kinds of contraceptives used. People's self-reliance seems to have increased, leaving only 11 percent of the people using contraception that is available from the government, whereas 89 percent of them pay for what they use. The using of midwife services rates the highest among the use of private services. This increase in self-reliance is obviously an effect of privatisation, which actually in an inconspicuous way had commenced with the promotion of the Blue Circle Family Planning. A number of women go to midwives or use other private services not necessarily because they can afford them, but also because there are no free contraceptive means at the Community Health Centres. Even if there are some, the choices are very limited; usually only in the form of the pill, which is not always appropriate for all women.

## Promoting and Protecting Sexual Health and Rights; Safe Contraception; Preventing and Treating HIV/AIDS

Regional Autonomy has made it difficult for the programme to progress since each region is occupied with restructuring. There are also not enough people who are capable of dealing with HIV/AIDS. The policy of using condoms for susceptible groups and the management of transmitted sexual diseases are also in a limbo. In addition to the problems of decentralisation, there are problems of budgeting. Since the beginning, coping with HIV/AIDS has always depended on foreign support. The Government of Indonesia has still not allocated any special fund for HIV/AIDS. The tackling of transmitted sexual diseases also faces a number of obstacles since the government only focusses on coping with gonorrhoea (GO) and syphilis. Other kinds of sexually transmitted diseases have not been paid attention to, and some, such as Chlamydia, have spread widely even to housewives. Another problem is the gender insensitivity of the policy on HIV/AIDS management, and its patriarchal bias. Woman commercial sex workers are always considered as transmitting vectors, while their consumers or guests have never been identified as vectors. On the other hand, women who are not prostitutes are neglected. Sexually Transmitted Diseases (STD) and HIV/AIDS have existed among them, but the problem has not yet been identified by the government or by them, although woman empowerment offices have made the KIE for them. Women's organisations do not generally work for women's health. They are more concerned with issues of violence and politics. Therefore, their involvement in the management of HIV/AIDS has not been effective since they have not mastered the existing health issues well. Moreover, most of non-commercial sex worker women are still not aware of the risks they face. They do not consider HIV/AIDS their problem.

In 1999, a new development became visible in the spread of HIV/AIDS - HIV infections became evident among those injecting drugs. In 1999, 18 percent of

those treated in Rehabilitation Hospitals for Drug Addicts (RSKO) Jakarta were infected with HIV. The number increased to 40 percent in 2000 and 48 percent in the year 2001. In 2000 in Kampung Bali, Jakarta, 90 percent of injected drug users were infected with HIV. Behaviour studies of drug-users in a number of cities show that they have high-risk behaviour: about 30 percent are sexually active but do not use condoms. It is estimated that 7-10 millions men in Indonesia are customers of commercial sex workers. Yet the use of condoms for self-protection from the risk of HIV transmission in each commercial sex trade has not reached even ten percent.

In the year 2000, there was a significant rise in the epidemic of HIV among commercial sex workers. In Tanjung Balai Karimun, Riau Province, the incidence rose from one percent in 1995/1996, to 8.38 percent in 2000. The prevalence of HIV among sex workers in Irian Jaya (Merauke) is 26.5 percent, 3.36 percent in DKI Jakarta (North Jakarta) and 5.5 percent in West Java. For transsexual sex workers, the epidemic rate in 2002 reached 22 percent, almost four times the rate in 1997. HIV has also been widely transmitted to households. In a number of regions in Jakarta, about three percent out of 500 pregnant women who tested voluntarily had been infected with HIV.

The estimates of HIV/AIDS in Indonesia by the Health Department and WHO in 2001 show that people suffering from HIV/AIDS numbered between 80,000 and 120,000. They consist of Injected Drug Users (IDUs 62,500 people), commercial sex workers and their guests (30,000 people); and ordinary people (between 15-49 years old, 11,520 people). For the year 2002, 90,000 – 130,000 people in all provinces in Indonesia were estimated to have HIV/AIDS. The prevalence of HIV in general is still quite low, but Indonesia is categorised as a country with concentrated epidemic levels since it contains epidemic pockets with prevalence over five percent from certain sub-populations.

Behaviour surveillance studies in a number of cities in Indonesia show that more than half the men with high mobility have purchased sex services during the last one year. Most of them have been married. Meanwhile, the number of people susceptible to HIV in Indonesia is estimated at 13 – 20 million.

Even though the percentage of HIV transmission among young IDUs has seen a major increase, the educational sphere has not responded satisfactorily. Much of the focus in education is on reproductive health without any consideration of issues of health and sexual rights. This kind of education often takes place outside of formal classes, and is not always sensitive to the needs of young people. The information provided is not complete and only emphasises that teenagers should not have free or pre-marital sex, and because sexuality is defined as existing only within marriage, teenagers and singles are hesitant to access the existing reproductive health services.

Non-commercial sex worker women are neglected in the coping strategies of STD and HIV/AIDS because they are defined as a low-risk group. Because of this, they have also been unable to gain any information or access to services for STD and HIV/AIDS.

Although commercial sex workers are the main concern in the management of STD and HIV/AIDS, they cannot really protect themselves from these diseases. Control remains in the hands of their male customers 90 percent of whom refuse to use condoms. The programme that emphasises the responsibility of men in tackling HIV/AIDS has not been run widely. One of the obstacles faced is how to influence the business world and mass media to run campaigns that stress the responsibility of men in coping with HIV/AIDS.

In general, people are still unable to access VCT (Voluntary Counselling Testing) services, as these have not yet been developed in many regions in Indonesia. There is no counselling before and after the tests, so even the notion of informed consent is unclear. Migrant workers seeking jobs abroad have to undergo mandatory tests. Support, care and treatment programmes for HIV/AIDS are mainly conducted in the big cities with barely any attention being given to other areas. The Basic Level Service has not developed care and treatment programmes for HIV/AIDS. Indonesia has been able to produce its own generic ARV but the problem is with the lack of counselling in the use of the medicine, which so far has not been conducted well. Medical staff is generally not ready to participate in the care and support programme.

Indonesia has made the following policies in relation to HIV/AIDS:

The National Strategy of HIV/AIDS Management 1994, which was revised in 2003 is in effect until the year 2007. This is an integrated policy accommodating the issues of susceptible groups, the human rights of HIV/AIDS patients, gender justice and equality, a healthy lifestyle, 100 percent condom use for commercial sex workers and their customers, harm reduction for drug-users, care and treatment programmes, VCT with informed consent, and non discriminatory services for HIV/AIDS sufferers. In 2004, six provinces (Jakarta, Papua, Riau, East Java, West Java, and Bali) considered susceptible to HIV/AIDS made the Sentani declaration which targetted 50 percent condom use in 2005, as well as harm reduction for injection needles, minimum use of 5000 ARVs for HIV/AIDS sufferers in 2004, reduction in the stigma and discrimination against HIV/AIDS patients, the establishing of HIV management organisations, efforts to support laws and budgeting for the implementation of HIV/AIDS management programmes. At present and in the first level regions (provincial), not all municipalities and regencies in Indonesia have put this strategy for HIV/AIDS management into their regional policies.

In the tenth year of ICPD in Indonesia, there has been some progress in the fields of affordability, acceptability and accessibility in KIE and services for HIV/AIDS. This is, however, limited not only to big cities, but also to certain groups, and because of this it has not been possible to control the epidemic.

There has also been some progress in prevention, harm reduction, and treatment for HIV/AIDS, especially in the discourses and policies at the national level (and in some provinces). However, little attention has been paid specifically to gender issues in HIV/AIDS with priority being given only to high-risk groups. Meanwhile the management of STIs has still not shown any significant progress. Where commercial sex workers are concerned, there has been no change in relation to STI incidence and among women who are not sex workers the issue has not been paid any real attention.

So far, information and education on reproductive health is only available for those who are already married. Sex education for the young is limited to big cities and private schools, and is still not part of the formal education curriculum. Reproductive health corners, established to provide information are, according to BKKBN and the Health Department, mainly non-functional.

## Gaps in Government Reports

The Government has made significant progress in data collection and in conducting surveys. The IDHS 2002-2003 for example, yielded comprehensive data and the Government report to the CPD General Assembly draws heavily on this data, particularly on demography and health. However, some areas, such as the reproductive health of IDPs, are not yet covered. Also absent are issues such as

violence against women (including violence against Indonesian women migrant workers), as well as the startling numbers of street children (most of whom are girls) who are obviously very vulnerable. Where violence is concerned, only domestic violence finds a mention. As for the issues of IDPs and migrant workers, while the report makes mention of their numbers it does not address issues of violence against them or indeed issues of reproductive health. There are, however, positive aspects as well. Unlike earlier years, the Government has been relatively open about providing information. Also, in Jakarta, NGOs have been involved, along with Government, in the preparation of the ICPD at Ten report, although it is unclear how much weight their recommendations have carried. Despite this, however, Government reports have tended to lay the blame for the Government's failure to achieve ICPD targets at the door of NGOs and society in general, and have tended to imply that because NGOs also receive foreign funds, they should share accountability for implementing programmes. The notions of participation and responsibility have also provided the Government a convenient cover to say that NGOs need to participate more if programmes are to be successful. Another constraint to implementation of programmes is the fact that Government departments often lack inter-departmental coordination.

Privatisation of the health sector and fiscal reform has added to these difficulties by making health services more expensive. The promise of improving quality that accompanied such reform has also not been fulfilled, as also the guarantee of access to services for the poor. Not only is implementation faulty, but there are also reports of corruption and a lack of transparency. As a result those most in need are unable to depend on healthcare security.[18]

## Main Implementation Constraints and Supporting Factors

### Constraints

Indonesia is one of the countries where economic recovery has taken a long time. Also, the monetary crisis has been aggravated by a number of natural disasters, which have, in particular, affected agriculture. The consequences of this in what is primarily an agricultural country do not need elaboration. Constant political turmoil and violence, as well as anti-State movements, have contributed to the instability. The inability of the State to deal with these various crises, and the growing corruption in its institutions, have led to a loss of faith in the State on the part of people. Weak law enforcement, a virtual absence of governance, a lack of attention to the regions, closure of many banks are all part of this scenario. In recent years, unemployment has grown as factories have had to close down, and the Government's assurances about recovery are beginning to seem misplaced.

Further, the export sector, often seen as a vital source of income for the State, has been on a downhill slide, which means that many more people are being pushed below the poverty line. As a result of the drop in the exchange rate of the Rupiah (IDR) against foreign currency, fuel prices have risen and in a sort of domino effect, the prices of basic commodities have also risen. The middle and lower classes have been particularly badly hit, especially when it comes to purchasing vital goods. Under such circumstances when immediate costs for consumption cannot be pushed down any further, people generally tend to economise on expenses for education and health as a strategy to survive.

The Government's attempts to find solutions have included using various grants and loans received and sometimes already allocated for other purposes, and

introducing safety net programmes. Presented as an alternative to raise the standard of living of the lower and middle strata of society, these programmes have largely been ineffective for a number of reasons, including the large-scale abuse of funds, both because of corruption and frauds perpetrated by the recipients.

In times of economic crises, the health sector is always among the first to face constraints. Costs of health services go up, but budgets are often reduced even when, in the first instance, they have been limited. In Indonesia, several plans to make health services more effective have been put in place but the economic crisis has meant that new, unforeseen problems have now arisen, such as, for example, problems relating to the availability of medicines and drugs. The Government's attempts to produce slightly inferior quality drugs indigenously have not had positive results mainly because they have not been able to keep prices low.

To come to terms with this difficult situation the Government of Indonesia has decided to use as much foreign money as possible and has even sold several vital State assets in order to meet the needs of its population – a decision taken in haste, without due consideration of the long term consequences and which can result in impoverishing the masses. Another strategy been to mobilise MNCs (multinational corporations) and TNCs (transnational corporations) by giving them opportunities to manufacture certain goods (such as pharmaceutical products) and recruit Indonesian labour. This system of managerial cooperation has various pros and cons. The opportunity to obtain a license in order to operate and run a business in Indonesia involves several facilities, for example the facility to determine the price of drugs, and this is precisely what creates the problem. Another example can be found in the food industry. Companies here are enabled to influence the taste of consumers as they work together with the Government. Government regulations also allow them to make their own arrangements regarding the labour force, and often they use this to tie workers down. Many of the new labourers are women whose husbands have lost their jobs as a result of the economic crisis. Women's educational levels and work experience are generally limited, so working as labourers is their most common choice. Their weak bargaining position is a factor that weighs heavily because in the past low wages constitute a characteristic of the female labour force. This is due to the general notion that women are not the main providers. Other basic rights of women such as maternity and menstruation leave, as well as time to breastfeed or protection against sexual harassment and violence of course will be considered a luxury that is not within reach of these women workers.

Meanwhile, although gender mainstreaming has already become part of Government policy, Government budgeting is yet to be influenced by it. Gender budgeting is interpreted as a formula to separate budgets for men and women; not as a matter of gender justice in terms of allocation of funds. The State Budget in the year 2001 only allocated 1.15 percent to the programme for institutionalising gender mainstreaming.[19]

The still extensive dependency of the Indonesian Government and NGOs on American sources of funds has influenced the comprehensive health services, which also provide abortion services. The ultra-conservative Bush administration has prohibited all funding agencies under USAID to promote or support abortion services. Even the UNFPA has been influenced by this policy.

Continuing conflicts in several provinces have rendered it more difficult for NGOs to work in these regions and to provide information and reproductive health services. The general trend towards conservativeness is reflected in the fact that polygamy has found widespread acceptance (because of a campaign

run by one man) and high Government officials publicly proclaim that they have more than one wife. Similarly, various parties have come out openly to claim that it is forbidden (*haram*) in Islam to choose a female president for the country.

### Supporting Factors

Women's empowerment is one objective of ICPD that is still in the process of implementation today. A number of efforts to eliminate violence in several domains include the socialisation of domestic violence as an issue and violence against women in general. Most such activities are organised by concerned NGOs and comprise aspects such as disseminating information, organising seminars, creating awareness of the Zero Tolerance norm.

Decentralisation (*Otonomi Daerah*), apart from being a constraint, can actually also be viewed as a supporting factor, as each region can develop programmes in accordance with local conditions, while aiming at optimising local potential. In many areas regional autonomy has meant that local government concentrates its efforts on ways to increase its income, amongst others by using the health services as 'a milch cow' to extract money. Access to health care has become a problem for less affluent social groups because of the costs. Therefore, the policy of the government to develop a system of social security for everyone is really made use of to help these groups of the poor in such a way as is meant by the policy and the strategy of decentralisation of the health care sector.[20]

Advocacy by NGOs is supported by the media in order to promote affirmative action. The quota of 30 percent women representatives in political bodies and the promotion of women candidates for the legislature are seen to have had an increasing impact. Although no significant progress has been made during this election compared to the previous one (the percentage of women in the legislative councils went up from 9 to 11), at least this time a number of members have been elected who are already gender sensitive and care about women's issues and several among them are even former NGO activists.

Despite many shortcomings in implementation several policies that have already been established or are in the process of formulation can be made use of to improve the situation. The era of openness makes it possible and easier for elements of civil society to work together. For example, many academics have become attracted to do research and give courses on reproductive health. In a society that still attaches high value to a positivist approach, academics still have an important role to play in order to convince society on the 'truth' of certain social facts.

## Future Concerns

The World Bank's insistence on privatising the health sector has led to major changes in government policy. Privatisation is a response to globalisation and neo-liberalism and in this case, has opened the way for multinational and transnational corporations in Indonesia because of the soft governmental regulations. Numerous corporations operating in the provision of health care services and the food sector have set up offices and production units in the country. The feminisation of poverty has a large influence on the labour force as women's limited access to work goes in favour of these corporations because of women's weak bargaining power. The increasing opportunities open to multinational and transnational corporations also weakens the regulating role of the Government.

Limitations on the distribution of drugs and other health care facilities are part and parcel of the privatisation programme that is often supported by grants from the World Bank. These help to put pressure on the Government in terms of policies and regulations that it may put in place. A limited choice of drugs, equipment, and health care facilities is one of the consequences of privatisation. Because America's influence is so strong, the changes in policy after the coming in of the Bush administration have had very negative consequences for Indonesian women, for example in lowering the budget for the health sector, which has a direct impact on women's health.

Some better off countries do make an effort to help the economies of so-called Third World countries by providing health care facilities, but their strategy is such that it creates dependency on the supply of such facilities. By way of the implementation of policies in the health sector the direction of development of the Third World follows the direction of the policies of these countries. The approach of the rich countries is to influence policy making in a wide sense so that low and middle income countries become ever more dependent. Donor agencies very openly influence policy making in Third World countries by giving assistance which intends to cripple national governments' ability to control their own health policies. NGO's should be aware of this systematic weakening of the position of their national governments. On the one hand they should be prepared to take a critical and controlling stand, but on the other they also need to stand by their government, both in terms of assisting in policy formulation as well as implementation of programmes in order to achieve the most optimal benefit for society.

The development of fundamentalist movements in several areas has been able to strengthen and at the same time also to challenge several indicators in ICPD. The large religious denominations embrace the principles of anti-abstinence and anti-abortion, such as the Catholic Church and part of the Muslim community. These religious communities still cling to their dogmas using these to oppose sexual and reproductive health rights. The choice for induced abortion is considered a sin and stipulated as illegal by law and the consequence of this is the loss of many women's lives each year.

## Challenges and Recommendations

Each region is unique and needs a special approach. This has been expressed in several research reports from the field. Often, the material in these reports is not made public because of the fear of social non-acceptance or rejection. For example, findings on HIV/AIDS are hidden from society at large although this may have serious consequences for the further spread and monitoring of the epidemic. Another challenge is the need to involve men in programmes of reproductive health considering their dominant role as decision makers in Indonesia, even in such matters as medication and birth. There are still many unmet contraceptive needs, as well as a lack of services in contraceptive distribution and marketing, and very little involvement of men overall in these issues.

**General recommendations for the Government:**

- Implement a comprehensive concept of reproductive health in a population and health care programme
- Pay more attention to reproductive health, and revise existing policies.
- Develop a cross sectoral system of cooperation involving various departments and offices in order to streamline programmes.
- Fight corruption.
- Ensure law enforcement.
- Stimulate and strengthen expertise and work attitude in reproductive health services.
- Develop work relationships between public and private sectors to deal with the provision of health care services and medicines and medical equipment.
- Make a database on matters of reproductive health and sexual health that is accessible to the public in all regions to facilitate the formulation of strategies and implementation of reproductive health programmes
- Review the decentralisation policy in the health sector, for preparing for the distribution of contraceptives to peripheral women
- Review privatisation of the health sector, of education and other sectors that touch upon the interests of the general public
- Formulate a programme for poverty reduction that is gender sensitive.
- Execute programmes in all regions – and do not give priority to certain regions only, such as Java. Pay due attention to the situation and conditions in each region to ensure adequate intervention through a programme.
- Give serious attention to HIV/AIDS security.
- Use research on Reproductive Health and rights as part of policy making.
- Ensure that young people and youth organisations become partners in developing youth programmes and are able to decide on the kinds of strategies that are needed to develop a programme. They should also be involved in the monitoring and evaluation.

**General recommendations for NGOs and GOs:**

- As mediators providing reproductive health services and in possession of independent means, be independent in choosing the organisation's approach and strategy.
- Make available alternative sources of funding that can be used to strengthen GOs in implementing reproductive health programmes, in particular at district and subdistrict levels.
- Urge donors to support innovative and alternative programmes and inspire trust that NGOs and government can work well together.
- Stimulate the government always to involve society and various women's organisations in the planning, implementation, monitoring and assessment of policies and programmes to ensure that reproductive and sexual health needs of society are fulfilled.
- Develop support for those regions where civil society is still not capable of organising advocacy on reproductive health issues.

**General recommendations for donor agencies:**

- Provide dynamic assistance and support to the adequate fulfilment of local needs.
- Cooperation between donors on the national level is needed to ensure an equal distribution of programmes to various regions/places.
- Unify the reproductive health approach of international donors engaged in the field of health care and development aid.

- Integrate reproductive health in relevant development and anti-poverty programmes and monitor and evaluate these regularly.
- Relocate the authority to plan, implement and control programmes from international bodies to local institutions or NGOs to create compatibility in the execution of programmes.

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## Abbreviations / Acronyms

| | |
|---|---|
| ADB | Asian Development Bank |
| ANC | Antenatal Care |
| APPC | Asian and Pacific Population Conference |
| ARH | Adolescent Reproductive Health |
| ARROW | Asian-Pacific Resource and Research Centre for Women |
| ARV | Antiretroviral |
| ASRH | Adolescent Sexual and Reproductive Health |
| BKKBN | Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Board Coordination) |
| CBR | Crude Birth Rate |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CPR | Contraceptive Prevalence Rate |
| CRC | Child Rights Convention |
| DA | Delivery Assistance |
| DIY | Daerah Istimewa Yogyakarta |
| DKI | Daerah Khusus Ibukota |

| | |
|---|---|
| FGDs | Focus Groups Discussions |
| FP | Family Planning |
| FPG | Focal Point Group |
| GAD | Gender And Development |
| GO | Government Organisation |
| GR | Growth Rate |
| HIV/AIDS | Human Immuno-deficiency Virus/Acquired-immune Deficiency Syndrome |
| IAIN | Institut Agama Islam Negeri (Islamic State Institute) |
| ICPD | International Conference on Population and Development |
| IDHS | Indonesia Demography and Health Survey |
| IDPs | Internally Displaced Persons |
| IMF | International Monetary Fund |
| IMS | Infeksi Menular Seksual (Transmitted Disease Infection) |
| IMW | Indonesian Migrant Workers |
| IPPF | International Planned Parenthood Foundation |
| IRRMA | Indonesia Reproductive Rights and Health Monitoring and Advocacy |
| ISR | Infeksi Saluran Reproduksi |
| ITP | International Training Programme |
| JP-BK | Jaring Pengaman Bidang Kesehatan |
| JPK | Gakin Jaring Pengaman Kesejahteraan Keluarga Miskin |
| JPS | Jaring Pengaman Sosial |
| KIE | Komunkasi Informasi Edukasi (IEC: Information, Education, Communication) |
| MDGs | Millennium Development Goals |
| MM | Maternal Mortality |
| MMR | Maternal Mortality Rate |
| MNC's | Multinational Corporations |
| MOH | Ministry of Health |
| MOWE | Ministry of Women Empowerment |
| NFPBC | National Family Planning Board Coordination (BKKBN) |
| NGO | Non Government Organisation |
| NTT | Nusa Tenggara Timur (East Nusa Tenggara) |
| NU | Nahdlatul Ulama |
| P2M | Pemberantasan dan Pengendalian Penyakit Menukar ( Eradication of Transmitted Diseases and Healthy Environment Making) |
| PHP | Provincial Health Project |
| PKBI | Persatuan Keluarga Berencana Indonesia (Indonesia Family Planning Association) |
| PMS | Penyakit Menular Seksual (Sexually Transmitted Diseases) |
| PoA | Programme of Action |
| PONED | Basic Emergency Obstetric Neonatal Service |
| PONEK | Comprehensive Emergency Obstetric-Neonatal Service |
| RH | Reproductive Health |
| RSKO | Rumah Sakit Ketergantungan Obat |
| RTIs | Reproductive Tract Infections |
| SAPs | Structural Adjustment Programmes |
| SDKI | Survey Demografi Kesehatan Indonesia (IDHS: Indonesia Demography and Health Survey) |
| SRHR | Sexual Reproductive Health and Right |
| STD | Sexually Transmitted Diseases |
| STI | Sexually Transmitted Infection |
| SUSENAS | Survey Sosial Ekonomi Nasional |
| TFR | Total Fertility Rate |

| | |
|---|---|
| TNC's | Transnational Corporations |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| UNIFEM | United Nations Fund for Women |
| USAID | United States Agency for International Development |
| VAW | Violence Against Women |
| VCT | Voluntary Counselling Testing |
| VIPs | Very Important Persons |
| WAO | Women's Aid Organisation |
| WB | World Bank |
| WCC | omen Crisis Centre |
| WG | Working Group |
| WHO | World Health Organisation |
| WHRAP | Women Health Research and Advocacy Programme |
| WID | Women in Development |
| YKP | Yayasan Kesehatan Perempuan (Women Health Foundation) |
| ZTP | Zero Tolerance Policy |

# Annexure

## Country Report: Researchers and Writers

| No | Data on Researchers and Writers | | | | |
|---|---|---|---|---|---|
| | **Name** | **Affiliation** | **Sex** | **Age** | **Education** |
| 1 | Triningtyasasih, Coordinator | Rifka Annisa Women's Crisis Centre | F | 36 | Communication and Medical Anthropology |
| 2 | Atashendartini Habsyah & Anita Rahman | Forum Kesehatan Perempuan, Jakarta | F | 52 | Medical Anthropology<br>- Women's Studies, UI |
| 3 | Desti Murdijana | Jaringan Kesehatan Perempuan Indonesia Timur, NTT | F | 43 | Psychology |
| 4 | Elly Yuliandari | Kelompok Study Gender dan Kesehatan, Surabaya | F | 41 | Psychology |
| 5 | Esti Susanti Hudiono | Hotline Surabaya | F | 45 | Counselling and Sociology |
| 6 | Hambali | Kespromatra / PKBI Jambi | M | 44 | S-1 Public Administration |
| 7 | Zohra Andi Baso | YLKSSI, Sulawesi Selatan | F | 52 | Environment |
| 8 | A.Henry Setiawan | HBI, DIY | M | 31 | Sociology and Anthropology |

## Notes

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[3] IRRMA country study in Madura (Maternal Mortality) and in NTT (Family Planning).

[4] Based on an experience participation in a BKKBN training.

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