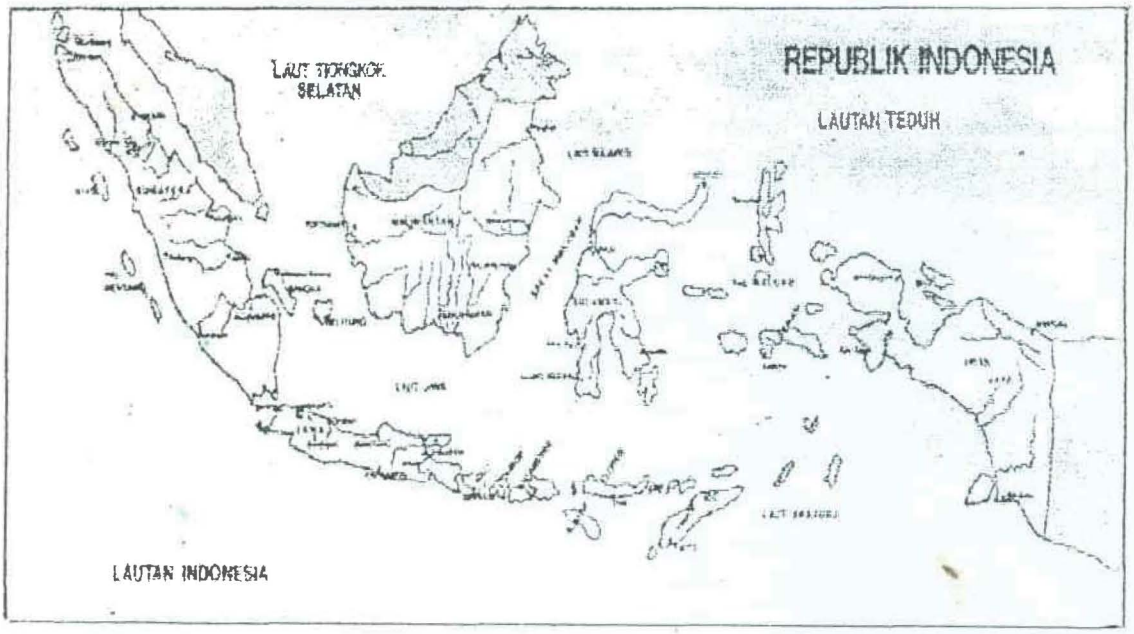
INDONESIA'S NGO COUNTRY REPORT FOR ICPD+ 10



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Indonesia Reproductive and Sexual Rights and Health Monitoring and Advocacy

Indonesia, Agustus 2004

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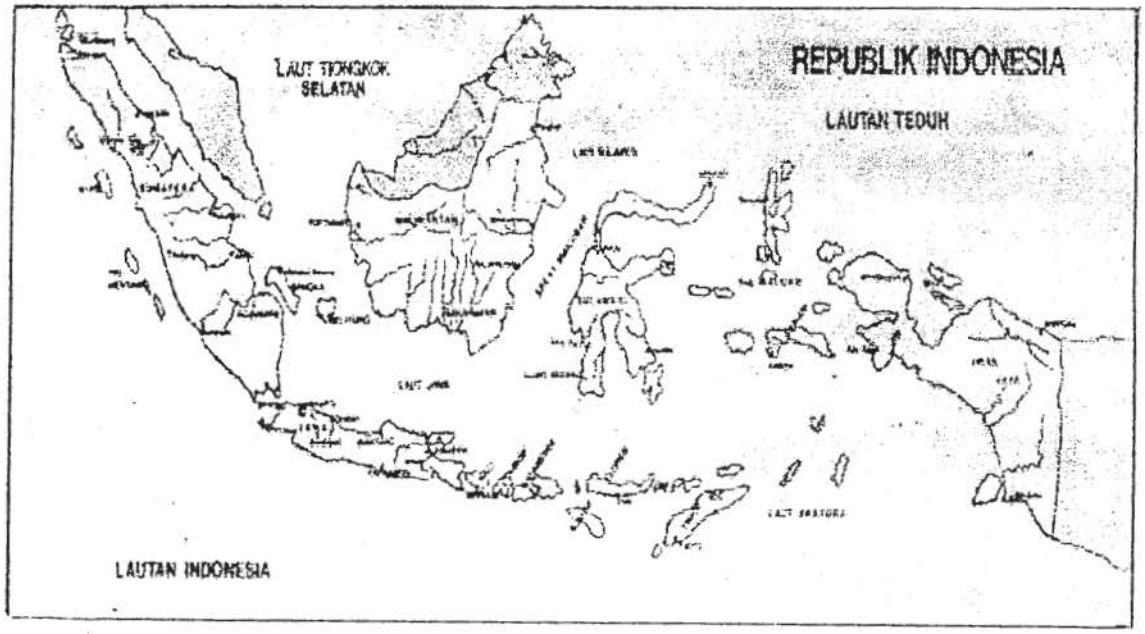

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Acknowledgements

This report was made possible with the generous support from Barbara Klugman of the Ford Foundation, New York, and ARROW. Acknowledgements also go to Ranjani K. Murthy and Rashidah Abdullah for useful comments, all respondents for willingness to share experiences and information, and all supporting teams, including Sita van Beumellen for the English editing.

List of Abbreviations

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 Coordinating Board)
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 (Yogyakarta Special Province)
DKI	Daerah Khusus Ibukota (Capital Special Teritory)
FGDs	Focus Group 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	Indonesian Demography and Health Survey
IDPs	Internally Displaced Persons
IMF	International Monetary Fund
IMS	Infeksi Menular Seksual (Sexually Transmitted Infection)
IMW	Indonesian Migrant Workers
IPPF	International Planned Parenthood Association
IRRMA	Indonesia Reproductive Rights and Health Monitoring and Advocacy
ISR	Infeksi Saluran Reproduksi
ITP	International Training Program
JP-BK	Jaring Pengaman Bidang Kesehatan
JPK Gakin	Jaring Pengaman Kesejahteraan Keluarga Miskin
JPS	Jaring Pengaman Sosial
KIE	Komunikasi 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's Empowerment
Na	not applicable
NFPCB	National Family Planning Coordinating Board (BKKBN)
NGO	Non Government Organisation
NTT	Nusa Tenggara Timur (East Nusa Tenggara)
NU	Nahdlatul Ulama
P2M	Pemberantasan dan Pengendalian Penyakit Menular (= Eradication and Control of Contageous Diseases)
PHP	Provincial Health Project

PKBI	Persatuan Keluarga Berencana Indonesia (the Indonesian Family Planning Association)
PMS	Penyakit Menular Seksual (=Sexually Transmitted Disease)
PoA	Program of Action
PONED	Penanganan Obstetrik Neonatal Esensial Dasar=Basic Emergency Obstetric Neonatal Service
PONEK	Penanganan Obstetrik Neonatal Komprehensif=Comprehensive Emergency Obstetric-Neonatal Service
RH	Reproductive Health
RSKO	Rumah Sakit Ketergantungan Obat (Hospital for Drug Addicts)
RTIs	Reproductive Track Infections
SAPs	Structural Adjustment Programs
SDKI	Survey Demografi Kesehatan Indonesia (=IDHS: Indonesian Demography and Health Survey)
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SUSENAS	Survey Sosial Ekonomi Nasional (National Social and Economic Survey)
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TNC's	Trans-national Corporations
UN	United Nations
UNFPA	United Nations Population Fund
UNIFEM	United Nation Fund for Women
USAID	United States AID
VAW	Violence Against Women
VCT	Voluntary Counselling Testing
VIPs	Very Important Persons
WAO	Women's Aid Organisation
WB	World Bank
WCC	Women Crisis Center
WG	Working Group
WHO	World Health Organisation
WHRAP	Women's Health Research and Advocacy Program
WID	Women in Development
YKP	Yayasan Kesehatan Perempuan (Women's Health Foundation)
ZTP	Zero Tolerance Policy

Table of Contents

domestic violence is more frequent than usual and the fate of young girls is at stake, because they become easier victims of sexual exploitation and trafficking.

IV. Assessing Progress in Achieving ICPD, Cairo Goals and Objectives

According to the 2000 Population Census, the population of Indonesia numbered 205.8 million in 2000 and was projected to reach 211.1 million people 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, a total which already has increased to about 92.7 million (44 percent of the population) in 2002. In 2000, more than 88 percent of the Indonesian population was Moslem.[10]

Table I: Basic Demographics Indicators[11]

Demographic indicators from selected sources, Indonesia 1990-2002

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
Percentage in urban areas	31	42	44
Reference Period	1986-89	1996-99	2002
CBR	28	23	22
CDR	9	8	10
Life Expectancy			
Male	57.9	63.5	64.3
Female	61.5	67.3	68.2

Poverty is very much part of Indonesian people's lives. The number of people living in poverty has increased from 22.5% in 1996 to 37.15% in 2001. Although GOI has frequently attempted to increase women's access to the economy, this was hampered as gender disparities were not looked into.

IV.1. Gender Equality, Social Equality and Equity

A. Gender Mainstreaming

In 2000, during the Wahid administration a Presidential Decree has been issued on Gender Mainstreaming.

Years before, in 1984, Indonesia already has ratified CEDAW by Law No. 7/1984. A Convention Watch Group was installed which periodically issues reports on the implementation of CEDAW in Indonesia and has the task to inform relevant stakeholders (government, universities and NGO's) on the purpose and contents of the Convention.

[10] IDHS 2002-2003
[11] ibid

At present, there is a governmental Women's Empowerment Office (BKPP) in 40 municipalities and regencies in the country. Some of these offices have performed quite well, but others do not have a clear idea what gender and gender mainstreaming is about. Moreover, due to the low status of this agency in the local bureaucracy it does not carry much authority and therefore it is not able to wield much influence.

Violence Against Women

Violence against women in Indonesia has been around for a long time, but it has become a public issue only recently after a lot of Chinese women became victims of sexual violence in the Jakarta riots in 1998. This triggered off a movement against VAW taking two forms. First, a National Commission on VAW was established in October 1998, and second, an increasing number of woman survivors of violence, in particular from areas of endemic conflict and violence (Aceh, Sambas, Ambon, etc) toke the courage to talk to the world about the acts of violence they have experienced. The new openness after the fall down of the Suharto regime encouraged these developments (The National Commission for Women, 2001 : 5).

A problem with VAW is the lack of reliable data. No records on the national level are available. A national survey to find out the incidence and prevalence of VAW has never been conducted. Fortunately, a few recent national reports contain relevant data. For example, the IDHS 2002-2003 and Indonesia's country report presented to the Demographic Assembly in New York in March 2004 provide data on domestic violence. The latter report quotes the following interesting and disturbing findings from a survey held in 2001 (HDR, 2001): out of a sample of 339 male respondents 11% stated they have ever beaten their wife, whereas 19% stated they have abused their spouse psychologically. Meanwhile, out of 362 female respondents 16% stated they have ever been beaten, kicked, or inflicted with burns (usually with a cigarette or an iron: writer) by their husband .[12] Information on cases of VAW is spread throughout a variety of institutions, such as bureau's that provide counselling to survivors of violence, police offices and hospitals. Unfortunately, not all institutions keep good records of VAW cases and the way cases are recorded differ from one institution to another, making it difficult to compile the data in a single database. Although the Bureau for Statistics (BPS) has not prepared data on VAW, an LSM that works on VAW has started a database of cases of VAW covering 13 provinces.

As an example, the following data are taken from one women's crisis center active in the country:

Table II: Violence cases handled by Rifka Annisa WCC, Year 1999-2002

CASE	1999	2000	2001	2002
Abuse by Husband	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**

Data Source: Rifka Annisa Women Crisis Center YogYakarta, 2003

[12] GO Indonesia Country Report, Jakarta, March 2004, conveyed in the CPD Assembly in New York March 2004

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According to a report by the National Commission for Women (2204) the figures for cases of VAW are 3,169 in 2001, 5,163 cases in 2002, and 5,934 cases in 2003 (389 cases concern girls under the age of 18).

In terms of services, a significant and positive change has taken place. In 2003 no less than 30 WCC in various provinces in Indonesia were active. Since 2000 a Women's Desk has been created at many police stations at district and municipals levels, as well as an Integrated Service Center at Indonesian Police Hospitals.

However, handling cases of VAW in court still meets with numerous difficulties, amongst others because the relevant prevailing laws do not provide just and unambiguous guidelines for the prosecution of offenders. The draft for a new law on domestic violence has been approved by the Consultative Body of Parliament (Badan Musyawarah MPR), but has not been accepted by Parliament as yet. The latest news is that approval is pending because the bill has not yet been approved of by the president (although she is a woman herself.)

Cases of rape are subject to the Criminal Code which is still a colonial legacy of the Dutch and definitely out of date. A constraint is also that the perspective of the law enforcers is not gender sensitive, so sentences are often very light. The amendment of the Criminal Code up to this day is still not yet final.

Trafficking of Women and Children

Only after a lot of pushing by NGOs and other countries, the government of Indonesia has begun to pay attention to trafficking of women and children. At present a Law against trafficking of people (*RUU Anti Perdagangan Orang*) as well as a National Action Plan Anti Trafficking are in place.

Indonesia's country report presented in New York only mentions a large number of Indonesian migrant workers abroad (the economic crisis has pushed even more Indonesians to find employment abroad than before). However, the report does not make mention the terrible conditions and even violence experienced by these workers.

Indonesia's report of Indonesia for the UN special reporter for Migrants' Human Rights for example showed that 972,198 women and 383,46 migrant workers are recorded for the period 1999-2002. Most of them work as domestic servant or labourer. The report also makes note of the working conditions of women workers: in particular domestic servants are prone to become a victim of violence. The WAO (Women's Aid Organization) Malaysia, for example, reported the following on 19 cases of Indonesian women workers they handled in 1997-1998: 11 women experienced physical abuse, 3 sexual abuse (rape), 2 had been held against their will, and of 7 others payment and documents were held back. The Indonesian Embassy in Saudi Arabia recorded over 1000 cases of sexual violence experienced by the Indonesian migrant workers between 1994-1997.

Research conducted under the auspices of UNIFEM, quotes the Kobumi (Migrant Worker Konsortioum – an NGO) report which even gives higher figures of migrants.

Table III : The Type and Number of IMW (Indonesian Migrant Workers) Cases abroad

Cases involving Indonesian migrant workers in 2001-2002.
Data from NGO sources
[13]

Case Type	Number of Case	
	2001	2002
1. Dead	33	177
2. Abused and Raped	107	48
3. Sexually abused	-	31
3. Ran away	5,598	313
4. Contact lost	24,325	517
5. No documents	1,563,334	697,000
6. Fake ID	32,390	386
7. Emprisoned	14,222	749
8. Deported	137,866	505,000
9. Fired	222,157	1,897
10. Put to Syariah trial	50	
11. Arrested	6,427	80,546
12. Not insured	65,000	47
13. Salary cut	125,004	
14. Salary witheld/unpaid[14]		41
14. Sentenced to death (or sentence pending)	2	10
15. Lash penalty		682
16. Forced into prostitution / trafficked-sold	-	2,633
17. Victims of Trafficking	-	24
18. Not allowed to pray	-	9
19. Conflicts	-	871
20. Stressed, depressed, insane	-	76
21. Fell Sick/ Handicapped	-	30
22. Held against their will[15]	1,101	470
23. Cheated[16]	1,820	1,685
24. Neglected[17]	34,707	2,478
25. Misled, exploited with regard to foreign valuta [18]		198
22. Others		30,847
Total number	**2,234,143**	**1,308,765**

[13] Research report of UNIFEM; quoted from the Defender Consortium for Migrant Workers (Kopbumi) year 2001 and 2002

Women and Politics

After a long struggle, Indonesia finally adopted affirmative action: a recommendation for a quota of 30 % women for the nomination of candidate members of parliament was finally approved by Parliament. However, many obstacles are still left, including on the part of the women themselves, so the final results of the general election held in May 2004 were disappointing: the number of female members in the legislative bodies at all levels has not increased significantly. In the election 1999, there were 9 % women in the parliament, whereas after the elections it is only 2 % more, i.e. 11 %.

With Megawati as President, woman leadership should not be a problem anymore. However, for reasons of political interest, several Islamic groups have raised again the issue of illegitimacy of female leadership in case a man is still available for the job.[19]

The Elderly

A National Plan of Action for Welfare of the Elderly, adopted in 2002, contains actions (1) to promote wellbeing of the elderly and a social security system, (2) to improve health services catering to their needs, (3) to strengthen family and community support, (4) to improve the quality of life, and (5) to develop special facilities for older persons.[20] Nevertheless, as conveyed by the government of Indonesia, the main obstacle to improve the welfare of the elderly remains the mobilization of needed resources.

B. Girl Child

Early Childhood Mortality

Early childhood mortality has decreased significantly over the past 10 years as is shown in the next table. This table also exhibits the fact that there are still wide discrepancies in infant mortality rates between provinces. While Bali only counts a rate of 14 per 1000 in the IDH Survey of 2002-2203, Gorontalo's rate is nearly five times higher.

Tabel IV. Trends in Infant Mortality: Infant Mortality Rates per province over the period 1994- 2003 ((per 1,000)

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	43

[19] Tempo, May 2004
[20] Indonesia ICPS+10 Field Inquiry Questionnaire, April 2003

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
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 Kalimantan	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 province. Previous surveya included East Timor which has been left out here.

Na = not applicable (Bangka Biliton, Banten and Gorontalo are new provinces created after regional autonomy was installed and separated from the provinces of South Sumatera, West Java and North Sulawesi respectively. So only figures for 2003-2003 are available.)

The table below shows, that no significant difference exists between mortality of male and female infants.

Table V. Neonatal, post neonatal, infant, child, and under-five mortality rates for the 10-year period preceding the survey, by demographic characteristic, Indonesia 2002-2003 (per 1000?)

Demographic Characteristic	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
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 interval					
< 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

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

Nutrition

Across Indonesia, one in three children under five is malnourished[21]. Despite an overall decrease in malnutrition of 5% between1992 and 1998 (see table below), there are regional as well as urban-rural variations. Although only in rural areas a significant decrease has been realized (malnutrition dropped from 38 to 32%) some remote rural districts in Sulawesi, Kalimantan, and East Nusa Tenggara still report up to 50% of the total population under five is malnourished. In rural areas the percentage of malnourished children has remained constant (27%).

[21] Unicef report

Table VI : Percent of Population under Five Malnourished by Region

	1992 (%)	1998 (%)
Indonesia (average)	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 malnutrition percentages between boys and girls.

In particular micronutrient deficiencies are of concern in Indonesia. Vitamin A is essential for normal vision and enhances the immune system. 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 higher mortality and increased severity of infectious diseases.[22]

Sexual Violence Against the Girl Child

Cases of sexual violence against children vary and can be classified as violence of a commercial nature (trafficking and child prostitution) and non-commercial sexual violence (sexual abuse and rape). Sexual violence occurs both in the public sphere (includes sexual violence against street children) and the domestic domain (incest). Classification of a case as a case against a child is made difficult by the different age limits used in Criminal Code (under 15 years old) on the one hand, and the Child Rights Convention and the Law on Protection of the Child on the other hand (under 18 years old).

There are indications that sexual violence in whatever form occurs a lot more often than comes out into the open. The violent conflicts taking place in Indonesia today cause more people to become poor, parents die and leave their orphaned children behind, thousands of parents choose to work abroad leaving their partner and children at home. These conditions also make girls more vulnerable to sexual violence. Young girls take to the streets because of poverty, or they are even sold by their parent(s) or enter prostitution at a very young age. Irwanto[23] estimates there are 21,000 children working as prostitutes in Indonesia. This estimate is based on his calculation that children make up 30% of the total number of prostitutes in Indonesia (73,990 in 2000 according to the Department of Social Affairs). This number does not yet include the number of children trafficked abroad. Experience with sexual violence in one's childhood often deeply affects a person and his/her future, in particular a person's sexual and reproductive health when growing up. The incidence as well as the social and psychological impact of sexual violence against girls makes it legitimate to pay more attention to the phenomenon and do something about it.

Early Marriage

In general, and particularly in the big cities, early marriage becomes increasingly uncommon, young people tend to delay marriage until they are older. However, some

[22] Helrn Keller International, 2001, as cited in IDHS 2002-2003
[23] Irwanto et all, 2001, as cited by ILO, 2004

provinces are known for their continued practice of early marriage. According to Susenas 1998 there are 7 provinces where 10% of the women aged 25-34 married (for the first time) when they were younger than 16. The highest percentage is recorded for

West Java (16%), followed by South Kalimantan and East Java (15%), Jambi (14%) and Bengkulu (11%). The phenomenon is much more prevalent in rural areas. [24]

C. Male Participation

Male participation in RH is often reduced to the practice of certain methods for birth control (mainly use of condoms and vasectomy). The table below shows that men's participation has hardly changed over the past 10 years. Men still use the means available to them on the same level, while women's participation shows considerable changes (for example the use of inject-able). Moreover, men's participation is still appalling low compared to women's involvement in practicing birth control.

Table VII : Trends in the use of contraceptive methods (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 Sterilization	2.7	3.1	3.0	3.7
Male Sterilization	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

Source : IDHS 2002-2003

The 2002-2003 IDHS does not include Nanggroe Aceh Darusalam, Maluku, North Maluku, and Papua province (nor East Timor). It is understandable that there are difficulties to be faced conducting a survey in these areas. However, any effort to gather data is important to steer interventions in the right direction. After all, it is exactly in areas ridden with conflict that health care services are most prone to deriorate.

In the meantime, those involved in the struggle for gender equality and a non-violent environment for women have hardly managed to turn these issues into public discourse. There are only a few male religious leaders actively promoting indiscriminative religious

[24] Challenges for a New Generation. The Situation of Children and Women in Indonesia, 2000, Unicef

teachings against women. A promising initiative a few years ago was the establishment of Cantik (Cowok anti Kekerasan = Boys Anti Violence) in Jakarta, but this organization has developed no activities to speak of after that. Perhaps more can be expected in the long run from another trend. More male university students register for courses and discussions on gender and society than before.

Of particular note is Rifka Annisa WCC's initiative to provide counselling to men who are violent at home. Unfortunately, only very few offenders (0,001%) have been willing to come and talk about their problems.

2. Reduction of Maternal Mortality and Promotion of Safe Motherhood and Safe Abortion

The government of Indonesia has always been proud of its Safe Motherhood Program, but in reality no significant decrease in MMR can be shown over the years. The analysis in the IDHS (Indonesian Demographic and Health Survey) of 1994 mentions a maternal mortality rate over the period 1990-1994 of 390 per 100,000 births, while unpublished data by the 1997 IDHS show a slightly lower figure, 334:1000.000 for the period of 1993-1997. However, since the maternal mortality rates and ratio have always been associated with high sampling errors, it is believed that the interval between the two figures overlaps and therefore it is difficult to conclude that there has been any decrease. The 2002-2003 IDHS shows a decrease to 307:100.000. However, once again, the same problem occurred with error sampling. Thus, it is still difficult to conclude that a decrease of MMR ever has materialized over the last 10 -15 years. [25]

The causes of maternity still show the same pattern. There has not yet any significant change in better access to relevant health care facilities. In Indonesia, 55.8% of births are assisted by trained medical staff, but in rural areas 69% of all births are assisted by indigenous medical practitioners, 19.6% by midwives, 2.7% by doctors, and 2.3% by others (neighbours, relatives) and in 1.4% the mothers deliver on their own (C&C 1995). The same discrepancy is visible with regard to medical checkups of the pregnancy until the 4th month: only 66.3% of pregnant women in the rural and 79.4% in the urban areas. Women who continue with another check-up or checkups up to the 8th month of pregnancy cover only 0.7% of all pregnant women in rural and 1.9% in urban areas.

Let's now have a look at the delivery. 56.96% of all births take place at home, 28.03% at maternity clinics and 2.46% at Community Health Care Centers (Puskesmas). The high rate of maternal mortality at the hospitals, the one place where a mother delivering her baby should have comprehensive assistance, is due to the fact that there is lack of facilities in the hospitals but also to the saddening fact that professional medical assistance at hospitals is often only sought when it is actually too late, because the woman's health condition has already deteriorated too much because of serious complications during or after delivery.
Apart from that, the majority of the medical staff still does not meet the requirements of the standards for PONEK (Comprehensive Emergency Obstetric-Neonatal Service) and PONED (Basic Emergency Obstetric Neonatal Service). Community Health Care Centers able to provide PONED number less than 10% of the total and about 40% of the Regional Public Hospitals at the second regional level do not have any obstetrician / medical support specializing in it. Worrying is also, that about 65% of these hospitals do not have a blood transfusion unit and therefore are not able to perform a caesarian requiring a blood transfusion for the patient.(Indonesian Health Dept., 1997). It is very ironic that the Health

[25] IDHS / SDKI 2002-2003

Dept has set a target of 95% of pregnant women to have their pregnancies checked 4 times during pregnancy by the year 2010 as well as 90 % of all deliveries to be assisted by midwives or medical staff that has sufficient competence. There is still a long way to go!

Another problem is that midwives and obstreticians are not evenly distributed throughout the country. Most obstreticians practice in the four biggest cities: Jakarta, Surabaya, Yogyakarta, and Semarang. Not surprisingly the MMR is relatively low in these cities. However, even here the ratio of competent medical staff compared to the number of inhabitants is not sufficient.

It is not yet common that abortion is recognized and presented as a cause of maternal mortality. Statistical data usually do not make any other differentiation than that between pregnancies and deliveries. If more detailed data are given, these can be ambiguous. Let's have a look at the following data provided by the Health Department that breaks down the causes of maternal mortality as follows:

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

However, excessive bleeding and infection might very well be the result of an (unprofessional / illegal) abortion, so the figure must be higher than the given 5%. Indeed, other estimates give much higher figures. Base on IDHS 2002-2003, it is stated that that abortion is the cause of at least 12%[26] of all cases of maternal mortality. The study by Herdayati (1997) even concludes that 17% to MMR can be attributed to abortion.

Although it is known that abortion takes many women's lives, safe abortior services are hardly available, if available usually very expensive (for reasons explained below) and last but not least, the whole idea of induced abortion (abortus provocatus) is still far from being officially accepted. Even though the government knows that unsafe abortions are life threatening and are a fact of social life, no significant steps have been made to do something about it. The government sticks to its viewpoint that abortion cannot not be legalized because it does not accord with religious values and positive law. Up till 2004 abortion is still illegal in Indonesia conform the Criminal Code and the Law on Public Health No.22/1992. The amendments of this law are still under discussion at the legislative. At present those who are engaged in providing abortion services (whether safe or unsafe from a medical point of view are still punishable by law. Some progress has been made: due to the advocacy of NGO activists more support has been created for legalization of abortion in the case of rape. There is also more support for legalization of abortion for pregnancies under 8 weeks. However, these changes in opinion are not yet reflected in a change of the prevailing laws.

Due to the illegal status of abortion, to get an abortion is often extremely expensive. A study conducted by YKP (2002) found that the average abortion rate is Rp 600,000, with the cheapest rate as low as Rp 190,000, and the most expensive Rp 2,000,000.

[26] Based on the SDKI 1997, the data from the Health Departement differ widely. According to Prof Azrul Azwar, abortion could be accountable for 50 % of MMR (Kompas 2002).

It is particularly interesting that contrary to the general opinion it are not mainly young single women who seek an abortion. Married women (in the official records callled housewives)[27] make up more than 50% of the approximately 2 million cases of abortion taking place in Indonesia every year. Most of these women got pregnant while not using any contraceptive method or device, but they did not plan nor wanted to have a child. Apparently the scarcity of free contraceptive means in a number of places as a result of changes within the National Family Planning Program of the BKKBN as well as the decreasing purchasing power within the poorer segments of society due the economic crisis - which on the one hand impedes the use of contraceptives but at the same time diminishes the ability to bring up and support children -, are all factors that very likely contribute to an increase in the number of cases of abortions. In fact field research indicates that this is what is actually happening. Respondents in Makasar (South Sulawesi) complain that after the regional autonomy, the costs for health care in the hospitals and at community health care centers have increased significantly. Even the contraceptive pills that used to be for free now have to be paid for. The same applies to the examination card, which today also has to paid for. In Makasar, the costs for such an injection before regional autonomy was effectuated were around Rp 5,000, while it is now more than double (Rp.12,000). Contraceptive pills have also become more expensive (from Rp 1,000 to Rp 1,000 - Rp 2,500). The costs for a delivery at the Community Health Centers which used to be Rp 65,000 are now Rp 90,000-Rp 100,000.

In other areas we find conditions that point in the same direction. For example, in the suburban areas (Kupang) of the East Nusa Tenggara (NTT), an injection with costs Rp 15,000-25,000 (transportation excluded); but if the village midwife happens to run out of the supply, the costs will be as high as Rp 25,000-30,000. In urban areas, an injection costs Rp 30,000 at the least. Many people cannot afford to buy contraceptives or contraceptive devices, now that these are not available for free anymore. If nothing changes, it is feared that the present 9 % women who make up the category of women with 'unmet needs' will very possibly increase, and the number of unwanted children as well. The SDKI (1997) found that 8 out of 10 births are wanted, therefore 2 out of 10 (20%) are not.

Several other points need attention, although on the surface everything seems to be fine. For example, the total fertility rate (TFR) has decreased and the use of contraceptives increased. Based on data from the SDKI 2002-2003, TFR has declined significantly over the past ten years, from 3.0 children in the period of 1988-1991 to 2.6 in the period 2000-2002.[28] However, a closer look reveals certain imbalances that should be taken seriously. TFR differs for different groups of women and regions. In the category consisting of the poorest women TFR is 4.4 compared to 3.4 for the category of the most well-off. In DIY, Central Java and Bali TFR is 2.1, while in NTT and South Sulawesi the figures are much higher, 4.1 and 3.6 respectively. The conclusion is obvious, appropriate strategies should be designed for particular for particular social-economic groups and regions taking into account local socio-economic conditions.

Meanwhile, there is also a delay in women's median age at first birth. The median age at first birth for women in the age group 25-49 has increased from 20.8 years in 1997 to 21.0 in 2002-2003. In addition, teenage childbearing has declined from 12% in the 1997 IDHS (=SDKI) to 10% in the 2002-2003 IDHS. In a number of regions, such as Madura in East Java and West Nusa Tenggara, the percentage of early marriage for girls is still high and

[27] YKP Study in 6 cities, 2002
[28] IDHS 2002-2003

therefore also their age at first birth. Once again, appropriate strategies and ways to implement programs have to be designed. The government cannot just point to local culture as an excuse for poor performance on matters such as continuing early marriage and, consequently, early age at first birth. It should actively sensitize the public on these issues through a culture-sensitive approach if it wants the family planning program to be more succesful on these points.

The use of contraception shows quite significant changes compared to previous years. First, in terms of the kinds of contraceptives mean used. Second, self-reliance has increased: at present only 11% of the contraception users get it for free from the government, whereas 89 % pays for it. This increase in self reliance is obviously an effect of the privatization in the health care sector, which actually started in an inconspicuous way with the promotion of the Blue Circle Family Planning (KB lingkaran Biru – self reliance Family Planning). At present many women go to a midwife or general practioners, not necessarily because they can afford it, but because there are no free contraceptives available anymore at the Primary Health Care (Puskesmas). Even if there are, the choice is very limited; usually only the contraceptive pill, which is not suitable for every woman. Today, midwives are most often asked for contraception, more often than medical doctors at their private practice.

IV.3. Promotion and Protection of Sexual Health Rights; Safe Contraception; Prevention and Treatment of HIV/AIDS

Regional Autonomy is an obstacle for progress with regard to the above programs since each region is busy restructuring its local institutions, and experts capable to deal with the problem of HIV/AIDS are rarely present/available at local levels. The implementation of the policy to promote the use of condoms for high-risk groups and the fight against STDs have stagnated. Apart from the problems as a result of decentralization, there is also a problem with the funding of these programs. Since its inception, the program to fight HIV/AIDS has depended on funding from abroad. GOI until now has not allocated special funds for the HIV/AIDS program. The government funded program for STDs only focusses on gonorrhea (GO) and syphilis. Other kinds of STDs, such as Chlamydia which also affects housewives, do not receive any attention whatsoever.

Another problem with the policy to come to terms with HIV/AIDS is its gender insensitivity or rather its outright patriarchal bias. Commercial sex workers are always considered as the transmitting vectors, while their consumers or guests are never identified as such. On the other hand, women who are not working as prostitutes but also may be at risk are completely neglected. Wives infected by their husbands are the most common example. STDs and even HIV/AIDS have been found in this group, but the government has not acknowledged this as a public health problem. Married women are defined as a low-risk group. Therefore they do not have easy access to information nor services for STD and HIV/AIDS. For example, these issues are not addressed in the KIE program designed by the women's empowerment offices. Organizations and NGOs concerned with women's issues in general do work in the field of women's reproductive health, but focus on the issues of violence against women and women's political participation. Therefore, their involvement in the management of HIV/AIDS is not very effective since they lack sufficient knowledge on existing reproductive health issues. Moreover, women who do not operate as sex workers are usually unaware of the risks they face. They do not consider HIV/AIDS their problem.

Of course it cannot be denied that commercial sex workers because of their work are at a high risk to be infected and infect others with the virus. In Tanjung Balai Karimun in the province of Riau the percentage of sex workers infected with HIV rose from 1% in 1995/1996 to 8.38% in 2000. In 2000, the prevalence of HIV on the sex workers in Irian Jaya (Merauke) was 26.5%, 3.36% in DKI Jakarta (North Jakarta) and 5.5% in West Java. As much as 22% of transsexuals were found infected, four times as much as in 1997.

Although commercial sex workers are the main concern in the fight against STDs and HIV/AIDS, they cannot really protect themselves against STDs and HIV/AIDS. The balance of power in the relation between sex worker and client is such that the power to make the decision for safe sex (using a condom) lies with the client. It is estimated that 7 to 10 million men in Indonesia are customers of commercial sex workers. Most men (90%) who use the services of sex workers refuse to wear a condom.

A behavior survey in a number of cities in Indonesia conducted with respondents that belong to the group of men with high mobility found that more than half of them had purchased sexual services during the past year. Most of these men are married. It is assumed that through men who make use of commercial sex HIV/AIDS makes its inroads into the household. An indication: in several areas of Jakarta around 3% out of 500 pregnant women who were tested voluntarily were found infected by HIV.

A program emphasizing the responsibility of men in the prevention of HIV/AIDS has not been run widely. One of the obstacles faced is how to penetrate the business world and mass media to conduct a campaign for the responsibility of men in coping with HIV/AIDS.

In 1999, a new phenomenon (for Indonesia) in the transmittance of HIV/AIDS came to the surface, i.e. HIV started to spread amongst intervenal drug users (IDU) at an appaling pace. In 1999 18% of those treated at the rehabilitation hospitals for drug addicts (RSKO) in Jakarta were found infected with HIV. This percentage increased up to 40% in 2000 and 48% a year later. In 2000, in Kampung Bali, Jakarta, 90% of all IDUs were found to be infected with HIV. A study behavior study of drug-users in a number of cities shows that they have high-risk behavior: about 30% are sexually active, and they go to prostitutes without the protection of a condom.

Even though the percentage of HIV transmittance amongst IDUs has increased drastically and at an alarming pace, information to the public in general and youth as the most vulnerable group in particular has lagged behind. An appropriate program to educate the latter group how to deal with drugs and HIV/AIDS is not yet developed.

What has been made available so far is an education program on reproductive health without special emphasis on sexual and reproductive health rights. This subject matter is not part of the regular curriculum and does not mirror the perspective of today's youth. In fact, it only emphasizes that teenagers should not engage in casual and pre-marital sex. Because the norm underlying this program is that sexual activity is only allowed for married couples, sexual activity of teenagers (as well as single persons in general) is considered out of bounds and therefore these groups are denied access to the existing reproductive health services, including provision of contraceptives. Needless to say, that this approach will not be very effective: it cannot be expected that all adolescents will abide by the teachings of the program and if they still engage in sexual activity, the guidelines given will fail miserably to protect them against the dangers.

The estimate of HIV/AIDS in Indonesia made by the Health Department with assistance by WHO in 2001 shows that people infected by HIV/AIDS at the time numbered between 80,000 -120,000 people. The groups affected are IDUs (62,500 persons), commercial sex workers and their clients (30,000 persons); and "others", a group of HIV infected people in the age of 15-49 (11,520 persons). The estimate for 2002 is a total of 90,000 – 130,000 persons infected, with persons infected in almost all provinces. The prevalence of HIV in general is still quite low, but Indonesia is now put in the category of countries with a concentrated epidemic level, because there are pockets of sub-groups in the population where the prevalence of HIV/AIDS is over 5%. Furthermore, the number of people susceptible to HIV in Indonesia is estimated to be somewhere between 13 and 20 million.

Meanwhile, the main focus of Indonesia's HIV/AIDS program is still on prevention. Even that part is mainly implemented by a number of NGOs which focus on the high-risk behaviour groups. The general public receives information on STDs and HIV/AIDS through the mass media, but there is a problem here because information provided in the media is often either incomplete, unclear, and/or even false. Worse than that, the media have even played a major role in creating the stigma and discrimination against people infected by HIV/AIDS. The impression is conveyed that they are dangerous because they can easily transmit their "disease: to others. Moreover, not rarely the identity of an HIV infected person is disclosed thereby inviting discriminatory behaviour from the environment which sometimes makes it difficult for them to remain a resident of or return to their community.

At present the general public has not yet access to VCT services (Voluntary Counseling Testing), because the possibility for such testing is not yet availabe in most regions of the country. Testing – if done – is often not accompagnied by the required pre- and post counseling, including the informed consent. Indonesian migrant workers seeking job abroad have to go through a mandatory test.

The program for support, care, and treatment of HIV/AIDS persons is only executed in a number of big cities in Indonesia, and is only run by NGOs and large hospitals. For health care services at a basic level no program for care and treatment of AIDS patients has been developed yet. At present Indonesia is able to produce its own generic ARV. What remains a problem is the counseling on the medication and the use of the drug: most health care providers are not ready to run a program providing care and support.

The health care services for STDs, albeit better developed than for HIV/AIDS are also not yet satisfactory. The public, women in particular, do not have easy access to health care services for infections of the reproductive organs. Moreover, the women themselves are often not aware that they might have an STD. Add to this the common idea held by health care providers that STDs are a problem of sex workers only, and the picture is complete why prevalence of STDs among women in general has remained an un-addressed problem.

The National Strategy for HIV/AIDS Management formulated in 1994 was revised in 2003 and will be in effect until 2007. This policy encompasses all vulnerable groups, the human rights of those infected by HIV/AIDS, gender justice and equality, a healthy life style, 100% condom use for commercial sex workers and their customers, harm reduction for drug-users, a care and treatment program, VCT with informed consent, and non-discriminatory services for those infected by HIV/AIDS. In 2004, the 6 regions where HIV/AIDS prevalence is relatively high (Jakarta, Papua, Riau, East Java, West Java, and Bali) made a joint statement called the Sentani declaration which includes 50% condom use in 2005, harm reduction for IDUs, a minimum of 5000 AIDS patients to be provided with ARV in

2004, efforts to reduce stigma and discrimination of HIV/AIDS infected persons, the establishment of organizations working on HIV/AIDS, efforts to create legal instruments of support, and allocation of a budget for the HIV/AIDS program. Not all provinces, regencies and municipalities in Indonesia have integrated this strategy into their regional policy planning.

In sum, In ICPD's 10th year in Indonesia there is some progress to show for in the fields of affordability, acceptability and accessibility of KIE and HIV/AIDS services. Progress has also been made in the prevention, harm reduction, and treatment of HIV/AIDS, mainly through public discourse and appropriate policies on the national level, as well as in some provinces. But this progress is limited to a few big cities and certain groups only. Moreover, policy and practice of the HIV/Program do not reflect the appropriate gender perspective. The program so far gives priority to high-risk behavior groups such as sex workers, transsexuals, IDUs, and homosexuals. Wives of husbands who like to change sexual partners frequently, are left out. As a result of these limitations, the epidemic has not been brought under control yet.

The control of STIs has not made significant progress. Prevalence of STIs amongst commercial sex workers has not declined, whereas STIs among women who are not working in the sex industry, have not received proper attention.

Meanwhile, information and education on reproductive health is still only provided to those who are already married. A start has been made with sexual education for adolescents, but it is only limited to big cities and private schools, and sex education is still excluded from the regular formal curriculum. The establishment of so called "reproductive health corners" reported by BKKBN and Health Department do not seem to work. Both the place and those sitting at the desk are not youth-friendly and the existence of the service itself is not brought effectively to the attention of the target group, so young people either are not interested in the service of do not know about it. So at the end of the story, appropriate services for adolescents and single persons are still not in place.

Gaps between reported and actual reality

In terms of available and relevant statistics on reproductive health aspects progress had definitely been made. The IDHS 2002-2003 for an example provides comprehensive data. In GOIs report to the CPD General Assembly, most data on demography and health refer to this survey as the source. However, data on some issues are still lacking or insufficient, such as on the reproductive health of IDPs, violence against women (including violence against Indonesian woman migrant workers), and the startling number of street children, many of them girls, a very vulnerable group. Only on domestic violence something was written and presented and the report also makes mention of IDPs and migrant workers, but only their numbers are given and nothing is mentioned about violence against them or (the threats to) their reproductive health.

In contrast to previous years when the government tried to cover up any shortcomings in the reproductive health sphere, the official stand apparently has changed because the latest reports do disclose problems. In Jakarta the BKKBN and Health Department have even engaged several NGOs in research and reporting on ICPD+10, although it remains to be seen whether their contributions will be written into the final reports.

Something that has not been discussed properly in Indonesia's country report presented to the general assembly of CPD in New York, March 2004, are the reasons for failure to achieve program targets. The report even exhibits a tendency to find scapegoats or put the blame on certain conditions in the country. In a meeting held at the head office of PKBI to discuss this report, high placed officials from the Health Department, BKKBN and the Minister of Women's Empowerment also blamed society, instead of holding their own agencies accountable. For example, one of the reasons put forward was that foreign funding for reproductive health given to the government is less than that received by the NGOs. The representative from BKKBN even stated that it is therefore more appropriate that NGO's are held responsible and are accountable for the funds received. The government also tends to take cover behind the word 'participation' to avoid responsibility. When the government fails to achieve its objectives, it is put forward that development is not the sole responsibility of the government, and that more active participation of civil society and NGOs is needed.

Even in the present era of regional autonomy it still happens that reports are primarily made to please the central government. This was implied in an interview given by an official of the Ministry for Women's Empowerment.[29] She stated that government policies and instructions for implementation were formulated and communicated to lower levels as best as possible. The problem encountered was that at these lower levels reports are sometimes written with the explicit order that the contents should "please the boss" (Asal Bapak Senang = as long as the boss is happy), and therefore irregularities in program implementation are covered up by presenting fictive data. The example given concerns the Program 'Movement to Care about Mothers" (Gerakan Sayang Ibu = Save Motherhood) initiated by the Ministry of Women's Empowerment. The aim of this program is to stimulate a more pro-active attitude on the part of the community to take care of the reproductive health of women, in particular women going through a high risk pregnancy or a delivery with complications. In the implementation of the project several obstacles were encountered, among others due to socio-cultural characteristics of the community as well as certain religious and traditional values and practices. A technical problem is that on the district level communities have never been trained to make optimal use of the available sources, resources and facilities. For example, data locally available which should be processed to create a useful database, were not processed and therefore it had not been possible to determine the targets and target groups appropriate for implementation of the program.

These problems provide vivid examples how confused people are in this era of regional autonomy. Politicians, officials, civil servants and the general public just have no idea how develop local potential. Before, development programs used to be channelled in a top-down way. This legacy is still influential two years after regional autonomy has been in effect. The new mandate to develop more bottom-up strategies has not yet resulted in a focused and well-structured process of development. Regional autonomy implies that raising the standards of reproductive health care has become the responsibility of the administration at the level of the regency. However, formulation of policies and guidelines for implementation of programs still takes place at the national level, while on the other hand its success depends on the priority given to these programs at the lower level and the capacity at that level to implement the programs. Success of the programs ultimately depends on the political will and commitment to the long term goals of the programs which may be realized only in - let's say - twenty years time. A firm commitment can hardly be expected from today's regional leadership. A concrete example: a *bupati* (head of a

[29] An interview with a staff of the Dept. Of Women Empowerment

regency or *kabupaten*) will always want to look good at the end of his five year term in office, so the reports of the local administration have to reflect his successes. Of course this means that programs achieving good results only in the long term, are unlikely to be given a high priority.

It is obvious from the above example that coordination between the departments concerned -the Department of Health, BKKBN and Ministry of Women's Empowerment-, is not as it should be. As has been aptly observed by an official of the Ministry of Women's Empowerment, these government agencies are still mainly focused on certain sectors within their competency and there is no common framework or outlook. This causes inefficiency, and will obviously make it difficult for any program to work.

Another tendency of the central government is to always highlight the national situation and national achievements, so the specific conditions of certain regions are practically ignored. Even though it was mentioned in the report that a number of provinces failed to reach the ICPD targets and that those were the poorest regions and the ones most affected by crises, no specific strategies planned for these regions are mentioned. Also, regional variations are glossed over. For example, the report of the Indonesian Delegation presented at the CPDs general assembly in March 2004 states that the TFR of Indonesia in 2002-2003 is 2.3, but no explanation is given why in Kupang (NTT) it is still as high as 4.1 [30] The same applies to CPR: Kupang rates far below the national average. Moreover, no mention is made of any efforts on the part of the government in the course of time to correct these gaps. It would have been appropriate if an explanation was given how the huge amounts of money intended to raise the general welfare, including reproductive health conditions, in those regions classified as poor, have been allocated through the various programs for subsidies (JP-BBM, JPS and so forth).

The formulated amendments to the 1992 Health Law and 1992 Population Law are not mentioned in the Indonesian country report either.

Privatization and financial reform of the health sector are also not discussed in the report, while field research has found that these reforms have increased the costs of health care services, including the costs of contraceptives. Meanwhile, the promised improvement onf the quality of these services used as a legitimation of the reform in the first place, is nowhere to be seen. The social safety net program intended to safeguard access of the poor to affordable health care services is not implemented well, nor in a transparent way. Even though no study has been made of practices of corruption in the implementation of the social safety net and health care security schemes (JPS and JPK Gakin), reports by the public and the media indicate the occurrence of irregularities. It is therefore doubtful, whether those who were supposed to benefit, have really gained substantially from these schemes in terms of better access to health care services.[31]

V. Main Constraints and Supporting Factors

1. Constraints

The economic crisis which has hit several regions around the globe since mid 1997, has been the major reason for economic decline in many Asian countries, including Indonesia. Indonesia is one of the countries where recovery takes a long time. Particularly

[30] IDHS 2002-2003
[31] Kompas, 12 April 2004, pg. 19

unfortunate was that the monetary crisis was aggrevated by a natural disaster in 1998: a prolonged draught brought about by El Niño caused great damage to the agricultural sector with serious consequences to general welfare as Indonesia still is a predominantly agricultural country. Simultaneously, after the Suharto government had stepped down, the country was plagued by political turmoil, riots and conflicts. Certain regions even strove for independence and wanted to separate from the Indonesian state. The general loss of faith in the central government can be attributed to a long simmering dissatisfaction about insufficient financial equity for the regions, weak law enforcement and the continued occurrence of rampant corruption throughout the country.

The government was also considered slow in its response to the socio-economic developments after the crisis had set in and even gave the impression that it was steered by neo-liberalist forces through policies dictated by international financial agencies. A significant number of banks were declared bankrupt and the policies of the government to handle this again caused a loss of faith, this time in the banking sector. This subsequently influenced the process of mobilisation of funds and the circulation of money. The malaise in the banking sector had a very negative impact on the productive sector. Unemployment rose as the result of the closure of numerous large and small companies and added to the problems the government had to deal with. The export sector, often mentioned as a vital source of income (devisa) for the state, went downhill and was followed by an approach that has also often been deployed by the previous New Order government, i.e. the policy of "tightening the waist-belt". This was portrayed as the most effective alternative to cut the expenses of the state and society in general, but at the same time pushed increasing numbers of the poor to a level below the poverty line.

Because the exchange rate of the Rupiah (IDR) against foreign currency dropped to ever lower levels, the price of fuel went up. This had a domino effect: the price of basic needs skyrocketed and it became increasingly difficult for the middle and lower classes to pay for vital goods. Facing the reality that immediate costs for consumption could not be pushed down any further, people generally tended to economize on expenses for education and health care as a strategy to survive.

During the economic crisis the government tried to find a solution using various grants and loans which it had received and which had already been allocated. Several safety net programs were introduced (already referred to in the above). The sums made available through these programs seemed and were presented as sufficient to raise the standard of living of the lower en middle strata of society. However, it turned out that the funds could not be absorbed at the needed level of urgency nor met actual needs. Abuse of funds occurred on a large scale, both because of corruption as well as fraudulent behaviour on the part of the recipients.

The health sector is one of the sectors that always faces constraints in times of crisis, in particular when it comes to services badly needed by the general public. On the one hand the cost of health care services that meet a certain standard are fairly high, while on the other hand the budget for the health sector is always very limited and has even been reduced after the crisis. Several efforts to provide adequate health care services have been realized, but as a consequence of the crisis, new problems have emerged with regard to health care facilities such as the provision of medicines and drugs, contraceptives, and other supporting operational health care facilities. The government has therefore anticipated this situation by producing drugs of a slightly inferior quality compared to drugs of well-known brands, but having the same function. These drugs are

knows as generic drugs. However, criticism is been called for as the price of drugs can still be said to be very high, much higher than drugs in India for example.

To come to terms with this difficult situation the Government of Indonesia has decided to use as much foreign funding as possible and even has gone so far as selling 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 having a tendency to empoverish the masses. For example, the government has mobilized MNC's (Multi National Corporations) and TNC's (Trans National Corporations) and also has made use of bilateral and multilateral relations with other countries to raise funds to cope with the crisis. Privatization of government services has been the regular form this cooperation has taken. An example of how this works is the opportunity given to MNC's that operate in the field of pharmacy to market certain products and recruit Indonesian labour. This type of cooperation has various advantages and disadvantages. The opportunity to obtain a license in order to operate and run a business in Indonesia involves several prerogatives, for example to determine the price of drugs. Another example can be found in the food industry. Companies operating in this sector of the economy are enabled to influence the taste of consumers as they work together with the government.

In general multinationals also enjoy by government regulation the privilege of making their own arrangements regarding their labour force, usually to the disadvantage of their workers, including women. This should be monitored closely because more and more women have entered the public sector to make a living as many husbands have lost their jobs due to the economic crisis. Women's educational levels and work experience are generally limited so they often have no other choice than becoming a low-paid worker. Their weak bargaining position is a factor that weighs heavily because in the past low wages already constituted a typical characteristic of the female labour force. This is related 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 not yet influenced by it. Gender budgeting is still often interpreted as allocating separate funds for "women's affairs" out of the total (national, provincial, regency) budget, not as the allocation of special funds out of the budget for each sector to correct gender imbalances within the sector. The State Budget in the year 2001 only allocated 1,15% to the program for institutionalizing gender mainstreaming[32].

The still extensive dependency of the Indonesian Government and NGOs on funding from the US will also have an impact on comprehensive health care services, for example on the services that offer safe abortion. The conservative paradigm of the Bush administration has prohibited all funding agencies under USAID to promote or support abortion services. Even the UNFPA has been influenced by this policy.

The continuation of conflicts in several provinces have rendered it more difficult for NGOs to operate freely in these regions to provide information and reproductive health care services. While at the same time it is clear that because of these conflicts public health care services in general and reproductive health care services for women in particular have deteriorated. Women are particularly vulnerable to dehumanizing experiences.

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[32] Sri dan Henry, dlm *Gender Budget Sebagai Analisis Pembangunan*, Jurnal Perempuan 19, Jakarta, 2001.

Polygamy has of late found fertile soil in Indonesia because of an intensive campaign by a certain businessman and the examples of high government officials who do not hide that they have more than one wife.

With regard to gender equality, the scramble for the presidency has caused various parties to proclaim that it is forbidden (haram) to choose a woman for president. This is a step backwards, although a woman president does not necessarily implies progress for women and an improvement of their status.

2. Supporting Factors

Women's empowerment is one objective of ICPD that is still in an overall process of implementation today. Efforts are made to eliminate violence against women in the public and domestic domain. Most activities are organized by concerned NGOs and consist of dissemination of information to the public and conducting workshops to create awareness on the Zero Tolerance norm for violence against women.

Regional autonomy, apart from being a constraint, can also be a supporting factor, as each region has the authority to develop programs in accordance with local conditions, while aiming at optimizing local potential. In many regions regional autonomy has had the effect that local government concentrates its efforts on ways to increase income, amongst others by using health care services as "a milking cow" to extract money. Actually the quality of health care centres should be improved to forestall that people will go to other regions for medication (or abroad if they can afford it).

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 should really be geared to help the poor in accordance with the objectives of the policy and the strategy for decentralisation of the health care sector.[33]

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

Furthermore, 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 more easy for representatives of civil society to work together. For example, many academics have become attracted to do research and give courses on reproductive health issues. 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".

[33] Decision by the Minister of Health, no 004/Menkes/SK/I/2003.

VI. Future Concerns Bearing on the Achievement of ICPD CAIRO

The World Bank's idea to stimulate privatisation in the health sector has been very influential and has caused a change in government policy towards this sector. Privatisation is assumed to respond to globalisation and neo-liberalism. Multi- and transnational corporations penetrate Indonesia because of the soft governmental regulations and attitude towards this change. Numerous corporations operating in the provision of health care services and the food sector have settled in the country. The feminisation of poverty has a large influence on the labour force as the limited access of women to gainful employement works in favour of these corporations because of these women's weak bargaining power. Increasing opportunities open to multinational and transnational corporations also weaken the regulating role of the government.

Limitations on the distribution of drugs and other health care facilities are part and parcel of the privatisation program which is often supported by grants from the World Bank that are subsequently used to prescribe all kinds of government policy regulations. Various steps have been taken by these organizers of health care in cooperation with regional hospitals to fulfill the hospital's needs for health care facilities. The present limited choice of drugs, equipment, and health care facilities is one of the consequences of privatisation.

The change in policy under the Bush registration compared of the policy of his predecessor Clinton can also be observed in the health and women's empowerment sectors. This change in policy has very negative consequences, such as a lower budget for the health sector, in particular for women's health.

Rich countries make an effort to help the economies of the countries in the Third World 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 has the aim 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 given lots of assistance, which intends to cripple their national governments to control their own policies in the health care sector. NGOs should be aware of this systematic weakening of the position of their national government. On the one hand they should be prepared to take a critical and controlling stand, but on the other should also patiently standing by their government, both in terms of assisting in policy formulation as well as implementation of programs in order to achieve optimal benefit for the public they serve.

The development of fundamentalist movements in several fields has been able to strengthen and at the same time also challenge several points of ICPD. Large religious denominations such as the Catholic Church and an influential part of the Muslim community embrace the principles of anti-abstinence and anti-abortion. These religious communities still cling to their dogma's using these to oppose sexual and reproductive health rights. The choice for induced abortion is considered a sin and stipulated as illegal by law with the grave consequence that unsafe abortions take many women's lives each year.