Fulfillment of Maternal Health as Part of Human Rights: A Case Study of Banyuwangi Municipality of East Java, Indonesia[1]

Team[2]

Abstract. *This article is result of research on the fulfillment of maternal health which conducted in one of city in East Java Indonesia. Approach used for this research is human rights based which also utilise 3-A and 1-Q elements (availability, accessibility, acceptability, and quality) and SPO scheme (Structure, Process, Outcome). Both of these elements and schemes are used to identify the level of fulfilment the State has achieved, because fulfilment of right to health covers not only on the availability of the service and facilities but also on the accessibility, acceptability of the local communities, and quality of the service. There are nine issues within maternal health rights which study in this research: early marriage and early pregnancy; family planning; pregnancy; childbirth; postnatal; abortion; violence against women; STIs and HIV-AIDS and knowledge on reproductive organ. All of these issues considered as basic issue for women in protecting their sexual and reproductive health rights.*

Keywords. *Maternal Health, Women's Rights, Right to Health*

Introduction

Health rights is one of basic right which should be fulfilled by government by providing information, facilities, programmes, funding, and policies. Since health rights covered a lot of issues, this research will focus only on sexual and reproductive health rights. To make the research more specific and contextual with the problem in the chosen area, research team choose one aspect from sexual and reproductive health rights which is maternal health.

Indonesia, as the world's fourth biggest population, has been undertaking a variety of efforts to fulfil rights of maternal and neonatal health as consequences of its participation in various conventions related to rights of reproductive health. Nevertheless, a range of problems requires more intense and integrative efforts for solutions. Data from WHO shown that number of maternal mortality rate in Indonesia is 420 per 100.000 live births. Due to incomplete management of pregnancy- or childbirth-related complications, 20,000 mothers died annually. This number is still high if Indonesia wants to achieve goal number 5 of Millennium Development Goals (MDGs) in 2015 for reducing three-quarter decrease in maternal mortality rate. This condition is recognized by Indonesian government

[1] This paper was presented by one of team member (Inge Christanti) at the First International Conference on Human Rights in Southeast Asia , 14-15 October 2010, Bangkok, Thailand

[2] This paper was summarized from research result of Center for Human Rights Studies by research team: Yoan N. Simanjutnak, Aloysia Vira Herawati and Inge Christanti

which stated that the trend seems to suggest that Indonesia still far from achieving this goal by 2015 (Stalker 2008, p. 19).

Other noteworthy conditions with respect to Indonesian women rights of maternal and neonatal health are high incidence of high-risk childbirth due to the absence of medical personnel aids competent in midwifery and a large number of unsafe abortions. Access to services related to pregnancy, childbirth, and parturition remains problematic in addition to lack of information on methods of contraception and on IMS and HIV/ AIDS. There is a high incidence in teenagers of undesired pregnancies and of premature marriages and limited access to information, education, communication and services of sexual and reproductive health (World Health Organization 2006, pp. 8-9).

Banyuwangi Municipality was chosen as research area based on the preliminary study[3] conducted by Centre for Human Rights Studies University of Surabaya (CHRS Ubaya) under the auspices of RWI and Sida concerning fulfillment of the rights of health and education in five regions in East Java Province. From previous research, the data showed that Banyuwangi Municipality has very wide areas with low ratio of population density to territorial width and the distance to be covered to reach health service sites are further that the other regions. Difficulty of access should be faced by population of Banyuwangi Municipality due to its position in the most east end of East Java Province, adjoining Bali Strait. In terms of maternal mortality rate of 2007 for Banyuwangi Municipality was 64.74 per 100,000 live births, with the highest rate occurred in District of Giri of 237.53 deaths per 100,000 live births. Neonatal mortality rate was 139 per 23,169 live births (6 per 1,000 live births) with the highest cases occurred in District of Giri (23.75 per 1,000 live births).

In increasing health reproductive means fulfilling maternal and neonatal health rights. Therefore, it is important to study the current condition of reproductive health rights in Banyuwangi Municipality with a selected focus on maternal health. This was considering that maternal health covered a variety of aspects, not only of information, access, service, and perception but also of power relation. Additionally, maternal health represented a highly critical basis of maternal mortality rate, neonatal

[3] Study in 2007 funded by RWI and SIDA concerning fulfillment of rights of health and education in five East Java regions of Malang City, Malang Municipality, Batu City, Surabaya City, and Banyuwangi Municipality.

mortality rate, and HIV/AIDS (United Nations Children's Fund 2008, p. 47 – 50).

Concept of Health and Reproductive Health

Health is one of fundamental rights which should be fulfilled since health has a big influence on any other human rights. It means that human rights principles of interdependent and interrelated (United Nation 1993, part I, para 9) are applicable for right to health. For example, right to health and right to education or right to work has a very close relation. Therefore, fulfilment of right to health becomes significant point for everybody.

As part of economic, social and cultural rights, fulfilment of right to health become state obligation. States is considered to bear responsibility for this right (Toebes, Bridgit 2001, p. 169). The notion of state obligation is also mentioned by Katarina Tomasevski in her article on right to health. From the international human rights law perspective, state has obligation on right to health by making policies, regulations or programmes which has relation to the protection and fulfilment of right to health (Tomasevski, Katarina 2001, p. 262).

Definition of health itself is describe in several covenants and conventions such as Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, Convention on Elimination of All Forms of Discrimination against Women, and Convention on the Rights of the Child. More elaborate explanation of right to health (article 12 of ICESCR) can be found in General Comment (GC) No. 14 of ICESCR. This general comment gives detail explanation specific on the protection and fulfilment of right to health by providing interrelated and essential elements in the right to health. These elements become some kind of guideline for state to fulfil right to health. The elements are: availability, accessibility, acceptability and quality (3A+Q).

Interpretation of right to health by committee on economic, social and cultural is not only concerning about appropriate health care but also the underlying determinants of health (United Nations 2000, part I, para 11). Sexual and reproductive health is one of the underlying determinants of health based on the committee's explanation in this GC. Discussion on sexual and reproductive health as part of right to health also occurred in the 1994 International Conference on Population and Development (ICPD). This program of action provides the definition of reproductive health as "a state of complete physical, mental and social well-being and not merely the absence

of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (International Conference on Population and Development 1994, chapter VII, para 7.2) Besides that ICPD in 1994 offered definition of sexual and reproductive health rights (SRHR) which covered decision of couples or individual to decide number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. Based on this definition, SRHR have some cross cutting issues that need to be seen. They are understanding the reproductive system, family planning (contraceptive method), sexual transmitted diseases (STI), HIV-AIDs, domestic violence, and gender and sexuality (Widyantori 2008, http://www.unfpa.org/adolescents/education.htm).

Statement of the Problem

The research intended to study condition of fulfilment of the rights of maternal health in Banyuwangi Municipality. Rights that should be fulfilled are rights which include in sexual and reproductive health rights. In order to study this fulfilment, research team compiled nine issues which related or contribute to achieve maternal health.

Methodology

Research Area

For the purpose of the research, research team has chosen three districts as sampling area. Then one village is chosen for each district. The villages are Mojopanggung village in Giri district, Tembokrejo village in Muncar district, and Segobang village in Licin district. These three villages differ in geographic location and have its own uniqueness representing three categories:

- Sub-district of Mojopanggung (District of Giri) representing urban area and ethnic group of Jawa-Osing[4]
- Village of Segobang (District of Licin) representing mountainous area with ethnic uniqueness (ethnic group of Osing)[5]

[4] The tribe of Java-Osing has happened because of the marriage between Javanese and Osingnese who has lived in Banyuwangi. Most of them are living in urban areas and working as traders, teachers, government officers, and etc.

[5] Osing tribe is indigenous people in Banyuwangi. They are majority people in some districts in Banyuwangi, include in Licin. Most of them work as farmer, but some of them works as trader and employee, such as teachers and government official. They use their unique language called Blambangan dialect; a similar with Javanese and Balinese language. For example of their uniqueness is that they used to build their house without nail. As an indigenous group, they used to close communication with someone who is not from their tribe. However, within the time being, they are now open to change and to adapt their uniqueness with modern society.

- Village of Tembokrejo (District of Muncar) representing coastal area with a high rate of poverty (majority of Madurese ethnic group)[6]

Research Issue

There were nine issues that explored in this research. These issues were: early marriage and pregnancy, family planning, pregnancy, childbirth, postnatal, abortion, violence against women, sexual transmitted diseases (STIs) and HIV/AIDS, and knowledge of sexual and reproductive organs.

Respondent

For this research, there were 360 respondents (120 per area), from 19 – 49 years of age and 18 teenagers were interviewed on one on one bases. Respondents were classified into three groups: both male and female in their reproductive age (19 – 49 years old), married and had children, and male female teenagers (between 15 – 18 years old who committed early marriages, both with and without having children).

Analytical Scheme

Rights holder and duty bearer are two sides that should be measure in human rights research. Right holder is people/community as owner of the rights which should be fulfilled. Duty bearer is the state who has duty to respect, protect and fulfil the rights. Usually, these duties referred to the context of economic, social and cultural rights (ecosoc rights). Each duty can be explained as follows:

- Duty to respect, that is, not actively to deprive people of guaranteed right
- Duty to protect, that is, not allow others to deprive people of guaranteed right
- Duty to fulfil, that is, to work actively to establish political, economic, and social systems and infrastructure that provide access to the guaranteed right to all members of the population (Green, Maria 2001, p. 1071-1072).

Many discussions on how to monitor rights fulfilment, especially for ecosoc rights should remember that these rights are subject to "progressive realization". It means that full realization of these rights can not be achieved in a short time yet state party should also ensure that there is no retrogressive condition (CESCR 1990, para. 9). State has obligation to make any efforts in order to respect, protect and fulfil ecosoc rights through its legislations,

[6] Madurese people lived in eastern part of East Java Province from Pasuruan Municipality up to Banyuwangi Municipality. They use Madurese language, and only some of them can use Javanese language. Madurese people have known as impulsive person, temperamental, and holding firmly to his believes. Yet they are also known as hard worker, discipline person, and thrifty.

policies, programmes, facilities, and so on for these rights need to be provided by state party. For example, right to health, people can have this right if state provides health facilities, health personnel, regulation on creating healthy environment, etc.

In order to measure "progressive realization" in ecosoc rights, committee on economic, social and cultural rights suggested an analytical framework which has principle of Availability, Accessibility, Acceptability and Quality (3A+ Q) (CESCR 1990, para. 12):[7]

- Availability means health facilities, goods and services as well as programmes which have to be available in sufficient quantity within state party.
- Accessibility means health facilities, goods and services have to be accessible in four dimensions:
  - o Non-discrimination
  - o Physical Accessibility
  - o Economic Accessibility
  - o Information Accessibility
- Acceptability means health facilities, goods and services must respect medical ethics and culturally appropriate for individuals, minorities, peoples and communities; have gender sensitive and life-cycle requirements and also designed to respect confidentiality and improve the health status of those concerned.
- Quality means health facilities, goods and services must also be scientifically and medically appropriate and of good quality. Also, good quality for skilled medical personnel, scientifically approved and unexpired drugs, hospital equipment, safe and potable water and adequate sanitation.

Besides that, the term "progressive realization" also made people in human rights community thought about indicator for monitoring progressive realization. This thought came up in the Vienna Declaration and Programme of Action (1993) which emphasized the importance of indicators. Paul Hunt, special rapporteur for the right to health proposed three categories of indicators: structural, process and outcome indicators (SPO) (Hunt, Paul 2003, para.52):

- Structural indicators focus on whether state has key structures and mechanisms which necessary for the realization of the right to health. For example, ratification of international treaties, adoption of national laws and policies to promote and protect right to health including regulatory agencies

[7] See also Preliminary Report of the Special Rapporteur on the Right to Education by Katarina Tomasevski which has similar principle.

- Process indicators measure programmes, activities and intervention of state.
- Outcome indicators measure influence of the programmes, activities and intervention made by state on health status and related issues (Hunt, Paul 2003, para.54-56).

Result

This section will consist of two main discussions. Firstly, the writer will give description about Banyuwangi Municipality and three research areas in terms of geographical, population and social condition. Then, the discussion will continue on explaining the condition of maternal health based on research data.

Banyuwangi Municipality At a Glance

Geographically, Banyuwangi is located in the eastern part of Java Island and surround by land and water. In the east and south part of this municipality is Bali strait and Indian Ocean while in the north and west are Situbondo, Jember and Bondowoso municipalities. As mentioned before, Banyuwangi's area is the largest area in East Java but with the lowest density with 273 per square km with total population of 1,580,441 in 2007 (BPS 2008, pp. 3-49). This cause by the biggest area within Banyuwangi is forest for about 31.72 percent. The rest of the area is used as housing (22.04 percent); plantation (14.21 percent); rice field (11.44 percent); un-irrigated agricultural field (2.80 percent); fishpond (0.31 percent); and others (17.48 percent).

Based on statistic data from Banyuwangi in Figures 2008(BPS 2008, pp. 101-103), local government has provides some health facilities to support the improvement of maternal health in Banyuwangi municipality. Number of Community Health Centre for 24 districts is 45 units and 105 units of Sub Community Health Centre. From 45 units of Community Health Centre only 15 units can take in-patient. There are also 164 unit of Integrated Service Post which usually scattered around villages to give health service focusing on mother and child's health.[8]

In term of maternal health, number of midwife plays an important role in supporting the health of mother and child especially in childbirth. In Banyuwangi municipality, there are 458 midwives available. The existence of traditional birth attendants cannot be eliminate for some people still use their services therefore health department of Indonesia has a program to train traditional birth attendant for reducing

[8] Unfortunately, data on number of community health centre which has capability of giving obstetric and neonatal care cannot be obtained.

unsafe childbirth. This municipality has 478 trained traditional birth attendants.

Mojopanggung Village (Giri District)

Compare to other villages for research location, this village is the closest village to municipality capital since this village is one of village in capital city. This village covered 233.6 Ha and there are 5,910 people live in this village (data until January 2008) (BPS 2007, pp. 4, 14). Government officers or working in a private sector are the highest occupation in this village (522) then followed by farm labor as the second highest occupation with 261 people.

To be able to reach the closest public facility, such as market, health care facility or administration office, people travel for about one hour. In this village, there is one Community Health Centre and 6 Integrated Service Post. Number of health personnel available 3 general practitioners, 2 dentists, 1 midwife and 1 trained traditional birth attendant (BPS 2007, pp. 21, 37). Data from Village/Sub-District Profile of Banyuwangi Municipality on maternal health showed that there were 62 life births in this village on 2008. Number of pregnant women in this village are 94 and they went to integrated post service for pregnancy routine check. 62 of pregnant women were helped by midwife for childbirth. Furthermore, there are 793 couples who used contraceptive methods in this village (BPS 2007, pp. 20, 40-42).

Tembokrejo Village (Muncar District)

The width of this village is 547.918 Ha which occupied by 28,259 people based on report from village officer (Village/Sub District Monthly Report 2008, Annex A-9). Many people work as fisherman (4,391) for this village is bordered by Balinese straits. Other preferred occupation for community is industrial labor (655), farm labor (413), and home industry (183) (BPS 2006, pp. 15-17).

The distance of this village to capital city of municipality is about 36 km and it need 1 hour drive to reach it. Although this village is wider than Mojopanggung village, people only need to travel for about quarter of hour to reach closest public facilities, such as market, health care facility, and administration office. People can get health care from several health facilities. There are 1 hospital, 1 community health centre, 1 sub community health centre, 1 village clinic, and 36 integrated service posts. Besides that, there are several health personnel who can give health care service to the people. The health personnel in this village consist of 2 general practitioners, 5 midwives,

21 nurses, 4 medical aides, and 21 traditional birth attendants (BPS 2006, pp. 21, 43).

Condition of maternal health in this village can be seen from its village profile. Data on the profile showed that on 2006, number of pregnant women was 134. Yet, the data recorded that only 119 women went to integrated post service to get routine pregnancy check. Midwife became the preferred choices for helping the process of childbirth by most women in this village (740). Number of childbirth is related with number of life birth in this village (740). For family planning program, there are 4,938 fertile couple who used contraceptive method (BPS 2006, pp. 40-42).

Segobang Village (Licin District)

Segobang village is located in the highland. Total width of this village is 701.78 Ha and most of the area used as out of farm land (642.70 Ha). Only 57.80 Ha is used as housing, public facilities and road. Based on the description from Medium Term of Development Plan of Segobang village of 2007-2012, road is the main target of development. Roads in this village often ruin caused by landslide and erosion for there are 4 rivers through the village and high rate of rainfall (Medium Term of Development Plan of Segobang village of 2007-2012, pp. 3-4, 14). The road condition make it difficult for people to travel even though distance of this village to capital city of municipality is only 17 km. Unfortunately, there is no information regarding how far or how long does people need to travel to travel to reach the closest public facilities.

5,563 people live in this village. Relevance to the use of the land, 1,205 people works as farmer and 201 people are merchants. There are also people who work by breaking stone (67) or renting motorcycle (50), and work as carpenter (43). To maintain and improve health of its people, there is 1 village clinic and 6 integrated service posts. These health facilities are supported by 1 midwife, 1 medical aide, and 5 trained traditional birth attendants (Medium Term of Development Plan of Segobang village of 2007-2012, pp. 9, 13, 20). Information on condition of maternal health is not available through Medium Term of Development Plan of Segobang village of 2007-2012.

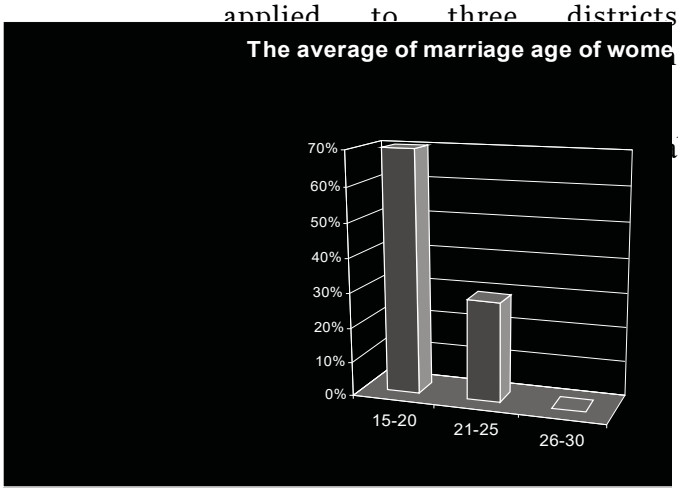
Condition of Fulfilment of Maternal Health

The research explored nine issues which were related to the fulfilment of maternal health. Each issue was examined using 3A+Q scheme: availability, accessibility (physically and economically), acceptability and quality. For the purpose of this paper, the writer chooses three issues that have

a significant problem related to fulfilment of maternal health as part of human rights. The issues are: early marriage and pregnancy, contraception and violence against women.

- **Early Marriage and Pregnancy**

  This issue was raised in the research in order to know the common age for female first marriage and youngest age to get pregnant. It is common to find females marriage and have their first time pregnancy in a very young age. The majority of respondents, 70 percent, mention 15 to 20 years old as the approximate age of first time marriage among girls in their district. This condition applied to three districts

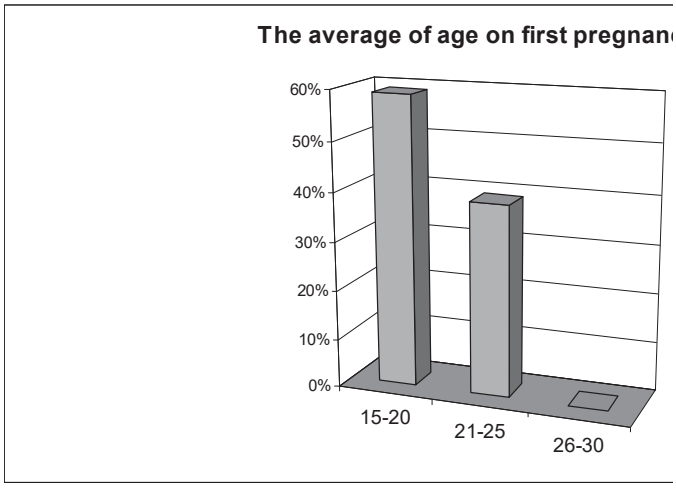


ble 1

More than half respondents (54 percent) informed that commonly female of 15-20 years old experience her first pregnancy (see table 2).

Data for this issue was difference for each district. 97 percent of respondent in Licin district stated that 15-20 years old is the common age for female to experience her first pregnancy. The number is slightly decrease in Muncar district with 60 percent respondent said that 15 -20 years old female of this district experiencing her first pregnancy. On the contrary, in Mojopanggung district only 19 percent respondent told that 15-20 years old female in their district experiencing her first pregnancy.

Table 2



Although many young female marriage and pregnant, there was no special service available for this young female at the Community Health Centre. Most of these young female (74 percent) went to village midwife to get pregnancy check. Similar condition is uttered in the focus group discussion by health personnel. It is said that health service in Community Health Centre is provided for everybody. There is no special section for teenager or young mother. Only for administration purpose, registration of teenager or young mother differs from other patient.

Information sessions regarding reproductive and sexual health issues are hardly find, there are only 10 percent of respondents stated that they have been attended this kind of session. This result is support by information from focus group discussion with health personnel and interview with head of family health and planning division. According to Head of Family Health and Planning division, since 2005 Teenage Reproductive Health Information and Counselling Centre were established. Yet, the role of this centre is starting to emerge in 2007. Reproductive and Sexual Health information session usually hold by Health Office of Banyuwangi Municipality based on request or invitation from schools, or other parties. There is also other information session and programme

regarding teenage reproductive and sexual health based on information from Giri's health personnel. Unfortunately, this information session and program does not available in all junior or senior high school around Banyuwangi Municipality.

This rate of first pregnancies was worrying compared to reference by World Health Organization (WHO). According to recommendations of WHO, the safest age for pregnancy and childbirth was 20 to 30. Pregnancy under age of 20 might lead to problems since physical conditions were not fully ready. Pregnancy and childbirth at that age increased maternal and child mortality rates by 4-6 times relative to pregnancy and childbirth at ages of 20 to 30. According to Convention on Children Rights and Act No. 23 of 2002 on Protection of Children, every children has rights to health that includes right to obtain information on reproductive organs and its functions and right to receive protection under legal rules in order for the fulfilment of those rights. Fulfilment of those rights was complete duty of the state. Therefore, a variety of national programs devised for teenager health should be more focused on reproductive health, especially on provision of information for teenagers in order to prevent occurrences of early marriages and pregnancies.

Right to information and education is important for maternal health since this right is one right in sexual and reproductive health rights which should be fulfilled. Having right and comprehensive information about sexual and reproductive rights can become basic knowledge for young female and male in making decision of getting married or pregnant at a young age. Fulfilling this right also means raising their awareness about risk or threat of married or pregnant too young. Understanding the risk or threat of married or pregnant too young could lead to decrease number of young female and male get married or pregnant in a young age. Eventually, it can also decreasing number of stillbirth or maternal death.

- **Family Planning**

Family planning had been known by majority of community in Indonesia for government given a very high priority for this issue as one of the program for national development. For this issue, the writer will limit her discussion on two schemes: availability of information for family planning and quality of information given to respondent (comprehensive information on contraceptives given by village midwives and doctors).

Health personnel have a very important role in fulfilling right to information on contraceptive for the people. In this research, this role is clearly assigned for doctors and village midwives. They are responsible for distributing comprehensive information, so that local people understand the purpose of contraceptive, as well as their types and side-effects. Majority of respondents have the experience of using contraceptive (84 percent). Around half of them chose injection (56 percent). Although the price is higher than pills, they prefer injection rather than the other popular methods because of its practicality. Injection is considered more practical for its longer period of effectiveness. Most respondents in discussion shared that using pill is not convenient for pill need to be taken everyday at the exact same time. There is also some worried regarding the use of pill for a long period.

Information on side-effects of contraceptives is equally important to the information on contraceptives itself. Based on survey and FGD results, respondents show a considerable level of knowledge on side-effects of contraceptives. Gaining much weight is known to be one of the side effects of using contraceptive for 86 percent of the respondents. Number two and three on the list are nausea or sickness feeling (72 percent) and menstruation cycle (70 percent). 27 percent of the respondents mention prolonged bleeding as a side effect of using contraceptive. Other side-effects are black stain (35 percent) and weight lost (29 percent). FGD respondents also mention approximately similar range of side-effects, and few additional side-effects, namely whitish, pain on low part of stomach, and continuous ulcer.

The survey showed that 35 percent of the total respondents gaining information about side-effect from village midwives; it is the biggest figure earned by village midwife, compared to other possible source of information. This showed that the obligation to fulfil right to information and education has been fairly conducted by village midwife, and the local people have expressed their recognition on the midwife's efforts. However, there were 30 percent of respondents who admit that they were gaining the information on side-effect their own efforts, and another 28 percent who were gaining the same information from their friends (see table 3).

It meant that, there were more than 50 percent of respondents have not experienced in practice the role

of village midwife in giving information on side-effect. This also implied that more people were giving out their own efforts to get information on side-effects of contraceptives, and that there is a lack of role of health personnel in disseminating information on side-effects of contraceptives. These people might have gotten the information on contraceptives from posters, radios, or televisions. As for teenagers, who got no direct services from the health providers, they knew about contraception methods from Indonesian Red Cross when visiting their school. Doctors at the community health centres were the second possible source of information, however the survey shows that only 2 percent of respondents gaining the information from doctors. It could have happened that doctors are not the most preferred source of information for the people.

The concern regarding this imbalanced role between village midwives and local people functioning as source of information should be placed upon the quality of knowledge owned by the local people. Presuming that there may have been a number of people giving inappropriate type of information, a misleading or misconception of side-

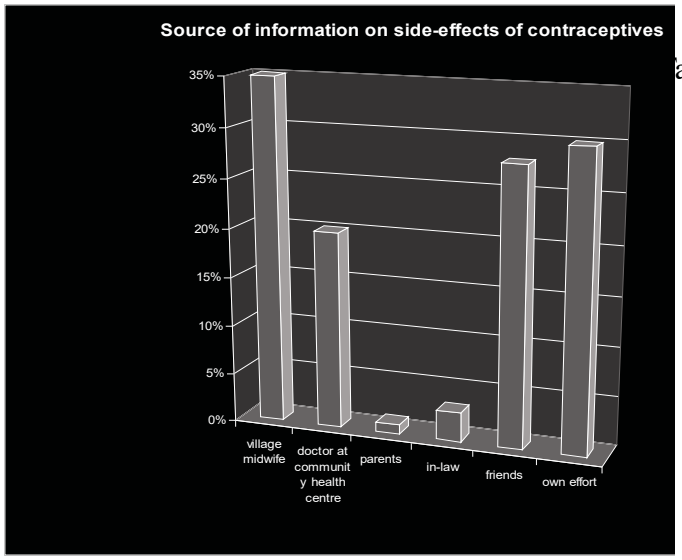


Table 3

effects of contraceptives might have occurred. Worse still, the problems are very much likely to be sustained for a long time and internalised among the local people, without any significant efforts to counter those misconceptions.

The fact that there are a considerable number of respondents prefer gaining information from their friends than village midwives, could have implied a problem as well as an advantage. Health institutions could have optimised the approach of peer-education to address the problem of equally distributed information on types of contraceptives as well as side-effects of contraceptives to local people. Of course, this approach would need another effort of selecting a group of local people as peer-educators and conducting consistent and qualified trainings, to ensure that holistic information is equally distributed. This research found that there is an issue on treating clients experiencing side-effect of contraceptive. This shows that in the implementation of family planning program the obligation to provide service and protection to women is actually more important than providing basic information for them. It is related to making available of the service as well as sustaining the level of reproductive health of those women.

- **Violence against women**

This issue was discussed in the research for violence against women often related with sexual behaviour and reproductive system, especially in a country where men and women are not equal culturally. Act of violence can be varied from mental, physical and verbal. It can happen from child to adult female. This research found out that female genital mutilation (FGM) or female circumcision (FC) can still be found in almost all three districts.

Before discuss about the incident of FGM in the research area, this section will explain about FGM definition first. Considering different methods used in conducting FGM in Indonesia and other countries, it becomes important to explore the differences, as well as to emphasise the degree of destructiveness on women and girl child. This will further lead to the basic understanding that FGM is a human right violation. Definition FGM based on WHO are all procedures from partial to total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons (WHO 2001, www.who.inte/entity/gender.other_health/teachersguide.pdf. FGM consists of several types (WHO 2006, p. 3):

1. Type I - excision of the prepuce, with or without excision of part or all of the clitoris
2. Type II - excision of the clitoris with partial or total excision of the labia minora
3. Type III - excision of part or all of the external genitalia and stitching/ narrowing of the vaginal opening (infibulation)
4. Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above

FGM practice in several areas in Indonesia shows a difference in methods of mutilating, ranged from pricking, piercing or incising of the clitoris and/or labia, stretching of the clitoris and/or labia, cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina, introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it, falling into category of Type IV of WHO's definition of FGM (Population Council and USAID 2003, p.28). Although practice of FGM had been found out through a research by Population Council Jakarta in 2003, there has not been a significant progress to eliminate this practice until now by government. Comparing the previous research by Population Council Jakarta with condition in Banyuwangi, issue in FGM have not been changed or undergone slight changes.

The field data shows that FGM practices still occur in the municipality of Banyuwangi, admitted by several doctors and midwives as well as a number of respondents during the discussions. Majority of respondents emphasize the importance of FGM, because it is believed to be a symbol of compliance to their religion. Due to the assumption that FGM is a common practice, and an obligation, no one is able to estimate the number of cases happen in Banyuwangi. None of them are able to specify certain numbers to prove the intensity of the practice, however, as FGM is believed to be part of their livelihood and is considered as common. The only situation they can ascertain is that many mothers are still taking their newborn girl babies to be genitally mutilated. FGM is usually conducted

on newborn babies aged 40 days, while some babies have even been mutilated when they are 6 days old. Sometimes FGM is conducted together with other rituals, usually baby wearing its first earrings and the cutting of baby navel.

During interviews with Traditional Birth Attendances (TBA), some different methods are admitted to be used in conducting FGM. One method is involving scraping the tip of clitoris on the right and left sides for several times with a new and sharp shaving razor. This has to be done very gently, not to causes any wound or bleeding on the scraped area. Complying with the rituals, the scraping should be done in a certain odd number of times, and the TBA could choose between five or seven times of scraping. The TBA explains that this is a ritual that has been accepted and followed for generations, thus it defines the execution of FGM. Another method of FGM is involving picking and piercing the tip of clitoris with a new and sharp shaving razor. According to the TBA, the picking and piercing should constitute minor bleeding on the clitoris, when then it will be cleaned with water. The TBA further states that the picking also leads to the removing of the part being picked. Another TBA describes a combination of scraping and picking the tip of clitoris. Afterwards, she would stop the minor bleeding by wiping a piece of cotton filled with iodine over the area. Looking at the above explanation, one might conclude that the FGM practice in Banyuwangi falls into type IV of the WHO's classification of FGM, or known as the unclassified definition of FGM. This most recent classification is included in the last version of FGM definitions published by WHO, UNICEF, and UNFPA joint-statement in April 1997.

FGM cannot be instantly eliminated, regardless of continuing efforts such as dissemination of the danger of FGM to households conducted by integrated service post; information session by Family Welfare Program, integrated service post, and religious forum; partnership program for village midwife and traditional birth attendant. An effort conducted by village midwife to prevent the risk of FGM to the babies' health is by giving an initial approval to provide FGM to the babies, but instead only performing regular check-up on the babies' genital health and hygienne. They usually clean the genital area from the remaining of the fetal membrane or baby powder, to prevent the genitals from getting infected or fungus. Afterwards, the village midwife takes the time to

provide an explanation to the mothers about the danger of FGM practice on the sexual and reproductive health of the babies. This approach has been effective in decreasing FGM practice, however it has also constituted a problem as this approach is creating a deviation in information.

There is still a high number of request from local people to be provided with FGM as well as a high number of cases of FGM conducted by non professionals. The Directorate General of Community Health has responded this situation by publishing a letter stating that all health personnel is not allowed to perform any kind of FGM. To highten the significance of this respond, there should also be an effort to involve religious and community leaders to help addressing this issue to the communities, as well as education and counselling on the effect of FGM to the health of women and girl child, and treatment and rehabilition for women victim of FGM.

Conclusion

In general local government of Banyuwangi has made effort in fulfilling maternal health rights in order to decrease maternal death and stillbirth. Yet, in some issue that need more consideration and effort from government. The issues are early marriage and pregnancy; contraception and violence against women (FGM).

Based on result of survey, research team found out that early marriage and pregnancy were common among community in Banyuwangi regardless of their education or cultural background. This fact should be recognized by local government as one of significant problem for increasing maternal health. Educating teenager of sexual and reproductive health become important entry point for prevention action by local government through junior and high school cooperating with local health office. Information on sexual and reproductive health is also one of key for raising teenager awareness of the risks and threat of marriage or get pregnant at a young age. There should be a change of perception in the community itself that discussing about sexual and reproductive health is taboo for teenager.

The next issue is comprehensive information regarding contraception. Family planning program has become one of priority from health programme in Banyuwangi Municipality. Community also has awareness of joining family planning program to limit number of children and spacing of having children. It can be said that the community has exercised their rights indirectly. Right of deciding number of children and spacing of having children as incorporated in sexual and reproductive

health rights. The problem in family planning program is on comprehensive information regarding contraception. The survey found out that half of respondents did not get enough information regarding side-effect of contraception. Even, couple of respondents experienced side-effect of certain contraception for years. Usually, village midwife suggested changing type of contraception without giving any explanation of why this side-effect happened. This condition should be change because everybody deserves to get comprehensive information regarding any health medicine or equipment that s/he need since it is also their right. Having comprehensive information (not only about types of contraception but also side-effect of each type of contraception), everybody make better decision on using types of contraception.

FGM is the last issue that local government should pay attention to for it violation of human rights. It could be seen that many health personnel known that practice of FGM exists in the community. Even, village midwives took part in FGM practicing although they did not really do any cutting. By doing this, village midwives mislead community about the practice of FGM. They should explain to community about risks of FGM practice. It is not easy to eliminate FGM practice but health personnel like village midwives should start take significant step. Partnership between village midwives and traditional birth attendances (TBA) can be an entry point for village midwives for eliminating this practice one step at a time.

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