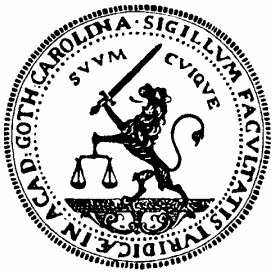

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The Right to Reproductive Choice in Lombok, Indonesia

- A minor field study on national implementation of international human rights law

Master thesis
20 points

Supervisor: Professor Gudmundur Alfredsson

International Law / Human Rights Law

Fall 2005

Contents

Summary

This is a thesis on women's right to reproductive choice and the implementation of this right on the Indonesian island of Lombok. As this is a graduate thesis on the Master Program in Human Rights Law, the point of departure is the regulation of the right to reproductive choice in international human rights law. To establish the content and scope of the right to reproductive choice, the material used are the sources of international law, mainly human rights treaties. The mapping of the national and local implementation of the international provisions is based on legislation, but also on interviews with government officials and stakeholders conducted during a Minor Field Study in Indonesia in 2005.

Indonesia is a state party to CEDAW and CRC, which provide for women's right to reproductive choice. In contrast to many other state parties, the Indonesian government has no reservations to substantive provisions of the two conventions, which means that the government is obligated to implement all norms in conformity with international law. Indonesia has a well-established national family planning program, which has gained international recognition for its success. However, national legislation limits the access to sexual and reproductive health information and services to married women, and excludes unmarried women and adolescents from the enjoyment of their rights.

Lombok, as a part of West Nusa Tenggara, is the main island of one of the least developed provinces in Indonesia. In comparison to other provinces, women in Lombok are less educated and the maternal and child mortality rates are high. There are no local regulations on family planning in Lombok and access to reproductive and sexual health information and services outside of the state sanctioned family planning program seems to be obstructed by local leadership.

The conclusion of this thesis is that despite the widely acknowledged family planning program, women's right to reproductive choice is not recognized in national and local legislation or policies. Issues relating to women's reproductive choice are currently not regarded as issues of human rights. In order to comply with the international obligations that the government has voluntary accepted, the first step is amendments of national legislation and adoption of local regulations.

Preface

> "The reason for choosing reproductive rights is quite obvious. These rights are inherent to the dignity, autonomy and personhood of all women around the world. Yet they are the first to be sacrificed, whether in the name of religion, culture, nationalism, fundamentalism, tradition, population policies or family values."[1]

I am deeply thankful to my two contact persons in Indonesia, Toma and Elin. Thank you Toma for arranging my meetings in Jakarta and thank you Elin for your interpretation work and for welcoming me as a guest in your home in Mataram. I could not have done this study without the kind help and support from the two of you!

I am grateful to Dr. Hafid Abbas, Director General for Human Rights Protection at the Ministry of Law and Human Rights for putting me in contact with Pak Slamet Martawardaya, Kakanwil in Mataram. My sincere thanks to you, Pak Slamet, and your staff for preparing the necessary documents and arranging meetings with provincial and district government officials in Lombok.

Thank you also Pak Dadi for your kind assistance at BKKBN in Jakarta.

I would like to thank all persons I interviewed for taking their time to meet with me. Thank you for sharing your experiences and giving me the most valuable material of this thesis. I hope my work can do it justice.

Johanna Nilsson

Lund, 28 October 2005

[1] *See* Manisha Gupte, 'Reproductive Rights in East Central Europe: A Public Health Concern' in Alicia Ely Yamin (ed.), *Learning to Dance: Advancing Women's Reproductive Health and Well-being from the Perspectives of Public Health and Human Rights*, 2005, Harvard University Press, Cambridge, p. 107.

Abbreviations

BKKBN	National Family Planning Coordination Board
CAT	Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Convention on the Elimination of All Forms of Racial Discrimination
CMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
CRC	Convention on the Rights of the Child
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPPA	Indonesian Planned Parenthood Association
IUD	Intra-uterine device
KAKANWIL	Head of Provincial Office on Law and Human Rights
Komnas HAM	Indonesian National Commission on Human Rights
Komnas Perempuan	National Commission for Anti-Violence against Women
LBH-APIK	Legal Aid Office of the Indonesian Women Association for Justice of West Nusa Tenggara
MFS	Minor Field Study
NGO	Non-governmental organization
NTB	West Nusa Tenggara
NTT	East Nusa Tenggara
POSYANDU	Temporary (usually monthly) health post for family health
PUSHAM	Human Rights Center
PUSKESMAS	Community health center at the sub-district level
Sida	The Swedish International Development Cooperation Agency
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

1 Introduction

1.1 Introduction to the Topic

Fixed gender roles are embedded in the interpretation of *Pancasila*, the Indonesian national philosophy.[2] The man is the head of the household and the woman is wife, mother and upholder of social values.[3] Traditionally, sexuality is not spoken openly about and sexual relations are matters reserved for married life. In reality however, the Indonesian society is rapidly changing and premarital sex is not uncommon among young people.[4] The unbalance between the official position on sexuality and the reality on the ground has various unfortunate consequences. Educational information in schools on reproductive health is focused on biology, anatomy and the establishment of happy and prosperous families,[5] not on sexuality and reproductive health.[6]

Indonesia is the world's fourth most populated country with an estimated population growth rate of 1.5 per cent per year.[7] The fertility rate has declined during the last 25 years, primarily due to massive family planning campaigns and programs.[8] In 1980 the fertility rate was 4.1, while the estimated fertility rate for 2004 is 2.49.[9] The Indonesian family planning program has gained international recognition, but its impact on human rights, particularly human rights of women, has been criticized. The program has mainly been focusing on women for both methods and responsibility for family planning.[10] According to the United Nations Population Fund (UNPFA), contraceptives prevalence rate seems to have

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[2] *See e.g.* Julia I. Suryakusuma, *Sex, Power and Nation – An Anthology of Writings 1979-2003*, 2004, Metafor Publishing, Jakarta, p. 167.
[3] *Ibid.* p. 132.
[4] Statistics on the prevalence of premarital sex are difficult to find and are usually not provided by the Indonesian government, but small-scale studies show that up to 27% of young Indonesians engage in premarital sexual relations. *See* Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Programs, USAID, 2003, p. 10.
[5] According to the Indonesian government, a prosperous and happy family consists of a husband, a wife and two children, *see e.g.* Act 10/1992 Concerning the Development or Population and Happy and Prosperous Families.
[6] *See* Iwu Dwisetyani , *Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Program*, POLICY Project, Research School of Social Sciences, Australian National University, 2003, p. 17.
[7] *See* Indonesia's Population, United Nations Population Fund (UNFPA), Indonesia, available on <www.un.or.id/unfpa/idpop_unfpa.html>, last visited 5 February 2005.
[8] *Ibid.*
[9] *See* Indonesia's Second and Third Periodic Report to the CEDAW Committee, CEDAW/C/IDN/2-3, p. 52. *See also* The CIA World Factbook, available on <www.cia.gov/cia/publications/factbook/geos/id.html>, last visited 7 February 2005.
[10] *Ibid.* p. 51. *See also* Indonesia's Population, United Nations Population Fund – UNFPA, Indonesia, available on <www.un.or.id/unfpa/idpop_unfpa.html>, last visited 5 February 2005.

stagnated at 57 per cent and the maternal mortality ratio is consistently high (370 per 100 000 live births).[11]

As Indonesia is a vast county and the largest archipelago state in the world, regional differences are evident. Success in family planning efforts is no exception. In the official statistics, the province of West Nusa Tenggara (*Nusa Tenggara Barat* or NTB) stands out for having a higher fertility rate of 3.05 and an infant mortality rate of 81 per 1000 – the highest number in Indonesia. The rate for the country in average is 46 per 1000.[12] The difference in under-five mortality rate is even more significant. West Nusa Tenggara has the highest number of 113.63 per 1000, followed by Kalimantan Selatan (South Kalimantan) with 85.67, whereas the average rate for Indonesia in total is 59.55.[13]

1.2 Subject and Aim

In this thesis, I will seek to identify how women's right to reproductive choice is implemented in Lombok, the main island of West Nusa Tenggara. The subject of the study is thus the realization of international human rights law on women's right to reproductive choice. The aim is to evaluate whether or not the Indonesian government is complying with its obligations under international law in relation to the right to reproductive choice in this particular province.

I intend to examine to what extent women in Lombok, irrespectively of marital status, have legal access to contraception and educational information on sexual and reproductive health. I will try to get a picture of the prevalence of educational information on reproductive and sexual health in schools, local medical clinics and other health facilities, and to what extent women and girls have access to such institutions. Additionally, I aim to assess to what extent women can get contraceptives and reproductive health care and where such services are provided.

I intend to put my study in its national and international legal context and to conclude how Indonesia is succeeding in implementing the relevant provisions of CEDAW and CRC.

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[11] *Ibid.*
[12] *See* Total Fertility Rate (TFR) by Province, 1971, 1980, 1990, 1994, 1997, 1998, 1999 and Infant Mortality Rate (IMR) and Under Five Mortality by Province, 1971, 1980, 1990, 1994, 1997, 1998, 1999, Badan Pusat Statistik (Indonesia's Non-Departmental Government Statistic Institution), available on <www.bps.go.id/sector/population/table5.shtml> last visited 7 February 2005.
[13] *Ibid.*

1.3 Definitions and Delimitations

A variety of terms is found in the literature on reproductive rights.[14] Commonly, 'reproductive freedom'[15], 'reproductive self-determination'[16] and 'reproductive choice'[17], are used to define and describe various 'rights'[18] relating to human reproduction.

As elaborated on by Corinne A.A. Packer, the term 'reproductive choice' is used as a short-form for:

> "the rights to decide freely and responsibly on the number and spacing of children and to have access to the information, education and means to enable [one] to exercise these rights."[19]

This definition corresponds with the wording of CEDAW Article 16(1)(e) and with the scope of this thesis. As the field of reproductive rights is a broad subject, I will limit the scope to the right to reproductive choice, limiting it in this context to the right *not* to procreate.[20] The immediate focus is on access to contraception and educational information on sexual and reproductive health.

Reproductive rights in general are often referred to as composite rights, overarching the division between civil and political rights and economic,

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[14] *See* Katarina Tomasevski, *Human Rights in Population Policies: A Study for Sida*, 1994, the Swedish International Development Cooperation Agency (Sida), Stockholm, p. 14.

[15] Professor Maja Kirilova Eriksson, adopts the term 'reproductive freedom', rooted in feminist legal theory, arguing that this term goes beyond the content of the right to reproductive choice as it also includes the *conditions* (emphasize added) under which this choice is made. *See* Maja Kirilova Eriksson, *Reproductive Freedom in the Context of International Human Rights and Humanitarian Law*, 2000, Martinus Nijhoff Publishers, the Hague, p. 7, footnote 21.

[16] Rebecka J. Cook, Bernard M. Dickens and Mahmoud F. Fathalla use the term 'reproductive self-determination' in connection to 'free choice of motherhood' as rights "that have been developed through interrelated rights, including the right to decide the number and spacing of one's children, the right to private and family life, the right to marry and found a family, and rights requiring maternity protection", *see* Rebecka J. Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights – Integrating Ethics, Medicine and Law*, 2003, Oxford University Press, NewYork, p. 175.

[17] The term 'reproductive choice' is used by Corinne A.A. Packer in *The Right to Reproductive Choice*, 1996, Institute for Human Rights Åbo Akademi University, Åbo.

[18] No all 'rights' presented under the headline of rights are actually rights under international law, *see* 2.1 below.

[19] *See* Corinne A.A. Packer, *The Right to Reproductive Choice*, p. 14.

[20] Scientific and medical progress has initiated human rights discussions on the right to procreate in a new perspective. Reproductive rights and modern technology, *e.g. in vitro* pregnancies, surrogate motherhood etc, creates conflicts of interest and controversies, but this debate is beyond the scope of this thesis. For further reading *see e.g.* Donald Evans (ed.), *Creating a Child – The Ethics, Law and Practice of Assisted Procreation*, 1996, Martinus Nijhoff Publishers, The Hague. *See also* Marie-Thérèse Meulders-Klein, Ruth Deech and Paul Vlaardingerbroek (ed.), *Biomedicine, the Family and Human Rights*, 2002, Kluwer International Law, The Hague.

social and cultural rights.[21] The full realization of reproductive rights involves the realization of a variety of interrelated rights, such as the right to life, the right to education, the right to health and freedom of information.[22]

According to Rebecca J. Cook and Mahmoud F. Fathalla, violations of reproductive right can be divided into three different categories. According to the authors, reproductive rights are violated when:

1. "Violations result from direct action on the part of a state, such as coercive sterilization and abortion;

2. violations relate to a state's failure to meet the minimum core obligations of human rights protection, such as by refusing or neglecting action shown capable of reducing maternal mortality rates; and

3. violations relate to patterns of discrimination, such as persistent and gross discrepancies in access to health services that cumulatively disadvantage the health of groups, such as unmarried adolescent girls."[23]

As the limited format of a master thesis necessarily calls for delimitations, I have chosen to address what I consider one of the core issues within the field of reproductive choice namely access to contraception and educational information on sexual and reproductive health. The rationale behind this choice of topic is the evident preventive character. The lack of knowledge and means to control one's fertility may result in serious consequences related to an unwanted or ill-timed pregnancy, affecting a person's health, societal and economic status. Consequently, if access to educational information and contraception can be secured, related problems can be prevented.

The right to knowledge and means to decide freely and responsibly of the number and spacing of one's children contains more than merely having access to information and contraceptives. The determinative factor is whether or not women *de facto* can exercise their rights. Full realization is thus difficult to measure and evaluate, as *de facto* access is dependent on cultural and societal norms affecting the lives of the individual woman or collective of women. However, regulating access to contraception and

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[21] *See e.g.* Rebecca J. Cook, 'International Protection of Women's Reproductive Rights', 24 *New York University Journal of International Law and Politics* (1992) p. 653.

[22] The traditional division of human rights into three 'generations'; the first consisting of civil and political rights, the second of economic, social and cultural rights and the third of collective rights, has been subject to criticism by many scholars. A statement often cited significant for a new approach is para. 5 of the 1993 Vienna Declaration and Programme of Action: "All human rights are indivisible, interdependent and interrelated". *See also* Manfred Nowak, *Introduction to the International Human Rights Regime*, 2003, Martinus Nijhoff Publishers, Leiden, pp. 23-25.

[23] *See* Rebecca J. Cook and Mahmound F. Fathalla, 'Duties to Implement Reproductive Rights' 67:1 *Nordic Journal of International Law* (1998) p. 12.

educational information on sexual and reproductive health under the law is a first step of *de facto* enjoyment of the right to reproductive choice, and such regulations can be measured and evaluated.

1.4 Method and Disposition

As elaborated on by Peter Westberg, one may use two different methodological approaches when conducting legal research.[24] The first is the 'rule-oriented approach' and the second is the 'problem- or interest-oriented approach'.[25] The rule-oriented approach is characterized as a more traditional method, primarily aiming to establish *de lege lata* through identification of the application of legal norms on particular issues.[26] The problem- or interest-oriented approach to legal research takes a different stand, placing a problem or interest, instead of a valid norm, in focus.[27] The aims of research are thus to analyze a problem or interest, with the law as the point of departure, but additionally looking beyond the law to identify conflicts of interests in order to resolve the problems.[28]

Overall, I believe the problem- or interest-oriented approach to be the most suitable method for this thesis. Although this approach does not exclude adopting elements from the rule-oriented approach,[29] I believe that the use of a more 'open' method will be more beneficial in reaching the aims of the thesis. Using the problem- or interest-oriented approach is not closing the door on law and opening it for sociology, economics or any other areas of social science – it is merely acknowledging that law does not exist in a vacuum.[30] The respect for women's right to reproductive choice is the interest that will serve as the point of departure.

Chapter 2 of the thesis consists of an elaboration on the right to reproductive choice under positive international human rights law. The method is thus rule-oriented, *i.e.* I intend to conclude the content and implications of the right. I do not intend to redefine the valid norms.[31] The way in which I try to

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[24] *See* Peter Westberg, 'Avhandlingsskrivande och val av forskningsansats – en idé om rättsvetenskaplig öppenhet' in *Festskrift till Per Olof Bolding,* 1992, Juristförlaget, pp. 421-446.

[25] I am not certain whether or not the author would agree with this translation of the Swedish terms 'den regelorienterade ansatsen' and 'den problem- och intresseorienterade ansatsen', but I rely here on the translation made by Christina Johnsson in *Nation States and Minority Rights - A Constitutional Law Analysis,* 2002, Uppsala University, p. 45.

[26] *See* Peter Westberg, 'Avhandlingsskrivande och val av forskningsansats – en idé om rättsvetenskaplig öppenhet' in *Festskrift till Per Olof Bolding,* pp. 427-436.

[27] *Ibid.* p. 436.

[28] *See* Christina Johnsson, *Nation States and Minority Rights - A Constitutional Law Analysis,* p. 46.

[29] *Ibid.* p. 46. *See also* Peter Westberg, 'Avhandlingsskrivande och val av forskningsansats – en idé om rättsvetenskaplig öppenhet' in *Festskrift till Per Olof Bolding,* p. 436.

[30] *Ibid.* pp. 438-440.

[31] There is an ongoing discussion among scholars on the content and scope of the right to reproductive choice. The limited format of a master thesis prevents me from presenting all views in this interesting debate. *See e.g.* Corinne Packer, *The Right to Reproductive Choice,* Maja Kirilova Eriksson, *Reproductive Freedom in the Context of International*

deduct and interpret the impact of various articles is a commonly used method in international law.[32]

Chapter 3 is an overview of international human rights treaty law binding upon Indonesia. The main focus is on CEDAW and CRC and the connotations on the right to reproductive choice for the state. This part of the thesis is predominantly descriptive and aims to illustrate the interaction between the Indonesian government and the UN treaty bodies on the issue of reproductive choice.

Chapter 4 gives an overview of the Indonesian human rights legislation. The main focus is on the 1945 Constitution and the 1999 Human Rights Act, and the protection of the right to reproductive choice and related rights in these instruments.

Chapter 5 has its focus on women's right to reproductive choice in Indonesia. A significant part of the chapter elaborates on the evolvement of the national family planning program and the mandate and working methods of the National Family Planning Coordination Board (BKKBN).

Chapter 6 elaborates on the situation in Lombok. Information in this chapter is mainly based on results of interviews conducted during the Minor Field Study.

Chapter 7 is the concluding chapter where I present some personal remarks and suggest a few areas of interest for future studies.

1.5 Material

This thesis is mainly based on material collected during a Minor Field Study (MFS) financed by a scholarship from the Swedish International Development Cooperation Agency (Sida).

The field study was conducted in Jakarta and Lombok between 23 June and 16 August 2005. The main aim of the field study was to collect information on women's right to reproductive choice through qualitative interviews with government officials, health workers and other stakeholders, such as representatives from NGOs.

Human Rights and Humanitarian Law, Rebecka J. Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights – Integrating Ethics, Medicine and Law*. For a quite controversial theory *see also* Jill M. Bracken, 'Respecting Human Rights in Population Policies: An International Customary Right to Reproductive Choice' 6 *Indiana International and Comparative Law Review* (1995) pp. 197-237.

[32] The method has been referred to as "The Method of Overkill". This seemingly harsh description refers to the strategy used liberal (feminist) human rights advocates when intending to prove the existence of a certain right in positive law by deriving it from as many documents as possible. *See* Karen Engle, 'International Human Rights and Feminism: When Discourses Meet' 13 *Michigan Journal of International Law* (1991-1992) p. 535. My sincere ambition in this thesis is however to stay true to positive international law and to avoid over interpreting the provisions.

During the field study I conducted 30 interviews: 22 with government officials on the central and local level, three with representatives from NGOs, four with health providers and one with a representative from an academic human rights center. The interviews were semi-structured and carried out with a number of questions as a point of departure. As the interviews were qualitative in character, different questions were asked depending on the position of the respondent. The interviews normally lasted for about one hour. In Jakarta, all interviews were conducted in English. In Lombok all interviews except two were held in Indonesian (*bahasa Indonesia*) and translated into English by an interpreter. The interviews were thereafter documented with transcribed notes.

I spent the first four weeks of the field study in Jakarta where I conducted 12 interviews. Most of the interviews were with government officials at the Ministry of Health, Ministry of Law and Human Rights and the Ministry of Women's Empowerment, in order to understand the structural context of regulations on the right to reproductive choice. I conducted five interviews with different directors at BKKBN to get insights on the work with the national family planning program. Furthermore, I interviewed representatives from the Indonesian National Commission on Human Rights (*Komnas HAM*) and the National Commission for Anti-Violence against Women (*Komnas Perempuan*) and one of the heads of Indonesian Planned Parenthood Association (IPPA).

The second part of the field study was carried out in Lombok, the main island of the West Nusa Tenggara province. In Lombok, I conducted ten interviews with government officials on the provincial and district levels. I interviewed two representatives from local NGO branches and one from the human rights center at Mataram University. In addition, I interviewed eight midwives working in two different community health centers (*Puskesmas*). Six midwives were interviewed in a group setting, and two were interviewed individually. Moreover, I interviewed four midwives at a Midwives' Association Clinic and two obstetricians and gynecologists, who were specialists at a public hospital.

Information obtained through interviews is referred to as accurately as possible in footnotes. However, when conducting the interviews, I sometimes came across sensitive information. In some cases, the information was valuable for the study, but the source would have an interest not to be exposed. Some of the health providers I interview shared their experiences with me on illegal practices, such as abortion services to unmarried women. In order to protect these individuals, none of the health providers are mentioned by name in this thesis. Furthermore, a number of government officials interviewed expressed a concern over information 'being published'. In order to respect the concern of these individuals, some references are made in a general, *e.g.* to 'interview with government official'. It is my sincere ambition that none of my sources should be put in an unpleasant position because of their helpfulness sharing experiences with

me. Although I regret that I cannot provide the reader of this thesis with complete references in all cases, the interest of the interview respondents is my first priority.

Regarding written material, the foundation of research has been studies of the traditional sources of international law, *e.g.* treaties and jurisprudence. The primary point of departure has been the United Nations human rights treaties. Additional sources have been interpretative documents, such as documents issued by the treaty bodies (summary records, concluding observations and general comments), and doctrinal texts.

2 The Right to Reproductive Choice in International Human Rights Law

2.1 Introduction

There are several international documents on reproductive rights and reproductive health. The most important and well-known documents date back to the early 1990s, as results of international conferences.

The World Conference on Human Rights in June 1993 resulted in the Vienna Declaration and Programme of Action, adopted in consensus by all 176 participating states.[33] Paragraph 5 of the Declaration contains one of the most quoted sentences in the international human rights context:

> "All human rights are universal, indivisible and interdependent and interrelated."[34]

Paragraph 18 deals specifically with human rights of women, emphasizing that all women should be guaranteed all human rights:

> "The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.
>
> Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. This can be achieved by legal measures and through national action and international cooperation in such fields as economic and social development, education, safe maternity and health care, and social support."[35]

The International Conference on Population and Development that was held in Cairo in 1994 resulted in the Cairo Platform of Action. The connection between reproductive health issues and human rights was extensively elaborated on in various paragraphs. One illustrative example is paragraph 7.3:

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[33] *See* The Preamble of the Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights, 14-25 June 1993, A/CONF.157/23.
[34] *Ibid.* para. 5.
[35] *Ibid.* para. 18.

> "(…) reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the 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. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents."[36]

Of additional interest is the 1995 Beijing Conference on Women. The extensive Beijing Declaration and Platform of Action refer to the Declarations from Vienna and Cairo,[37] and elaborate on women's reproductive rights in various paragraphs.[38]

Despite the similarities between the texts of the above-mentioned documents and the wording of provisions in various human rights conventions, it is essential to distinguish these documents from sources of international law.[39] Although severe forms of non-compliance with a conference document could possibly result in bad publicity for a government, it is only violations of provisions of international law that create state obligations.[40] In order not to loose track of what is *really* women's right to reproductive choice under human rights law, *i.e.* positive international law binding upon states, it is essential to focus on the sources of international law.[41]

The Statute of the International Court of Justice (ICJ) is widely recognized to provide the most authoritative statement on what constitutes the sources of international law.[42] The listing is found in Article 38(1) and consists of:

> a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting states;

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[36] *See* Programme of Action of the International Conference on Population and Development, adopted at the United National Conference on Population and Development, 5-13 September 1994, A/CONF.171/13, para 7.3, available on <www.unfpa.org/icpd/icpd_poa.htm>, last visited 18 May 2005.
[37] *See e.g.* The Beijing Platform of Action, adopted at the Fourth World Conference on Women, 4-15 September 1995, A/CONF.177/20, paras. 2 and 97.
[38] *Ibid.* paras. 17, 30, 74, 95-99.
[39] As an example, the wording of Programme of Action of the International Conference on Population and Development, para 7.3 is similar to the wording of CEDAW art. 16(1)(e).
[40] *See e.g.* Manfred Nowak, *Introduction to the International Human Rights Regime*, pp. 2-3. For further elaboration and critique of the use of conference documents as sources of law, *see* Corinne A.A. Packer, *The Right to Reproductive Choice*, pp. 18-23.
[41] *Ibid.*
[42] Malcolm N. Shaw, *International Law*, 5th edition, 2003, Cambridge University Press, Cambridge, p. 66. The list has been criticized for being both too inclusive and too exclusive, but no alternative listing has won a more general approval than art. 38(1) of the Statute of the International Court of Justice. *See* Peter Malanczuk, *Akhurst's Modern Introduction to International Law*, 7th ed., 1997, Routledge, London, p. 36.

> b. international custom, as evidence of a general practice accepted as law;
>
> c. the general principles of law recognized by civilized nations;
>
> d. (…) judicial decisions and the teachings of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Against the background of Article 38(1), this thesis will commence with an elaboration on relevant articles found in international human rights treaties. Although no treaty or right has a higher legal value than another,[43] the instruments will be dealt with below according to relevance for the particular issues at stake for this thesis. Keeping in mind that the findings of UN treaty bodies, *i.e.* monitoring committees, are not *per se* sources of international law, it is the prerogative of the committees to provide guidance as to how the treaty provisions should be interpreted.[44] General Comments,[45] General Recommendations,[46] and findings in communications[47] to the Human Rights Committee (HRC) will therefore be used in this context. A fact adding to the confusion about what constitutes binding provisions on the right to reproductive choice is that the treaty bodies frequently refer to the conference documents from Vienna, Cairo and Beijing.[48]

2.2 Convention on the Elimination of All Forms of Discrimination against Women

Although no international human rights treaty deals explicitly with the right to reproductive choice using that exact wording, CEDAW is the convention that captures most of its content. It is noteworthy that the rights in the convention apply to all women, regardless of marital status.[49] In Article 16(1)(e) it is stated that:

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[43] *See* para. 5 of the Vienna Declaration and Programme of Action, where it is stated that: "All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis".
[44] *See* Manfred Nowak, *Introduction to the International Human Rights Regime*, p. 99.
[45] *See* art. 40(4) of ICCPR and art. 45(d) of CRC.
[46] *See* art. 19 of ICESCR and art. 21(1) of CEDAW.
[47] *See* art. 41 of ICCPR and Optional Protocol to the Covenant on Civil and Political Rights.
[48] *See e.g.* General Recommendation No. 21, 'Equality in Marriage and Family Relations', (Thirteenth Session), 4 February 1994, A/47/38, para. 36. *See also* General Comment No. 14, 'The Right to the Highest Attainable Standard of Health', (Twenty-Second Session), 11 August 2000, E/C.12/2000/4, paras. 2 and 43.
[49] *See* Art. 1of CEDAW.

> "States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women (…) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."

The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) elaborated on the content of Article 16 in General Recommendation No. 21. The CEDAW Committee concluded that having children particularly affected the life of women and that although the decision to have children should preferably be made together with the partner, the decision should not be limited by another subject.[50] To make an informed decision, women therefore should have access to information about the use of contraceptive measures and guaranteed access to sex education and family planning services.[51]

The CEDAW Committee furthermore referred to Article 10(h) on education.[52] In this provision it is specifically stated that the right to education includes access to educational information on family planning:

> "States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women (…) access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."

Article 12(1) and (2) on the right to health care stipulates that:

> "State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

The CEDAW Committee has concluded that from this provision follows the responsibility for the state party to ensure, without discrimination,[53] sexual health information, education and services for all women and girls.[54]

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[50] "(…) spouse, parent, partner or Government", *see* General Recommendation No. 21, 'Equality in Marriage and Family Relations', (Thirteenth Session), 4 February 1994, A/47/38, para. 22.
[51] *Ibid.*
[52] *Ibid.*
[53] It is in this context also relevant to emphasize Article 1, which states that the provisions in the convention apply to all women regardless of marital status.
[54] Against the background that "Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices.(…)" *See* General

Article 14(2)(b) is of particular interest for this thesis since it acknowledges the particular difficulties for women in rural areas to access health care:

> "States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right (…) to have access to adequate health care facilities, including information, counselling and services in family planning.''

2.3 Convention on the Rights of the Child

Convention on the Rights of the Child (CRC) is a treaty establishing special rights for children, as children are particularly vulnerable and in need of special protection.[55] However, the wording of Article 24(2)(f) on the right to health acknowledges a close link between the health of the child and the health of the parents:[56]

> "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. (…) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures (…) to develop preventive health care, guidance for parents and family planning education and services."

Article 13(1), on the other hand, provides the right of the child[57] to seek and obtain information:

> "The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice."

Although educational information on family planning or other related issues are not explicitly mentioned, there seems to be no constraints to including such information under the scope of Article 13.[58] However, Article 13(2) contains a possibility for the state party to limit the above-mentioned right through law:

Recommendation No. 24, 'Women and Health, Article 12', (Twentieth Session), 2 February 1999, A/54/38/Rev.1, chapter I, para. 18.

[55] *See* The Preamble of The Convention on the Rights of the Child, United Nations General Assembly Resolution 44/25 of 20 November 1989.

[56] *See* Corinne A.A. Packer, *The Right to Reproductive Choice,* p. 33.

[57] According to CRC art. 1, everyone under the age of 18 is a child, which means that the convention is applicable to all persons under that age. The Committee on the Rights of the Child has emphasized that CRC applies also to married persons under the age of 18, *see* General Comment No. 4, 'Adolescent Health and Development in the Context of the Convention on the Rights of the Child', (Thirty-Third Session), 1 July 2003, CRC/GC/2003/4, paragraph 20.

[58] *See* Corinne A.A. Packer, *The Right to Reproductive Choice,* pp. 65-66.

> "For the protection of national security or of public order (ordre public), or of public health or morals."

Despite the possibility for the state to restrict the freedom to seek and obtain information on the basis of *e.g.* public morals, the CRC Committee has emphasized the importance of children and adolescents having access to information on family planning:

> "The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning." [59]

2.4 International Covenant on Civil and Political Rights

The International Covenant on Civil and Political Rights (ICCPR) does not have any particular provisions on the right to reproductive choice.[60] However, ICCPR contains a provision on the freedom to seek, receive and impart information, similar to Article 13 in CRC. Article 19(2) of ICCRP states that:

> "Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice."

As in the case of CRC, the provision is complemented with Article 19(3), providing a possibility for the state party to limit the right:

> "The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary (…) for the protection of national security or of public order (ordre public), or of public health or morals."

The freedom to seek, receive and impart information is a general provision, thus also including information on family planning and sexual and reproductive health. The HRC has emphasized that the rights provided in Article 19 as such may not be jeopardized by restrictions under Article

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[59] *See* General Comment No. 4, 'Adolescent Health and Development in the Context of the Convention on the Rights of the Child', (Thirty-Third Session), 1 July 2003, CRC/GC/2003/4, para. 10.

[60] There are several authors who argue that the right to life in ICCPR art. 6 does/should include the right to reproductive choice, based on reasons of equality and/or because of the high number of pregnancy related deaths around the world. *See e.g.* Dina Bogecho, 'Putting it to Good Use: The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health' in 13 *Southern California Review of Law and Women's Studies* (2004) pp. 241-243. *See also* Rebecca J. Cook, 'Human Rights and Reproductive Self-Determination' in 44:4 *American University Law Review* (1995) pp. 993-994.

19(3).[61] Although limitations on the basis of public health and morals are arguably of lesser practical relevance than limitation on other grounds,[62] the HRC has nevertheless concluded in *Hertzberg, et al. v. Finland* that:

> "(…) public morals differ widely. There is no universally applicable common standard. Consequently, in this respect, a certain margin of discretion must be accorded to the responsible national authorities."[63]

It has additionally been argued that the right to decide the number and spacing of one's children is a matter of 'privacy', as provided in Article 17(1):[64]

> "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation."

According to Nowak, the notion of the right to privacy should be understood to protect:

"(…) that particular area of individual existence and autonomy that does not touch upon the sphere of liberty and privacy of others". [65]

Although the HRC has concluded that the right to privacy is necessarily relative as all persons live in society,[66] Nowak argues, on the basis of HRC jurisprudence, that the right to decide over one's own body and the right to sexual autonomy should also fall under the right to privacy.[67]

2.5 International Covenant of Economic, Social and Cultural Rights

Under the International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 2(1), state parties are requires to take steps, to the

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[61] 'However, when a State party imposes certain restrictions on the exercise of freedom of expression, these may not put in jeopardy the right itself.' *See* General Comment No. 10, 'Freedom of Expression, Article 10, (Nineteenth Session), 29 June 1983, HRC/Gen I/Rev.2, para. 4.

[62] *See* Manfred Nowak, *U.N. Covenant on Civil and Political Rights – CCPR Commentary*, 2nd revised edition, 2005, N.P. Engel Publisher, Arlington, p. 466.

[63] *See Hertzberg, et al. v. Finland*, 61/1979 (R.14/61), 2 April 1982, para. 10.3.

[64] *See* Rebecka J. Cook, Bernard M. Dickens and Mahmoud F. Fathalla, *Reproductive Health and Human Rights – Integrating Ethics, Medicine and Law* p. 176. *See also* Corinne A.A. Packer, *The Right to Reproductive Choice*, pp. 27-28.

[65] *See* Manfred Nowak, *U.N. Covenant on Civil and Political Rights – CCPR Commentary*, p. 385.

[66] *See* General Comment 16, 'The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation, Article 17, (Thirty-Second Session), 8 April 1988, para. 7.

[67] *Ibid.* pp. 389-391. *See e.g. Toonen v. Australia*, 488/1992, 13 March 1994, para. 8.1 where HRC concluded that "In so far as article 17 is concerned, it is undisputed that adult consensual sexual activity in private is covered by the concept of "privacy"."

maximum of available resources, to achieve progressively the full realization of the rights of the Covenant.[68]

Article 12 states that all persons have the right to the highest attainable standard of physical and mental health. According to the Committee on Economic, Social and Cultural Rights (ESCR Committee), this provision contains both freedoms and entitlements and the freedoms include the right to control one's health and body, including sexual and reproductive freedom.[69] Article 12(2)(a) has the main objective to improve the survival of the child stating that:

> "The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for (…) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child."

According to the World Health Organization (WHO), infant mortality and stillbirth are often the unfortunate consequences of improper child-spacing and poor maternal health.[70] Consequently, it has been argued that facilitating access to family planning method would be a progressive step to achieve full realization of the right to the highest attainable health, in conformity with ICESCR.[71]

2.6 Conclusions

As there are a number of international documents on the right to reproductive choice, it is essential to distinguish between what constitute binding legal provisions and what do not. This is not an uncomplicated task, as the dividing lines are sometimes blurred in interpretations of law, *e.g.* findings of treaty bodies.

However, regarding CEDAW Articles 1, 10(h), 12, 16(1)(e) and 14(2)(b) the wording of the text itself is quite clear. Concluding that all women have

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[68] *See* Asbjörn Eide, *Economic, Social and Cultural Rights as Human Rights*, in Asbjörn Eide, Catarina Krause and Allan Rosas (ed.), *Economic. Social and Cultural Rights – A Textbook*, 2nd revised edition, 2001, Martinus Nijhoff Publishers, Dortrecht/Boston/London, p. 10. Despite what is commonly understood, not all rights in ICCPR are 'immediate'. The provision on equality of spouses in ICCPR 23(4) merely calls for progressive implementation, which makes some of the critique against ICESCR seem rather unfair. *See* Manfred Nowak, *The Prohibition of Gender-specific Discrimination under the International Covenant on Civil and Political Rights* in Wolfgang Benedek, Esther M. Kisaakye and Gerd Oberleitner (ed.), *Human Rights of Women – International Instruments and African Experiences*, 2002, Zed Books, London, p. 108.

[69] *See* General Comment No. 14, 'The Right to the Highest Attainable Standard of Health', (Twenty-Second Session), 11 August 2000, E/C.12/2000/4, para. 8.

[70] *See* 'World Health Report 2005 - Make Every Woman and Child Count', p. 51. Available on <www.who.int/whr/2005/en/index.html>, last visited 2 June 2005. *See also* Corinne A.A. Packer, *The Right to Reproductive Choice*, p. 34.

[71] *Ibid. See also* General Comment No. 14, 'The Right to the Highest Attainable Standard of Health', (Twenty-Second Session), 11 August 2000, E/C.12/2000/4, paras. 14, 44(a).

the right to reproductive choice would not be reading too much in to the original text.

CRC Article 24(2)(f) is also clear regarding the obligation of adopting appropriate measures to give parents access to family planning guidance and facilities.

Regarding the other provisions elaborated on above, one must resort to interpretations made by the treaty bodies. As previously concluded, the mandate of the treaty bodies to interpret the provisions in the treaties is founded in international law. However, since the interpretations (*i.e.* General Comments, General Recommendations and HRC findings) do not as such constitute sources of international law, this remains a complicated issue.

3 Indonesia and International Human Rights Law

3.1 Introduction

During the Soeharto presidency, the relations between Indonesia and the UN were periodically tense.[72] However, CEDAW and CRC were ratified in 1984 and 1990 respectively. Under the 17 months of Habibie's presidency in 1998 and 1999, CAT[73] and CERD[74] were ratified together with ILO Conventions No. 105, 111 and 138.[75] Arguably, human rights was a priority on Habibie's agenda in order to demonstrate that the new regime was different from the authoritarian governance of the preceding order.[76]

3.2 Status of International Human Rights Treaties

Indonesian is a state party to CERD, CEDAW, CRC and CAT. The government has furthermore signed the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) and the optional protocols of CRC and CEDAW.[77]

Indonesia has a rather weak reporting record, as have most of its neighbouring countries.[78] No report has ever been submitted under CERD,[79] the reports on CAT and CRC have been several years late and there has been no report submitted under CEDAW since 1997.[80]

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[72] President Soekarna had broken the relations with the UN and Soeharto was struggling with *de jure* recognition of his *de facto* presidency in the late 1960s, which affected international relations. *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History,* in Terence H. Hull (ed.), *People, Population and, Policy in Indonesia,* 2005, Equinox Publishing, Jakarta, p. 16.
[73] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
[74] International Convention on the Elimination of All Forms of Racial Discrimination.
[75] *See* Hikmahanto Juwana, 'Assessing Indonesia's Human Rights Practice Post-Soeharto: 1998-2003' 32:1 *Indonesian Quarterly* (2004) p. 54.
[76] *Ibid.* p. 53.
[77] *I.e.* Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict and Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography. *See* 'Multilaternal Treaties deposited with the Secretary-General', United Nations Treaty Collection Database.
[78] The reporting history of all state parties to the UN Human Rights Treaties are available on <www.bayefsky.com>, last visited 22 August 2005.
[79] CERD was ratified in 1999 and the Initial Report was due 25 July 2000. *Ibid.*
[80] *Ibid.*

The Indonesian government has made relatively few reservations to ratified treaties.[81] The only reservation to CEDAW concerns Article 29(1), the mandate of ICJ to solve conflicts over interpretations of provisions in CEDAW.[82]

Indonesia is not yet a state party to ICCPR and ICESCR. The parliament has however decided that the two Covenants should be ratified.[83] The decision contains a reservation to Article 1 on people's right to self-determination.[84] The ratifications of ICCPR and ICESCR have been on the agenda since the presidency of Abdurrahman Wahid[85] in the late 1990s. According to the the National Action Plan on Human Rights (*Rencana Aksi Nasional Hak Asasi Manusia Indonesia*, in short *RAN-HAM*) for the period 1998-2003, ICESCR was to be ratified in 1998 and ICCPR in 2003.[86] There are different explanations to the delay, varying from lack of time to lack of parliament priority.[87] One of the controversial issues that have arguably slowed down the ratification process was Article 4(2) in ICCPR, under which some rights cannot be subject to derogation.[88] According to the views of some parliamentarians however, no rights could be free from derogation in times of emergency.[89]

Apart from the ratifications being a central issue in the 2004-2009 *RAN-HAM*, the Ministry of Law and Human Rights recently hinted that the ratification was now close. According to reports in the Indonesian media,

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[81] *See* 3.3 and 3.4 below for further elaboration on CEDAW and CRC. The full text of reservations and state objections are available through 'Multilaternal Treaties deposited with the Secretary-General', United Nations Treaty Collection Database.

[82] Reservations to the mandate of ICJ are common. As of November 2005, 40 state parties had a reservation to art. 29(1). *Ibid.* Although article 29(1) seems to be a procedural provision, "the non-respect for this procedure may well result in a substantive right remaining unclarified and, therefore, possibly not respected". *See* Corinne Packer, *The Right to Reproductive Choice*, p. 137.

[83] *See* 'House Ratifies Covenants Ahead of Recess', *The Jakarta Post*, 2 October 2005. As of 2 December 2005, Indonesia was not listed as a state party to the Covenants in 'Multilaternal Treaties deposited with the Secretary-General', United Nations Treaty Collection Database.

[84] *Ibid.*

[85] Abdurrahman Wahid is perhaps better known under the name of Gus Dur.

[86] *See* Presidential Decree No. 129/1998 on the Human Rights National Action Plan, p. 11 (my translation) the original text is available on <www.ham.go.id/ran.asp>, last visited 23 September 2005.

[87] *Ibid.* Interview with a Legal Officer and Investigator, The Indonesian National Commission on Human Rights (Komnas HAM), 18 July 2005.

[88] *Ibid.* Article 4(2) states that: "No derogation from articles 6, 7, 8 (paras. 1 and 2), 11, 15, 16 and 18 may be made under this provision", *i.e.* in time of public emergency as defined in art. 4(1). The rights concerned are the right to life, freedom from torture and slavery, the right not to be imprisoned for a inability to comply with contractual obligation, freedom for retroactive punishment, the right to be recognized as person before the law and freedom of though, conscience and religion.

[89] According to the Legal Officer and Investigator at the Indonesian National Commission on Human Rights (Komnas HAM), there is a reluctance to accept the fact that *e.g.* the right to life is non-derogable in the conflict in Aceh.

Justice and Human Rights Minister Hamid Awaluddin addressed the ratification issue during the Aceh peace talks in Helsinki.[90]

The 2004-2009 *RAN-HAM* sets the agenda for ratifications of several other international human rights instruments and optional protocols the in coming five years.[91]

3.3 Convention on the Elimination of All Forms of Discrimination against Women

CEDAW was ratified by the Indonesian government on 13 September 1984 and entered into force on 13 October the same year through Act No. 7/1984.[92] The only Indonesian reservation to CEDAW concerns Article 29, the mandate of the International Court of Justice to solve disputes between state parties regarding interpretation or application of the convention. This is rather surprising considering that the convention is subject to extensive reservations, especially by other predominantly Muslim states.[93] The reservation to Article 29 is arguably based on Indonesian culture:

> "(…) by tradition and culture, Indonesia sought to settle disputes through dialogue and consultation among the parties concerned. That reservation, however, in no way affected the Government's serious commitment to implementing the other provisions of the Convention."[94]

Judging by the reporting history to the CEDAW Committee, the governmental commitment to CEDAW seems higher than to some other treaties.[95] Since ratification, Indonesia has reported three times, although

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[90] The questions discussed was about the prospect of allowing local political parties as part of democratic rights in Indonesia, and the Minister then answered that ICCPR and ICESCR would be ratified. *See* 'Aceh: Peace in Our Time?', *Tempo*, 19-25 July 2005.
[91] The RAN-HAM was enacted through Presidential Decree 40/2004 on 11 May 2004 and is available in English through <www.ham.go.id/ran.asp>, last visited 23 September 2005.
[92] *See* 'Multilaternal Treaties deposited with the Secretary-General', Part I, Chapter IV. Available through the United Nations Treaty Collection Database. *See also* 'Second and Third Periodic Report of State Party, Indonesia', 12 February 1997, CEDAW/C/IDN/2-3, 12 February 1997, p. 7.
[93] Neighbouring countries Malaysia and Singapore have reservations to various key articles (*e.g.* arts. 2 and 16) and several predominantly Muslim countries have extensive reservations, *e.g.* Kuwait, Morocco and Egypt. *See* Multilaternal Treaties deposited with the Secretary-General, United Nations Treaty Collection Database.
See also Hanna Beate Schöpp-Schilling, *Reservations to CEDAW*, in Ineta Ziemele (ed.) *Reservations to Human Rights Treaties and the Vienna Convention Regime – Conflict, Harmony or Reconciliation*, 2004, Martinus Nijoff Publishers, Leiden/Boston, pp. 6, 8 and 10. *See also* Hilary Charlesworth, Christine Chinkin and Shelley Wright, 'Feminist Approaches to International Law' 85 *American Journal of International Law* (1991) p. 633.
[94] *See* Statement of Mr. Wibisono, the representative of the Indonesian government at the meeting of the CEDAW Committee at the UN Headquarters on 10 June 1998, in 'Summary Record of 377th Meeting, Eighteenth session of the Committee on the Elimination of Discrimination against Women', 2 February 1998, CEDAW/C/SR.377', p. 3, para. 10.
[95] *See* 3.2 above.

there is a backlog since 1997.[96] Periodic reports were due in 1997, 2001 and a third was due in October 2005.[97]

The latest report was submitted in February 1997 as a combined second and third periodic report. The CEDAW Committee examined the report during its eighteenth session in June 1998. The report itself was drafted in 1996 and consisted of 106 pages, including 25 pages of charts and tables.

Issues of reproductive rights were addressed in several paragraphs, mainly focusing on aspect of maternal health and the success of the national family planning program.[98] When the report was under consideration and discussions between the CEDAW Committee and representatives of the Indonesian government were held, several Committee members attended to questions of reproductive rights. The main concern was the reported allegations of coercion in the implementation of the national family planning program, which arguably left women without individual or informed choices regarding contraception methods.[99] Other issues of concern were the fact that the family planning program only targeted women, but that women needed to obtain their husbands consent in various reproductive health matters.[100]

In the Concluding Observations, the CEDAW Committee recognized the success of the national family planning program as an example of "the Government's ability to take highly effective steps to improve the situation of women"[101]. However, the CEDAW Committee expressed concern over the lack of informed choices with respect to family planning methods and the issue of husband veto in cases of sterilization and abortion.[102]

Interestingly enough, the CEDAW Committee did not address the fact that the Indonesian family planning program only targeted married women, despite the wording of Article 1 of the Convention.[103] Furthermore, the issue of educational information on reproductive and sexual health was not

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[96] *See* 'Reporting History by State – Indonesia', <www.bayefsky.com/docs.php/area/rephistory/state/80/node/3/treaty/cedaw/opt/0> last visited 18 September 2005.
[97] *Ibid.*
[98] *See* 'Second and Third Periodic Report of State Party, Indonesia', 12 February 1997, CEDAW/C/IDN/2-3, pp. 47-54.
[99] Allegations of coercion came from non-governmental sources. According to the Summary Records, the government representatives never responded to the allegations. *See* Statement by Ms. Shalev, 'Summary Record of 378th Meeting, Eighteenth session of the Committee on the Elimination of Discrimination against Women', 2 February 1998, CEDAW/C/SR.377, p. 9, para. 32.
[100] *Ibid.* p. 6, para. 18. *See also* 'Second and Third Periodic Report of State Party, Indonesia', 12 February 1997, CEDAW/C/IDN/2-3, pp. 51-54.
[101] *See* 'Report of the Committee on the Elimination of Discrimination against Women, Eighteenth and nineteenth session', A/53/38/Rev.1, p. 25, para. 280.
[102] *Ibid.* pp. 26-27, paras. 284 and 297. It should be noted that abortion is illegal in Indonesia and that the cases of abortion referred to by the CEDAW Committee are cases when the woman's life is in danger. *See* 5.6 below.
[103] "…irrespectively of their marital status…"

attended to. The only remark made on this subject was by Committee member Ms. Shalev, who pointed out that the state report made no mention of HIV/AIDS education programs to adolescents.[104]

3.4 Convention on the Rights of the Child

When ratifying CRC through a presidential decree in 1990,[105] a declaration was made that Articles 1, 14, 16, 17, 21, 22 and 29 would not be applied beyond the limits of the 1945 Constitution.[106] The declaration sparked national and international criticism and was perceived as a reservation, in spite of the governmental labelling.[107] The declaration was however withdrawn on 2 February 2005,[108] following the enactment of the Act No. 23/2002 on Child Protection.[109]

The latest Indonesian state report was submitted in February 2002 and considered by the CRC Committee in January 2004, during the thirty-second session.[110] Like the Indonesian CEDAW report, the state report on CRC was an extensive document of over 100 pages.

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[104] *See* 'Summary Record of 378th Meeting, Eighteenth session of the Committee on the Elimination of Discrimination against Women', 2 February 1998, CEDAW/C/SR.377, p. 10, para. 33.

[105] Since CRC was ratified through a presidential decree and not a legislative act, the convention cannot be used as a reference for drawing new legislation or amending existing laws. According to the second periodic report, there are plans to reinforce the status of CRC through a ratification act. *See* 'Second Periodic Report of State Party, Indonesia', 7 July 2003, CRC/C/65/Add.23 p. 9. *See also* Benny S. Tabalujan, *The Indonesian Legal System: An Overview*, published online by New England School of Law, available on <www.llrx.com/features/indonesia.htm>, last visited 4 November 2005.

[106] *See* Multilaternal Treaties deposited with the Secretary-General, Part I, Chapter IV, note 20, available through the United Nations Treaty Collection Database for the full text of the declaration.

[107] *See* 'Second Periodic Report of State Party, Indonesia', 7 July 2003, CRC/C/65/Add.23 p. 6. Ratifying states may make declarations and reservations according to art. 51 which was modeled after CEDAW art. 28. Reservations cannot be made "against the object and purpose of the treaty". Contrary to CERD, but similar to CEDAW, CRC does not contain a definition of what constitutes the 'object and purpose of the treaty'. *See* William A. Schabas, 'Reservations to the Convention on the Rights of the Child', 18:2 *Human Rights Quarterly* (1996) p. 476.

[108] *Ibid.* In resent years, a number of countries (of which many are Asian or have a predominantly Muslim population) have withdrawn reservations to CRC *e.g.* Egypt (2003), Malaysia (1999), Myanmar (1993), Pakistan (1997), Tunisia (2002). *See* 'Survey of Reservations, Objections and Withdrawals', available via United Nations Treaty Collection Database.

[109] Critics argue however that Act 23/2002 on Child Protection is inadequately implemented and its effectiveness too dependent on subjective societal perceptions on what is 'exploitive'. *See* 'Always on Call: Abuses and Exploitation of Child Domestic Workers in Indonesia', Human Rights Watch, Vol. 17, No. 7(C), June 2005, p. 58.

[110] The second periodic report was due in October 1997. *See* 'Reporting History by State – Indonesia', <www.bayefsky.com/docs.php/area/rephistory/state/80/node/3/treaty/cedaw/opt/0> last visited 29 October 2005.

In the report, issues related to reproduction are mainly dealt with in the section on health, where *e.g.* statistics on child and maternal mortality were presented.[111]

During the CRC Committee's consideration of the report in January 2004, several Committee members raised questions regarding adolescent sexual and reproductive health. Committee members expressed concern over the low age of sexual consent, which is 12 years, and the fact that minimum age for marriage differs between boys and girls.[112] Additionally, the programs for combating the spreading of HIV/AIDS were discussed.[113]

In the Concluding Observations, the CRC Committee expressed concern over the fact that many girls are married by the age of 15, and thereby considered as adults and excluded from protection as children.[114] The Committee members were furthermore troubled by the fact that no organized system of reproductive health counselling and services, nor education on sexually transmitted infections (STI), including HIV/AIDS, existed.[115] The Committee recommended the Indonesian government to cooperate with NGOs in order to establish a system for formal as well as informal sex education. The Committee furthermore recommended the government to ensure that adolescents had access to both reproductive health counselling and services, and to provide education opportunities for married and pregnant girls.[116]

3.5 Conclusions

It is interesting to note that the CEDAW and CRC Committees have expressed concern over the inadequate reproductive health information and services to adolescents, despite the widely acknowledge success of the Indonesian family planning program. Surprisingly, the CEDAW Committee did not comment on the fact that unmarried women are excluded from the state sponsored programs and services.

The effects of the upcoming ratifications of ICCPR and ICESCR on national legislation and policies will be an interesting development and the concrete effects are yet to be seen.

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[111] *See* 'Second Periodic Report of State Party, Indonesia', 7 July 2003, CRC/C/65/Add.23 pp. 50-67.
[112] Under Act 1974/ on Marriage, the marriageable age for girls is 16 years of age, whereas it is 19 for boys. *See* 'Summary Record of 920th Meeting, Thirty-fifth session of the Committee on the Rights of the Child', 13 January 2004, CRC/C/SR.920, pp. 3-4, paras. 12, 16.
[113] *See* 'Summary Record of 921st Meeting, Thirty-fifth session of the Committee on the Rights of the Child', 13 January 2004, CRC/C/SR.921, pp. 4-5, paras. 22-24.
[114] *See* 'Concluding Observations: Indonesia, Committee on the Rights of the Child, Thirty-fifth session, 26 February 2004, CRC/C/15/Add.223, p. 5, para. 26.
[115] *Ibid.* p. 11, para. 58.
[116] *Ibid.* pp. 12-13, paras. 59-63

4 Domestic Human Rights Legislation

4.1 The 1945 Constitution

The 1945 Constitution of the Republic of Indonesia was hastily drafted after the declaration of independence,[117] and before Soeharto resigned, the text had never been amended.[118] Since 1999 the Indonesians have seen their Constitution amended four times. The amendments have been part of a political process to reform the nature and structure of the national institutions and the relationship between them.[119] Furthermore, the amendments have gradually enhanced the constitutional protection of human rights – arguably the most radical change to the original constitutional philosophy.[120]

The most significant improvement of the human rights protection in the Constitution came with the amendment in 2000, when Chapter XA on human rights was enacted. Chapter XA consists of a catalogue of rights, including an individual right to development.[121] The constitutional protection of economic and social rights is extensive, as provisions provide for rights to obtain medical care, social security and housing.[122] Some rights guaranteed in Chapter XA overlap with rights guaranteed in other chapters of the Constitution.[123]

There is no specific provision on gender equality or human rights of women. However, under Article 28I(2) there is a prohibition of "discriminatory treatment based on any grounds whatsoever". Under Article 28H(2) there is a right to "special treatment to have the same opportunity and benefit in order to achieve equality and fairness".[124] Apart from the provision on the

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[117] *See* Tim Lindsey, 'Indonesian Constitutional Reform: Muddling Towards Democracy' 6 *Singapore Journal of International and Comparative Law* (2002) pp. 244-245.
[118] *See also* Benny S. Tabalujan, *The Indonesian Legal System: An Overview*, published online by New England School of Law, available on <www.llrx.com/features/indonesia.htm>, last visited 4 November 2005.
[119] *See* 'Preface by Professor Jimly Asshiddiqie, Chairman of the Indonesian Constitutional Court' in the printed publication of the 1945 Constitution of Indonesia and the Act Number 24 of 2003 on the Constitutional Court of the Republic of Indonesia, Secretariat General 2003.
[120] *See* Tim Lindsey, 'Indonesian Constitutional Reform: Muddling Towards Democracy', p. 254. *But see* Shafiah Fifi Muhibat and Lina A. Alexandra, 'Human Rights', 32:3 *The Indonesian Quarterly* (2004) p. 288.
[121] On the international arena, the (eventual) right to development is a debated question. *See e.g.* Stephen Marks, 'The Human Right to Development' in 17 *Harvard Human Rights Journal* (2004) p. 137.
[122] *See e.g.* arts. 28H(1) and 28H(3).
[123] *E.g.* freedom of religion is guaranteed in art. 28E(1) and art. 29(2).
[124] Thus, despite the lack of a clear definition of 'discrimination', there is a rather extensive room for affirmative action under the Constitution.

right to obtain medical care, there is another provision relating to reproductive rights in Article 28B(1), which states that "every person has the right to establish a family and to procreate based upon lawful marriage".

As in other national constitutions, human rights can be restricted through law.[125] Under Article 28I(1) however, there are certain right that cannot be restricted under any circumstances. The list consist of the right to life, freedom from torture, freedom of thought and conscience, freedom of religion, freedom from enslavement, recognition as person before the law, and the right not to be tried under a law with retrospective effect.[126]

4.2 Act No. 39/1999 on Human Rights

The Act No. 39/1999 on Human Rights (Human Rights Act) with its 106 articles is an extensive instrument on human rights protection. The first six chapters contain a catalogue of rights divided into sections, including sections on women's and children's rights.[127]

Article 1 provides definitions of what constitutes human rights and violations thereof. The Indonesian definition of human rights has its roots in natural law, with a reference to human rights as "a set of rights bestowed by God".[128] The definition of 'human rights violations' in Article 1(6) is unconventional and inclusive compared to *e.g.* the definitions under the UN instruments:

> "Human rights violations mean all actions by individuals or groups of individuals, including the state apparatus, both intentional and unintentional, that unlawfully diminish, oppress, limit and/or revoke the human rights of an individual or group of individuals guaranteed by the provisions set forth in this Act, and who do not or may not obtain fair and total legal restitution under the prevailing legal mechanism."

Judging by the formulation of the first part of the provision, the main violator that the legislator had in mind was a private actor. This approach takes an opposite stand compared to most traditional definitions of human rights violations, where in most cases only state actors can be held responsible for human rights violations.[129] Under a traditional definition,

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[125] Article 28J(2) reads: "In exercising his/her rights and freedoms, every person shall have the duty to accept the restrictions established by law for the sole purpose of guaranteeing the recognition and respect of the rights and freedoms of others and of satisfying just demands based upon considerations of morality, religious values, security and basic order in a democratic society."

[126] The list of human right that cannot be restricted through law corresponds in large to the list of non-derogable rights in ICCPR art. 4.

[127] Throughout the document in its official English translation, the individual is exclusively referred to as 'he' or 'him'. In *bahasa Indonesia*, the neutral '*dia*' is used.

[128] *See* Article 1(1), Law No. 39/1999 on Human Rights.

[129] There are exceptions from this traditional definition of human rights violations, when states fail to provide an individual protection from a private actor, *see e.g. Velasquez Rodriguez* v. *Honduras*, 29 July 1988, Inter-American Court of Human Rights, Series C No. 4.

criminal law, and not human rights law, would regulate *e.g.* the infliction of injuries one individual cause another.[130] Another unusual feature is that unintentional action, as well as intentional actions, may constitute human rights violations.

There are several provisions in the Human Rights Act that relate to issues of reproductive rights. Article 10(1) states that "everyone has the right to marry legally, to found a family, and to bear children".[131] There is no further guidance in the elucidation act, 'Notes to Republic of Indonesia Act No. 39 of 1999 concerning human rights', on whether or not 'legal marriage' is a precondition for the right to found a family and bear children.[132] Article 53(1) states that a persons life commence at conception and that "every child has a right to life, to maintain life and to improve his standards of living" from that moment. However, the interpretation of Article 9 on the right to life calls for an exception in cases of abortion when the woman's life is in danger.[133]

Although there is no general right to obtain medical care or adequate health services in the Human Right Act, Article 41(2) provides a right for pregnant women to "special facilities and treatment".[134] A woman is also entitled to special protection from work or professions that could harm her safety or reproductive function.[135] According to the interpretation of this article, the special protection means "health services related to menstruation, pregnancy, birth, and providing the opportunity to breastfeed".[136] Article 49(3) states that these special rights are "guaranteed and protected by law".

4.3 The Human Rights Commission

There are two main bodies established through law to handle cases of human right violations: the National Commission on Human Rights (*Komisi Nasional Hak Asasi Manusi – Komnas HAM*) and the Human Rights Courts.

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[130] *I.e.* if a person punches his friend in the face, the incident would be a considered a crime in many jurisdictions, but not necessarily a human rights violation. If a prison guard treats an inmate the same way, the incident would however likely be considered a human rights violation.

[131] The right to bear children is most likely limited to women.

[132] *See* 'Notes to Republic of Indonesia Act No. 39 of 1999 concerning human rights', Supplement to the State Gazette of the Republic of Indonesia, No. 3886.

[133] *Ibid.* This exception corresponds with the provision in article 15, section 2, paras. 1-2 of Act No. 23/1992 on Health, *see* 5.6 below.

[134] There is hence no corresponding provision to art. 28(H) in the Constitution on the right to obtain medical care. The right for children to adequate health services is however provided in art. 62.

[135] *See* art. 51(2). The official English translation of the provision reads: "Women have the right to special protection in the undertaking of work or a profession that could put her safety and/or her reproductive health." Likely, the words 'at risk' or similar have been lost in translation, or the provision will not make sense.

[136] *See* 'Notes to Republic of Indonesia Act No. 39 of 1999 concerning human rights', Supplement to the State Gazette of the Republic of Indonesia, No. 3886.

Komnas HAM in its current form was established through the adoption of the Human Rights Act in 1999.[137] According to Article 76(1) the mandate of the commission is mainly to "study, research, disseminate, monitor and mediate human rights issues". The 35 commissioners are selected by Parliament and the selection is validated by the President.[138]

Article 89 contains a list of the *Komnas HAM* mandate, which can be summarized as follows:

- cooperate with regional and international agencies for the continuous protection of human rights;
- monitor and investigate the implementation of human rights;
- extend its opinion, consideration and proposal to the related government agencies in order to continuously improve the observance of human rights;
- spread the national and the international concept of human rights both to the national as well to the international communities.[139]

Individual or groups of individuals may submit written or oral complaints of human rights violations to *Komnas HAM*.[140] In these cases, the commission has its primary function as a mediator between the parties, but may also recommend the parties to present their case in court or recommend to government or parliament to follow up on the case.[141]

Komnas HAM has not yet received any complaints regarding violations of the right to reproductive choice in Indonesia and currently these issues have no particular priority.[142]

4.4 The Human Rights Courts

The Human Rights Courts were established through the enactment of Act 26/2000 on Human Rights Courts (Human Rights Courts Act). The same

[137] *See* arts. 75-103, 105 of Act No. 39/1999 on Human Rights. *Komnas HAM* succeeded the National Commission of Human Rights established by Presidential Decree No. 50 of 1993. *See also* 'Sejarah Komnas HAM', <www.komnasham.go.id/tentang_komnasham.htm>, last visited 16 October 2005.
[138] *Ibid.* art. 83(1). The commissioners should be selected among "public figures who are professional, dedicated, have a high level of integrity, who fully comprehend, the aspiration of a democratic and welfare state based on justice, and who respect human rights and obligations", *see* art. 76(2).
[139] *See* 'Indonesian Commission on Human Rights', The Asia Pacific Forum of National Human Rights Institutions, <www.asiapacificforum.net/member/indonesia/index.html>, last visited 16 October 2005.
[140] *See* art. 90(1) of Act No. 39/1999 on Human Rights.
[141] *Ibid.* art. 89(4).
[142] Interview with a Legal Officer and Investigator at *Komnas HAM*, July 2005 who explained that reproductive rights are commonly not viewed as an issue within the mandate of the commission. The respondent regretted this fact, but found it understandable as the level of knowledge about reproductive rights is generally low. In July 2005, there were however three projects which partly related to reproductive rights: anti-violence against women, trafficking and internally displaced persons.

law provided for the establishment of *Ad Hoc* Human Rights Courts, with a mandate to hear cases of gross human rights violations that took place prior to the coming into force of the Human Rights Courts Act.[143]

The Human Rights Courts are permanent district courts that will hear cases of gross violations of human rights.[144] What constitutes gross violations of human rights is defined in Article 7 as "the crime of genocide and crimes against humanity". Theses crimes are further defined in Articles 8 and 9.[145] Under the Human Rights Courts Act, individual responsibility applies and for the worst forms of violations, the penalty is death.[146] This rather unusual feature in human rights legislation has been subject to criticism from *e.g.* Amnesty International.[147]

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[143] *See* art. 43 of Act No. 26/2000 on Human Rights Courts. I will not elaborate further on the *Ad Hoc* Human Rights Courts in this thesis.
[144] *Ibid.* arts. 1(3) and 3(1).
[145] *See* art. 8 "The crime of genocide as referred to in Article 7 section a is any action intended to destroy or exterminate in whole or in part a national group, race, ethnic group, or religious group by:
1. killing members of the group;
2. causing serious bodily or mental harm to members of a group;
3. creating conditions of life that would lead to the physical extermination of the group in whole or in part;
4. imposing measures intended to prevent births within a group; or
5. forcibly transferring children of a particular group to another group."
Article 9 states that:
"Crimes against humanity as referred to in Article 7 section b include any action perpetrated as a part of a broad or systematic direct attack on civilians, in the form of:
1. killing;
2. extermination;
3. enslavement;
4. enforced eviction or movement of civilians;
5. arbitrary appropriation of the independence or other physical freedoms in contravention of international law;
6. torture;
7. rape, sexual enslavement, enforced prostitution, enforced pregnancy, enforced
8. sterilization, or other similar forms of sexual assault;
9. terrorization of a particular group or association based on political views, race, nationality, ethnic origin, culture, religion, sex or any other basis, regarded universally as contravening international law;
10. enforced disappearance of a person; or
11. the crime of apartheid."
[146] *Ibid.* arts. 1(4), 36-37.
[147] *See e.g.* 'Indonesia: Urgent measures needed to ensure justice for victims of human rights violations in Papua', Amnesty International Public Statement, 7 May 2004. Available on <www.web.amnesty.org/library/Index/ENGASA210172004?open&of=ENG-IDN>, last visited 16 October 2005.

5 Women's Right to Reproductive Choice in Indonesia

5.1 Introduction

Indonesia has gained international recognition for its successful national family planning program in terms of decreasing population growth. President Soeharto received the United Nations Population Prize in 1989,[148] and since 1983 the BKKBN offers training courses on family planning to participants from other developing countries.[149] The total fertility rate has declined from 5.6 in 1971 to 2.4 in 2001.[150] Despite this positive development, Indonesia still has the highest maternal mortality ratio in South East Asia with approximately 370 deaths per 100 000 live births.[151] The high number of maternal mortality is mainly caused by complications during pregnancy or delivery, of which 15-30 per cent of the cases are believed to be direct results of unsafe abortions.[152]

As elaborated on further below, there is a distinct dividing line between services available for married women and unmarried women respectively. Here a clarification is warrented as the definition of marital status is *per se* a factor complicating access to services. In the Indonesian language, there are two words for 'married': *menikah* and *kawin*. Both translate into 'married' but have different meanings and implications. *Menikah* is an official marriage that is usually registered, whereas *kawin* is an unofficial marriage that is recognized culturally and religiously by the community, but not by the State.[153] *Kawin* marriages are more common among poorer people, as marriage registration and obtaining a certificate is relatively expensive.[154] This has even resulted in an Indonesian television reality show called 'Marry for Free' (*'Nikah Gratis'*), where a poor young couple can win an

[148] *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History*, in Terence H. Hull, (ed.), *People, Population and, Policy in Indonesia* , p. 54.
[149] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 9.
[150] *See* Annual Report 2003, 'Empowering Women by Addressing Issues on Sexual & Reproductive Health and Rights', Indonesian Planned Parenthood Association, p. 6.
[151] *Ibid.* p. 7. *See also* Indonesia's Population, United Nations Population Fund – UNFPA, Indonesia, available on <www.un.or.id/unfpa/idpop_unfpa.html>, last visited 5 February 2005.
[152] *See* Annual Report 2001, 'Young People Speak About Reproductive Health', Indonesian Planned Parenthood Association, p. 6.
[153] *Kawin* is also a synonym for sex and animal mating, which indicates that the *kawin* marriage is of a more informal character than the regulated *menikah*.
[154] In Jakarta the registration fee is around 150 000 - 200 000 rupiah (15-20 USD).

official wedding ceremony and get their marriage certificate for free.[155] The practice of *kawin* marriages is problematic; especially for women if the marriage is dissolve. As *kawin* marriages are not regulated in law, women are left with limited rights in the case of divorce, eventual children may be considered illegitimate and there is no minimum age to marry *kawin*.[156] Another unfortunate consequence of *kawin* marriage is that women may be excluded from family planning services, as they are not officially married and cannot provide a marriage certificate to prove their marital status.[157]

5.2 The National Family Planning Program

The first organized family planning initiatives in Indonesia were taken by individuals dedicated to women's health, after the ending of the Second World War.[158] In the early 1950s, just shortly after Indonesia gained independence, Dr. Julie Sulianti Saroso from the Ministry of Health was sent to Sweden on a fellowship from the WHO to study the Swedish maternal and child health system.[159] Upon her return, Dr. Saroso held a speech broadcasted from *Radio Republik Indonesia* on the need to include the distribution of contraceptives in the public health policy, in order to reduce maternal and infant mortality.[160] The initiative was not well received by President Sukarno and Vice President Hatta. In the 1950s, the use of contraceptives were rejected by influential religious leaders, and the political leadership regarded Indonesia's growing population as a key to developing of a strong state.[161] However, the demand for family planning services and information was addressed by a group of doctors and feminists who founded The Indonesian Planned Parenthood Association (IPPA) in 1957.[162]

Shortly after the installation of President Soeharto and the launch of the 'New Order' in 1968, the *Badan Koordinasi Keluarga Berencana Nasional* – BKKBN was established.[163] A contributing reason behind the establishment of BKKBN was arguably the influence of international

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[155] Interview with Ms. Mira Diarsi, *Komnas Perempuan*, 7 July 2005.
[156] Interview with Dr. Ramona Sari, Head of Family Planning and Reproductive Health Division, IPPA, 27 June 2005.
[157] *Ibid.* Women can have difficulties proving their marital status, since they have no marriage certificate. Whether or not such certificate is required in order to access contraception varies between providers, *see* chapter 6.4 below.
[158] *See* Lynda Newland, 'The Deployment of the Prosperous Family: Family Planning in West Java', 13(3) *National Women's Studies Association Journal* (2001) p. 25.
[159] *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History*, in Terence H. Hull, (ed.), *People, Population and, Policy in Indonesia*, p. 5.
[160] Dr. Saroso had been studying the works of Gunnar and Alva Myrdahl and was convinced that sex education and birth control would build strong families, since family welfare in particular depended on the health of the mother. *Ibid.* pp. 5-6.
[161] *Ibid.* pp. 11-13.
[162] *Ibid.* p. 10.
[163] BKKBN was established in 1970 and replaced and re-enforced the less powerful first board, the Family Planning Institute (*Lembaga Keluarga Berencana Nasional* – LKBN, founded in 1968. *Ibid.* pp. 14-15, 21.

donors, Indonesian state planners and the UN, all emphasizing population control as a precondition for development.[164] BKKBN was a new type of governmental body. It was not a ministry, but a coordination board for different ministries and organizations, which reported directly to the President.[165]

Under the decades to come, BKKBN travelled a complex road. In terms of population control, the national family planning program was successful. Statistics from BKKBN present a dramatic decrease of the total fertility rate (TFR), from 5.6 in 1968 to 2.6 in 2003.[166] The family planning program was initially focused on distributing contraceptives to married women and on encouraging them not to have more than two children.[167] With a large part of the population being illiterate, the information campaigns and distribution of contraceptives had to be carried out by BKKBN personnel visiting the villages in person.[168] To manage this time-consuming task, BKKBN developed an advanced monitoring apparatus in the 1970s. The monitoring was based on monthly reports submitted from the fieldworkers on village level reporting on the number of *akseptors* (married women on contraceptives). These reports travelled through the hierarchy of sub-levels all the way to capital level.[169] The percentage of *akseptors* rose from 15 per cent of all married women in 1976 to 50 per cent in 1995,[170] and is today estimated by BKKBN to be 60.3 per cent.[171]

Despite the widely acknowledged success of the family planning program, voices of concerns were raised both on the national and international level in the late 1980s, regarding the methods of program implementation The criticism mainly concerned the recruitment of women to the family planning

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[164] Soeharto signed the *World Leaders' Declaration on Population* in December 1967, ressuming the relations with the United Nations that Suharto had broken. *Ibid.* pp. 16-19.
[165] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 6.
[166] *Ibid.* pp. 5, 7.
[167] There was, and still is, hence a division of mandate between BKKBN and the Minsistry iof Health. BKKBN focuses on motivating and recruting family planning acceptors whereas the Ministry of Health provides health services. This difference in mandate (and arguably approach) makes the Indonesian family planning map somewhat difficult to overview. *See* Saparinah Sadli, Kristi Poerwandari and Anita Rahman, 'Country Study of Indonesia' in *Taking up the Cairo Challenge: Country Studies in Asia-Pacific*, 1999, ARROW, Kuala Lumpur, p. 260.
[168] *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History*, in Terence H. Hull (ed.), *People, Population and, Policy in Indonesia*, p. 26.
[169] *Ibid.* p. 27.
[170] *See* Sri Moertiningsih Adioetomo, *Reshaping Populations*, in Terence H. Hull, (ed.), *People, Population and, Policy in Indonesia*, p. 151.
[171] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 5. According to estimations made by UNFPA, the number is 53 per cent, *see* 'Indonesia', available on <www.un.or.id/unfpa/idpop_unfpa.html>, last visited 5 November 2005.

program and whether the *akseptors* accepted voluntarily or were left without a choice. A strongly criticised BKKBN recruitment method was the 1980s *Safaris,* where hundreds of women were gathered by fieldworkers and brought to health centres or temporary facilities where they had intra-uterine devices (IUD) or implants inserted.[172] The *Safaris* made the news outside Indonesia after the wife of a USAID driver had an IUD inserted without her knowledge or consent.[173] National religious leaders criticised government for treating people "like animals" and express concerned over the inappropriateness of male doctors inserting IUDs in Muslim women.[174] Some of the worst stories about rural women facing gunpoint when 'volunteering' as *akseptors* were later proven false, but it seems to be undisputable that the *Safaris* left little room for an informed consent.[175]

In 1993, the main act of legislation on family planning and reproductive health was enacted: Act No. 10/1992 Concerning the Development of Population and Happy and Prosperous Families. The law sets out a number of provisions on what constitutes a happy and prosperous family. The focus is on the nuclear family consisting of a married heterosexual couple and two children. According to the law, decisions on the number and spacing of children should be taken by both spouses together.

The adoption of the law reformed the work of BKKBN, which went from mainly focusing on distributing contraceptives to married women to today's family health based approach.[176] The backbone of this new profile is the annual family enumeration. The family enumeration system has developed since the late 1970s and consists of 12 steps.[177] The annual enumeration is carried out by village field workers collecting data on an estimated total number of 42 million families.[178] Families are categorized into five different levels of prosperity, from 'Pre-prosperous' to 'Prosperity III+', depending on fulfilment of different criteria.[179] The results of the mapping are mainly used by village administrators in community planning projects,[180] but have

[172] *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History,* in Terence H. Hull, (ed.), *People, Population and, Policy in Indonesia,* pp. 36-39.
[173] *Ibid.* pp. 38-39.
[174] *Ibid.* pp. 37-39.
[175] *Ibid.* pp. 50-51.
[176] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, pp. 15-16.
[177] *See* 'Family Enumeration: Data Base for National Family Planning Program', National Family Planning Coordination Board (BKKBN), Center for International Training and Collaboration, 2004, Jakarta, pp. 4-7.
[178] *Ibid.* p. 4.
[179] *Ibid.* pp. 9-10. The criteria of prosperity are linked to economic, social and spiritual indicators. BKKBN concluded in 2004 that: "Pre-KS and KS-I categories sometimes included families who were well-off economically but who, because of religious disinterest or personal preferences concerning house construction, were classified as having low family welfare." *Ibid.* p. 11.
[180] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 34.

also proven useful for government when distributing assistance to particularly poor areas.[181] The fact that village leaders (and in the end government) have full access to information on personal matters, such as individual choice of contraceptives, have been criticised as unnecessary intrusion on privacy.[182]

5.3 Reproductive Health Decentralized

After the fall of the New Order and President Soeharto in 24 May 1998 followed a period of rapid structural change of Indonesia public administration. During the two years of B.J. Habibie's presidency, Indonesia went from almost total central control to extensive regional autonomy.

The demand for greater regional influence of political matters had been growing since independence from the Dutch colonial power.[183] However, there was a fear that increased regional autonomy would break the diverse and multi-ethnical nation into pieces through claims of session.[184] The solution was to transfer the political decision power to units that were too small to provide ground for mobilization of separatist movements. With Act 22/1999 on Regional Governance, regional autonomy was granted to the lower level of the 300 districts, instead of the 32 provinces.[185]

Under Act 22/1999 on Regional Governance, the local government have the mandate to decide over which kind of public services to provide, and to organize the budget accordingly.[186] There are five areas of public administration that are not subject to decentralization; foreign policy, national defence, fiscal and monetary authority, the judicial system and religious affaires.[187] Among the public service subject to decentralization, there are eleven mandatory services that the district government are obliged to provide *e.g.* education and health services.[188]

Act No. 22/1999 on Regional Governance additionally established local governments on the provincial level. The mandate of these governments is mainly to coordinate and the functions of the districts.[189]

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[181] Interview with Mr. Ida Bagus Permana, Director of Program Policy Integration, National Family Planning Coordination Board, BKKBN, 13 July 2005.
[182] *E.g.* in the 1980s, the choice of contraceptives in the individual household was indicated by a symbol on the house wall. *See* Terence H. Hull and Valerie J. Hull, *From Family Planning to Reproductive Health Care – A Brief History*, in Terence H. Hull (ed.), *People, Population and, Policy in Indonesia*, p. 36.
[183] *Ibid.* p. 63.
[184] Habibi ordered the provincial referendum on independence for East Timor, which resulted in the establishment of the independent state of Timor L'Este. *Ibid.* pp. 60, 62. *See also* Yose Rizal Damuri and Delima Amri, 'Decentralization', 32(3) *The Indonesian Quarterly* (2004) p 273.
[185] *Ibid.* p. 274.
[186] *Ibid.* p. 273.
[187] *Ibid.* p. 273.
[188] *Ibid.* pp. 274-275.
[189] *Ibid.* p. 273.

Family planning is not among the eleven mandatory public services that the districts need to provide – a fact regretted by among others BKKBN.[190] Both central government officials and stakeholders at the local level express concern over the lack of local government dedication to what is categorized as 'social development' *e.g.* family planning and health issues.[191] Arguably, there is less understanding of development that cannot be easily measured, and local governments are thus more likely to prioritize 'physical development', *e.g.* constructing buildings and improving infrastructure.[192] Approximately 75 per cent of the today 416 districts have some form of local regulations on family planning, but the responsible bodies often have several other responsibilities.[193]

From the central level of the Ministry of Health, there is a concern that district governments are not accustomed to handle the providing of contraceptives.[194] After decentralization, the districts should not only plan the distribution, but also purchase the contraceptives and keep them in stock. As a result, contraceptives are in short supply in some districts and in some provinces subsidies have been cut due to increasing cost.[195]

Evidently it is difficult to verify the perception that local governments generally do not prioritize reproductive health issues without a survey of the budgeting of all 416 districts. However, one indicator on the general level is that only 30 per cent of total district government expenditure was used for development purposes in 2002, whereas 70 per cent was spent on officer's salaries and material.[196]

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[190] Interview with Mr. Ida Bagus Permana, Director of Program Policy Integration, National Family Planning Coordination Board, BKKBN, 13 July 2005. BKKBN as an authority, although not a ministry, has also been subject to decentralization to the provincial level through the enactment of Act No. 22/2002. *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 29.

[191] *Ibid.* Interview with Ms. Nurti Mukti Wibawati, Officer for Advocacy and Facilities for Women's Health, Ministry for Women's Empowerment, 18 July 2005.

[192] *Ibid.*

[193] As a result of what has been described as "decentralization euphoria", the number of districts is constantly increasing as new districts are created through local division of existing ones. *Ibid.*

[194] Interview with Dr. Soewarta Kosen, National Institute of Health Research and Development, Center for Health Services and Technological Research and Development, Ministry of Health, 8 July 2005.

[195] *Ibid.* Interview with Ms. Beauty Erawati, Executive Director, Legal Aid Office of the Indonesian Women Association for Justice of West Nusa Tenggara, Mataram, 21 July 2005.

[196] *See* Yose Rizal Damuri and Delima Amri, 'Decentralization', p. 275.

5.4 Educational Information on Sexual and Reproductive Health

The Indonesian official view on educational information on sexual and reproductive health is complex. BKKBN is the main provider of information on family planning and reproductive health. However, BKKBN policies draw a clear dividing-line between services provided to married couples and services for unmarried individuals.

Married women can access educational information on reproductive health through the reproductive health services provided by midwives and through the *Puskesmas* and monthly family health posts (*Posyandu*). However, the services are primarily focused on family planning and distribution of contraceptives and less so on providing information.[197] According to the results of the 'Demography and Health Survey 2002-2003', the knowledge of STIs is low among Indonesian married women. 73.1 per cent of all ever-married women had no knowledge at all of STIs.[198] The survey shows that women with higher education and women in urban areas have better knowledge of STI, whereas as 92.3 per cent of the women without any education have no knowledge of STIs.[199]

To estimate the prevalence of pre-marital sex in Indonesia is difficult, as data is limited and the issue considered taboo.[200] However, BKKBN estimations suggest that the pre-marital sex prevalence rate is somewhere between nine and 30 per cent.[201] Surveys done by IPPA in five cities in 2001 suggest a rate of 16.38 per cent, with large variations between the provinces.[202] Despite a widespread belief within the organization that knowledge of contraception would promote immoral behaviour among unmarried persons, BKKBN initiated information campaigns targeting adolescents in the mid-1990s.[203] The first campaign had a 'family-centred

[197] *See* Chapter 5.7 below for further elaboration on information on *e.g.* side-effects.
[198] *Ibid.* p. 183.
[199] *Ibid.* p. 183.
[200] When asked, the tolerance of young people towards pre-marital sex is low (around 3 per cent), as virginity is highly valued for women (98 per cent). There is no significant difference between rural and urban areas, but young people with less than primary education are slightly less negative towards pre-marital sex (around 92 per cent). Few unmarried persons admit that they have had pre-marital sex: one per cent of female and three per cent of male respondents. Married persons are much more likely to say that they had sex before they married: five per cent of the female and 12 per cent of the male respondents. *See* 'Indonesia Young Adult Reproductive Health Survey 2002-2003', Badan Pusat Statistik, 2004, Jakarta, pp. 78-81.
[201] *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 24.
[202] The highest percentage was found in Kupang, Nusa Tenggara Timur (42.5 per cent) and the lowest in Cirebon, West Java (6.7 per cent). *See* Annual Report 2001, 'Young People Speak About Reproductive Health', Indonesian Planned Parenthood Association, p. 6.
[203] These campaigns were arguably outcomes of commitments made at the Cairo Conference. *See* T.H. Hull, E. Hasmi and N. Widyantoro, '"Peer" Educator Initiatives for

approach', *i.e.* encouraging parents to talk about sex with their children. Evaluation of the project showed that the distributed material was well received by the parents, but mostly for their own information and not as a foundation for discussion.[204] The project was completed in 1996.[205]

The general level of education in Indonesia is increasing, but there is still a difference between men and women and between urban and rural areas. Most boys and girls enrol for primary school, but only a minority complete primary education. Primary education is compulsory and even included in the 1945 Constitution as an obligation for the individual to undertake.[206] However, as schools in spite of the law charge pupils tuition fees and require them to purchase books and school uniforms,[207] the economic burden is commonly too heavy for the family to endure.[208]

Sex education is not included in school curricula at any level. The 'Indonesia Young Adult Reproductive Health Survey 2002-2003' shows that the level of adolescent knowledge of some sexual and reproductive health issues are limited. Nearly all persons between the age of 15 and 24 years old recognized at least one method (modern or traditional) to avoid pregnancy.[209] However, few young adults knew *when* a woman could become pregnant during the menstrual cycle.[210] Furthermore, less than half of all young adults knew that a woman could become pregnant as a result of only one sexual intercourse.[211] Even though most young people had heard

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Adolescent Reproductive Health Projects in Indonesia' 12(23) *Reproductive Health Matters* (2004) p. 29.

[204] *Ibid.* p. 30.

[205] *Ibid.*

[206] After the Constitution amendments in 2002, Art. 31(2) now reads "Every citizen has the obligation to undertake basic education, and the government has an obligation to fund this."

[207] Act No. 20/2003 on National Education provides for free, compulsory basic education for children age 7-15 years old.

[208] Despite Article 31(2) of the 1945 Constitution, primary education is subject to tuition fees. Under Regulation 11/2005, it is prohibited for teachers and other school personnel to sell school textbooks to pupils. However, this regulation is frequently ignored. *See* 'Schools Defy Regulation, Sell Textbooks to Students', *Jakarta Post*, 6 August 2005. *See also* Katarina Tomasevski, 'The Right to Education: Report submitted by Katarina Tomasevski, Special Rapporteur in Accordance with Commission Resolution 2002/23, Addendum, Mission to Indonesia 1-7 July 2002, E/CN.4/2003/9/Add.1, 18 October 2002. Available online via <www.right-to-ducation.org/content/unreports/unreport8prt1.html#summary>,last visited 17 September 2005.

[209] Out of 4165 young persons interview, 94.6 per cent of the female and 91.1 per cent of the male young persons said that they *recognized* at least one of the 12 modern and traditional described by the interviewer. *See* 'Indonesia Young Adult Reproductive Health Survey 2002-2003', Badan Pusat Statistik, 2004, Jakarta, p. 37. How many methods the respondents could *themselves* name and describe were not covered in the survey.

[210] 53 per cent of female and 32 per cent of the male respondents knew that there were certain days of the cycle when women are fertile, but among that group of respondents, only 29 per cent of the female and 32 per cent of the male pinpointed the correct days. *Ibid.* p. 28.

[211] The level of knowledge of this fact seems to have declined since the survey in 1999. 49.5 per cent of the female and 45.5 per cent of the male respondents knew that one single

of HIV/AIDS,[212] only 17.8 per cent of the young women knew that the use of a condom could prevent the spread of HIV.[213]

BKKBN concluded in a report on women's empowerment that although government claims that reproductive health issues are integrated into the courses in biology, physical fitness and religion, the education is not sufficient.[214] With no set standard on what should be included, the degree and content of information given is thus dependent on the commitment of the individual teacher. Government promotion of sex education in schools seems to be limited to extra-curriculum activities.[215] Some schools offer sex education through peer-education as an extra-curriculum subject, after approval from parents.[216] These activities are often initiated and sponsored by NGOs, such as IPPA.[217]

There seems to be several explanations to why sex education is not part of school curricula. One reason is the fear that sex education will awaken children's and young peoples interest in sex at a premature age.[218] Another explanation is that sex education arguably does not fit into the school curricula or that it would be unfair if a child's final grade would be affected as a result of a failed test in sex education.[219]

5.5 Access to Contraception

Under Act No. 10/1992 Concerning the Development of Population and Happy and Prosperous Families, all married couples have the right to access family planning. As stated above, unmarried women are by law excluded

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sexual intercourse can result in pregnancy compared to 58 per cent and 50 per cent in 1999. *Ibid.* p. 29.

[212] 86.5 per cent of the female and 81.4 per cent of the male participants. *Ibid.* p. 65.

[213] 24.5 per cent of the young male adults knew that the use of condoms protect from HIV. *Ibid.* p. 67.

[214] *See* 'Women Empowerment and Gender Issues in Indonesia', National Family Planning Coordination Board (BKKBN), Center for International Training and Collaboration, 2004, Jakarta, p. 16.

[215] *See* 'Statement by Dr. Meutia Farida Hatta Swasono, State Minister for Women's Empowerment, Republic of Indonesia, on 1 March 2005 at the 49th Session of the United Nations Commission on the Status of Women', p. 7. The statement is available online on <www.un.org/webcast/csw2005/ statements/050301indonesia-e.pdf> , last visited 22 August 2005.

[216] Interview with Mr. Eddy N. Hasmi, Director for Adolescent & Reproductive Rights Advocacy, National Family Planning Coordination Board, BKKBN, 13 July 2005. A BKKBN peer-education pilot project in East and Central Java is currently under evaluation. *See* T.H. Hull, E. Hasmi and N. Widyantoro, '"Peer" Educator Initiatives for Adolescent Reproductive Health Projects in Indonesia' 12(23) *Reproductive Health Matters* (2004) pp. 32-34.

[217] Interview with Dr. Ramona Sari, Head of Family Planning and Reproductive Health Division, IPPA, 27 June 2005.

[218] *Ibid.*

[219] Interviews with Mr. Eddy N. Hasmi, Director for Adolescent and Reproductive Rights Advocacy, National Family Planning Coordination Board, BKKBN, Jakarta, 13 July 2005 and Ms. Nurti Mukti Wibawati, Officer for Advocacy and Facilities for Women's Health, Ministry of Women's Empowerment, 18 July 2005.

from government-sponsored family planning. Act No. 10/1992 Concerning the Development of Population and Happy and Prosperous Families restricts information and display of contraception methods in Article 21:

> "Display and or demonstration of contraceptive devices, drugs and methods may only be performed by competent personnel in the field of ramify planning and in the proper place and in the proper way."

This rather vague provision is further elaborated upon in Elucidation Law No. 10/1992 Concerning Population Development and the Development of Happy and Prosperous Families. On Article 21 it is stated that:

> "This article is intended to protect society from actions which could detract from the morality of the Indonesian nation. Even though this Law allows for the display and or demonstration of contraceptive devices, drugs, and methods, in practice this must be limited to family planning purposes performed by competent personnel, and with due regard for Indonesian national systems of values."

The contraceptives prevalence rate among married women in Indonesia is estimated to be approximately 50-60 per cent.[220] Marital status is thus the determinate factor for access to contraception. Through the extensive BKKBN family planning program described above, married women are to a large extent provided with modern forms of contraception. Women belonging to the poorest families as defined by the family enumeration criteria, have the right to obtain a special card entitling them to contraceptives free of charge.[221] Poverty in this context is defined as not having enough income to eat more than once a day. The number of poor people has tripled after the financial crisis in the late 1990s, of which many do not have a health card.[222]

As women bear the main responsibility for family planning in terms of method, the absolute majority of contraceptives distributed are implants, injections, IUDs and pills. Male participation in family planning, *i.e.* condom use and vasectomy, remains low at 1.3 per cent.[223] Most women

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[220] According to estimations made by UNFPA, the percentage is 53 pre cent, whereas BKKBN estimates a prevalence rate of 60.3 per cent. *See* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 5 and www.un.or.id/unfpa/idpop_unfpa.html>, last visited 8 August 2005.

[221] *See* Coeli J. Geefhuysen, *Safe Motherhood in Indonesia: A Task for the Next Century*, in Marge Berer and TK Sundari Ravindra (ed.), *Safe Motherhood Initiative: Critical Issues*, 1999, Blackwell Science Ltd, London, p. 66.

[222] *Ibid.*

[223] Interview with Dr. M. Tri Tjahjadi, Director for Male Participation, National Family Planning Coordination Board, BKKBN, Jakarta, 13 July 2005. The use of condom constitutes 0.9 per cent of total contraception for married couples. *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 67. Despite BKKBN efforts to increase the use of condoms, Mr. Adhyaksa Dault, State Minister for Youth and Sports Affairs, has opposed condom use as a method to prevent the spread of HIV/AIDS, arguing that it would be against Indonesian religious and nationalist principles. *See* 'Minister Opposes Condom Use to Fight HIV', *The Jakarta Post*, 13 August 2005.

buy contraceptives in public health facilities, *i.e. Puskesmas* and *Posyandu*, but many also go through private channels such as private clinics. Hormonal injections are the most commonly used method.[224] Injections are generally considered to be practical, effective and affordable, which make this method convenient for both providers and receivers.

The extent of which women can make informed choices about contraception methods seems to vary. Although the days of BKKBN *Safaris* are over, there is arguably still a widespread patronizing attitude among contraception providers to know what is best in terms of choice of contraception for individual women. Evidently this perception is difficult to verify without extensive research of attitudes among health providers. However, official statistics indicate that women are commonly not given adequate background information to make informed decisions. According to 'Indonesia Demographic and Health Survey 2002-2003', less than 30 per cent of the women are informed about side effects when provided with contraceptives by a health worker.[225] Alarmingly, women undergoing sterilization are the least likely (16.9 per cent) to be informed about side effects or exiting alternative methods.[226] Only 82.7 per cent of women (79.9 per cent in rural areas) undergoing sterilization are informed that sterilization is permanent and that they will not be able to have more children.[227]

5.6 The Abortion Paradox

Abortion is prohibited through Article 15, section 2, paragraphs 1-2 of Act No. 23/1992 on Health, stating that:

> "In cases of emergency, and with the purpose of saving the life of a pregnant woman or her fetus, it is permissible to carry out certain medical procedures.
>
> Medical procedures in the form of abortion, for any reason, are forbidden as they violate legal norms, ethical norms, and norms of propriety. Nevertheless, in case of emergency and with the purpose of saving the life of a pregnant woman and/or the fetus in her womb, it is permissible to carry out certain medical procedures."[228]

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[224] *Ibid.* 27.8 per cent of married women on contraception use injectables.
[225] Interviews with Mr. Eddy N. Hasmi, Director for Adolescent & Reproductive Rights Advocacy, National Family Planning Coordination Board, BKKBN, Jakarta, 13 July 2005
[226] *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, pp. 76-77. *See also* Katarina Tomasevski, *Human Rights in Population Policies: A Study for Sida*, p. 55 on 'free and informed consent' to sterilization: "For individual's consent to be valid it has to be *free*, namely the person can provide or withhold consent without coercion and without sanctions for refusal, and *informed*, that is , the patient has to be informed about the medical intervention, its consequences and implications, about the implications of refusal, and about alternatives to the proposed intervention."
[227] *Ibid.*
[228] The translation here used is originally provided in Iwu Dwisetyani , *Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Program*, POLICY Project, Research School of Social Sciences, Australian National University, 2003, p. 2.

The provision has been criticized for its contradictions and ambiguity, leaving women uncertain of what the law really states.[229] 'A certain medical procedures' should however be understood to mean abortion, although it is not explicitly mentioned.[230] In the case where abortion is permitted there are certain conditions that must be fulfilled. The decision must be:

1. based on a medical report which urges that the action should be taken;
2. conducted by authorized experts;
3. with agreement from the pregnant mother, the husband or the members of the family;
4. in specific facilities for that purpose.[231]

It is acknowledged that views on abortion differ in Indonesia, but there is a strong opposition against legalization from Muslim leaders.[232] The current legislation was supported by a *fatawa*, or Islamic legal ruling, issued by the Indonesian Council of *Ulama* (*i.e.* religious scholars) in 1983.[233] In paragraph 2 of *fatawa* it is stated that:

> "Abortion practiced in any form and at any stage of pregnancy is forbidden in Islam (*haram*) because it constitutes murder. This includes menstrual regulation by pills. Exception is granted only if the abortion us conducted to save the life of the mother."[234]

Despite the strict legislation, it is common knowledge that abortion services are widely provided by both medical and non-medical personnel throughout the country.[235] For obvious reasons there is no available statistics on the practice of illegal abortions in Indonesia, but the number is estimated to be increasing.[236] In 'Incidence and Social-psychological Aspects of Abortion in Indonesia', a study from the Centre for Health Research at University of Indonesia, it was estimated that 2.5 million women seek abortion each year and approximately 2 million abortions were carried out in 2001.[237] According to the calculations made in the study, there are approximately 43 abortions (including spontaneous abortions) per 100 live births, or 37

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[229] *Ibid. See also* 'Indonesia Reproductive Health Profile 2003', Ministry of Health Republic of Indonesia and the World Health Organization, 2003, Jakarta, p. 55.
[230] *See* Indonesia's Second and Third State Report on CEDAW, CEDAW/C/IDN/2-3, 12 February 1997, p. 53.
[231] *Ibid.*
[232] *Ibid.*
[233] *See* MB Hooker, *Islam and Medical Science: Evidence from Indonesian Fatawa: 1960-1995* in Timothy Linsey (ed.), *Indonesia – Law and Society*, 1999, The Federation Press, Leichhardt, p. 165.
[234] *Ibid.*
[235] Interview with Ms. Mira Diarsi, Komnas Perempuan, 7 July 2005. *See also* Iwu Dwisetyani , *Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Program*, p. 15.
[236] *See* 'Indonesia Reproductive Health Profile 2003', Ministry of Health Republic of Indonesia and the World Health Organization, 2003, Jakarta, p. 56.
[237] *Ibid. See also* Annual Report 2003, 'Empowering Women by Addressing Issues on Sexual & Reproductive Health and Rights', Indonesian Planned Parenthood Association, p. 6.

abortions per 1000 women age 15 to 49 years.[238] Although this number is higher than the numbers presented in earlier estimations (varying from five to 35 abortions per 100 live births), WHO and the Ministry of Health still considered the 43 abortions per 100 live births to be too low a number.[239] It is furthermore estimated that about 30 per cent of all abortions are carried out on adolescents.[240]

A frequently presented view is that the prohibition of abortion is merely forcing women to resort to unsafe alternatives with traditional healers and non-professional health practitioners when wanting to end an unwanted pregnancy.[241] Many women try a herbal solution (*jamu*) which can be bought from street vendors, or traditional massage.[242] It is estimated that 70 per cent of all women seeking abortion service at IPPA Jakarta Clinic has first tried to abort on their own or with the help of a traditional healer (*dukun*).[243]

5.7 Conclusions

It is clear that the national family planning program and the efforts of BKKBN to promote the ideal of a prosperous family of four, has had a positive effect on slowing the population growth. Moreover, most married women today have access to modern forms of contraception through the state sponsored programs, which is a major improvement compared to the situation two decades ago. Although coercion in the implementation of the programs is now in the past, the lack of informed choices and access to educational information still seems to be present threats to the right to reproductive choice.

The situation for adolescent girls and unmarried women are not as encouraging, as these groups by law are excluded from access to reproductive health services and information.

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[238] *Ibid.* As a comparison, in Sweden there are approximately 17.2 induced abortions per 1000 women age 15 to 49 years, which is the highest number in the Nordic countries. Finland has the lowest number with 9 per 1000 women. *See* 'Statistics Health and Diseases – Aborter 2004', 2005:3, The National Board of Health and Welfare (Socialstyrelsen), p. 12. Available via <www.socialstyrelsen.se/Publicerat/2005/8766/2005-42-3.htm>, last visited 1 December 2005. It should be noted that the Swedish statistics do not include spontaneous abortions.

[239] *Ibid.*

[240] *See* Annual Report 2001, 'Young People Speak About Reproductive Health', Indonesian Planned Parenthood Association, p. 6.

[241] Interview with Ms. Mira Diarsi, Komnas Perempuan, 7 July 2005. *See also* Iwu Dwisetyani , *Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Program,* pp. 15-16. *See also* Annual Report 2001, 'Young People Speak About Reproductive Health', Indonesian Planned Parenthood Association, p. 6.

[242] Interview with Dr. Soewarta Kosen, Ministry of Health, National Institute of Health Research and Development, Center for Health Services and Technological Research and Development, 8 July 2005. *See also* 'Indonesia Reproductive Health Profile 2003', Ministry of Health Republic of Indonesia and the World Health Organization, p. 56.

[243] *See* Iwu Dwisetyani , *Adolescent and Youth Reproductive Health in Indonesia – Status, Issues, Policies and Program*, p. 12.

6 Women's Right to Reproductive Choice in Lombok

6.1 Introduction

Lombok is the main island in the eastern province of West Nusa Tenggara. Lombok is divided into four districts consisting of Mataram City, West Lombok, Cental Lombok and East Lombok.[244] The province capital is Mataram, with a population of 300 000. Lombok is a predominantly rural island and is considered to be one of the least developed in Indonesia.

West Nusa Tenggara has a high maternal and infant mortality rate compared to the country in average.[245] The estimated maternal mortality ratio of 750 deaths per 100 000 live births is more than twice as high as the country in general.[246] West Nusa Tenggara has a fertility rate of 3.05 and an infant mortality rate of 74 per 1000, which is the second highest rate in Indonesia.[247] The country average rate is 35 per 1000.[248] The difference in under-five mortality rate is even more significant. West Nusa Tenggara has the highest rate in Indonesia with 103 per 1000.[249] The rate for Indonesia in general is 46 per 1000, less than half compared to West Nusa Tenggara.[250]

During the summer of 2005, national media reported on the relatively high number of child mal-nutrition cases in Lombok. According to estimations made by the *Dharma Wanita*,[251] more than 2000 children in Lombok suffered from mal-nutrition in July 2005.[252] The media attention has led to

[244] The Mataram district is categorized as *Kota, i.e.* city district and the other three as *Kabupatem, i.e.* rural districts.
[245] There are no official statistics on the maternal mortality rate per province. According to officials at the Ministy of Health on the central and provincial level however, NTB has a higher maternal mortality rate than most other provinces.
[246] *See* Linda Rae Bennett, *Women, Islam and Modernity – Single Women, Sexuality and Reproductive Health in Contemporary Indonesia*, 2005, RoutledgeCurzon, London/New York, p. 15.
[247] The highest infant mortality rate of 77 per 1000 is found in Gorontalo in Sulawesi. *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 233
[248] *Ibid.* p. 112.
[249] *Ibid* p. 233.
[250] *Ibid.* p. 109
[251] The national organization for wives of civil servants.
[252] Interview with Ms. Sri Sustini, Head of *Dharma Wanita* in NTB, Mataram, 29 July 2005.

various initiatives on the national and local levels, mainly in the format of charity donations of milk formula to poor families.[253]

The population of Lombok is thus widely recognized to be struggling with health-related problems, which has led to the establishment of various NGOs working to improve public health.[254] The high maternal mortality rate and other related issues were recently discussed at a seminar on gender and health, involving representatives from local governments, the health sector, *Dharma Wanita*, *Agama* (religious council), NGOs and the Provincial Office for Law and Human Rights.[255] The common opinion was that Act 23/1992 on Health should be amended to include a section on the right to reproductive health, as many women in the province die after resorting to unsafe abortions. The local health authorities estimate that 30-50 per cent of the maternal deaths are related to unsafe abortions, and that 80 per cent of women seeking abortion are 'ordinary women'.[256] There was however no discussion on amending the law to additionally include the reproductive rights of unmarried women.[257]

6.2 The Status of Women in Lombok

As this issue could be the subject of a dissertation, this sub-chapter provides only a brief overview of some of the characteristics particular for the Lombok society.

As concluded above, the majority of people in Lombok live in the rural areas. Kota Mataram only has about 300 000 inhabitants.[258] Lombok is widely recognized in Indonesia as one of the most conservative provinces, where the ruling is influenced by traditional and paternalistic values.[259] Traditional gender roles are thus deeply rooted in the communities.

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[253] *Ibid.* In late July, representatives from *Dharma Wanita* in Jakarta visited Mataram to donated milk formula. Earlier the same month a locally based Chinese charity organization distributed milk formula under ceremonial forms in a Mataram *Puskesmas* that I visited.
[254] Interview with Dr. Soewarta Kosen, Ministry of Health, National Institute of Health Research and Development, Center for Health Services and Technological Research and Development, Jakarta, 8 July 2005.
[255] *See* '80 Persen Pelaku Aborsi IRT', (80 per cent of Abortion Cases are Housewives), *Lombok Post*, 4 August 2005. The seminar was held in Mataram on 3 August 2005.
[256] *Ibid.* The term used is *Ibu rumah tangga*, meaning housewife.
[257] Interview with Mr. Slamet Martawardaya, Head of Provincial Office for Law and Human Rights, (*KAKANWIL*), Provincial Department for Law and Human Rights, NTB, 4 August 2005. *Ibid.* The article highlights the fact that most women seeking abortion are married. The point made is that the current legislation fails to recognize reasons other than life-threatening health conditions to allow abortion. Arguably, the law should be amended to include reasons such as family economy and contraception failure.
[258] Interview with Ms. Sri Hidayati, Head of Development of Potential and Social Organization, Social Bureau of Kota Mataram, 25 July 2005.
[259] Interviews with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005 and Ms. Ida Aziz, Director for Women's Empowerment, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, Mataram, 23 July 2005.

School fees are often burdening the family economy,[260] and education of girls tends to be less prioritized than education of boys.[261] The median years of schooling for ever-married women in West Nusa Tenggara are 4.6 years, the lowest in Indonesia.[262] 26.6 per cent of ever-married women in the province have no education at all.[263] Additionally, West Nusa Tenggara has the lowest female literacy rate with merely 66.7 per cent of the ever-married women being literate.[264]

Traditionally, women are the last ones to eat when the family faces a shortage of food.[265] Women marry at an earlier age than in most other provinces and polygamy is socially accepted and widely practiced.[266] The maximum of four wives in polygamous marriages is commonly not recognized in the local religious interpretations.[267] Recently there have been reports in the Indonesian media on the prevalence of particularly young mothers in West Nusa Tenggara. According to Media Indonesia Online, 60 per cent of the first-time mothers in Lombok are between 14 and 19 years old.[268]

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[260] According to a school teacher in Mataram, the fee for primary education in public schools is around 300 000 rupiah (30 USD) per month.
[261] Interview with Ms. Ida Aziz, Director for Women's Empowerment, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, Mataram, 23 July 2005.
[262] The median years of schooling for ever-married women in Indonesia are 5.6. The median years of schooling for men in NTB are also low at 5.4. *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 200.
[263] This is the highest percentage in Indonesia. The percentage for women in the country in general is 7.9 per cent. 12.4 per cent of currently married men in NTB have no education. *Ibid.* pp. 200-201.
[264] This is the lowest percentage of literacy in Indonesia. The percentage for women in the country in general is 86.4 per cent. 82.3 per cent of the currently married men in NTB are literate. *Ibid.* pp. 202-203.
[265] Interview with Ms. Ida Aziz, Director for Women's Empowerment, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, Mataram, 23 July 2005. This traditional practice is however not unique for Lombok but exists in many societies around the world. *See* Fran P. Hosken, 'Towards a Definition of Women's Human Rights', 3 *Human Rights Quarterly* (1981), p. 2.
[266] Interview with Ms. Beauty Erawati, Executive Director, Legal Aid Office of the Indonesian Women Association for Justice of West Nusa Tenggara, (LBH-APIK) Mataram, 21 July 2005. The median age of marriage for women currently 25-49 years old was 18.7 years old. *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 230.
[267] Interview with Mr. Sahan, Staff working with violence against women, Division for Women's Empowerment, Provincial Department for Social, Welfare and Women's Empowerment, Mataram, 23 July 2005. For further elaboration on polygamy under regulations in Indonesian Sharia Law *see* Simon Butt, 'Polygamy and Mixed Marriages in Indonesia: The Application of the Marriage Law in the Courts' in Timothy Lindsey (ed.), *Indonesia Law and Society*, pp. 122-144. *See also* Abdullahi An-Na'im, 'The Rights of Women and International Law in the Muslim Context' 9 *Whittier Law Review* (1987) p. 491.
[268] *See* 'Banyak ibu di Lombok melahirkan pada usian 14 tahun', *Media Indonesia Online*, 10 June 2004, now available on <www.mediaindo.co.id/berita.asp?Id=42767>, last visited 7 February 2005.

There are various projects on the provincial and district level to ameliorate the status of women and to improve gender equality. The main focus is on eliminating domestic violence. The projects are primarily based on *sosialisasi* ('socialization') of new values into the community through targeting the local and religious leaders.[269] The challenges faced by the project coordinators are both structural and financial, as the projects are often subject to organizational changes and lack of funding.[270] In addition, there is the challenge of gaining acceptance from the local and religious leadership and from the community. The perception of success in this matter varies between the providers.[271] There is no policy in Lombok on reducing the practice of *kawin* marriages, as it is associated with polygamy and viewed as part of local practice sanctioned in religious interpretations.[272]

Religion plays an important role in the everyday life on Lombok. The district of Mataram has been declared a religious city (*Kota Ibadah*) and local religious leaders have a significant influence over decisions made on the provincial, district and village level.[273] Whereas every village has a local leader,[274] there are often at least four or five religious leaders per village.[275] Every village has at least one mosque and all men are expected to attend Friday prayers. The same does not apply to women, as not all mosques provide prayer facility to accommodate female visitors.

6.3 Reproductive Rights in the Human Rights Framework

There are two different official bodies responsible for the protection and promotion of human rights in West Nusa Tenggara: the Provincial Department for Law and Human Rights and the Provincial Law Bureau (*Biro Hukum NTB*).

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[269] Interview with Ms. Ida Aziz, Director for Women's Empowerment, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, Mataram, 23 July 2005.

[270] *Ibid.* As an example, the Provincial Social Department only has the budget to sponsor projects on aid to victims of domestic violence in 2-3 districts per year. Interview with Ms. Sri Hidayati, Head of Development of Potential and Social Organization, Social Bureau of Kota Mataram, 25 July 2005.

[271] *Ibid.* Some of the interviewed respondents involved in programs on women's empowerment consider the response as predominantly positive, whereas others mostly experienced skepticism from the male part of the community.

[272] The practice is sometimes referred to as *kawin sirih*. Interview with Mr. Sahan, Staff working with violence against women, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, 23 July 2005.

[273] The crucial role of religious leaders in decision-making is viewed by various government officials as an important asset in the socialization process of 'new values', such as anti-violence against women.

[274] In Mataram and other city districts (*kota*), the village leaders are called *Pak lurah*, whereas the village leaders in rural districts (*kabupaten*) are called *Kepala desa*.

[275] Interview with Ms. Sri Hidayati, Head of Development of Potential and Social Organization, Social Bureau of Kota Mataram, 25 July 2005.

The two bodies have overlapping mandates in promoting and protecting human rights. The main difference is that the Provincial Department for Law and Human Rights has a vertical structure, subordinated to the central Ministry of Law and Human Rights, whereas the Provincial Law Bureau has a horizontal structure working on the provincial level.[276]

The Provincial Department of Law and Human Rights has, despite its name, not had any division on human rights until August 2005. After enactment of necessary regulations and the formation of the responsible teams, the human rights division will be divided into two subsections, one working with dissemination of human rights and one working with protection and realization of human rights.[277] Once the structure is in place, the division will commence drafting the provincial *RAN-HAM*, provided that funding is granted from the local government. As of August 2005, there was no decision made on funding, but the Head of the Provincial Office of Law and Human Rights, (*KAKANWIL*) estimated that they would receive the funding during 2006.[278]

Until now, the human rights activities at the Provincial Department of Law and Human Rights have been restricted to socialization of human rights to a number of villages. The socialization has been carried out together with the Human Rights Center (*PUSHAM*) at Mataram University, involving 20 villages during 2004 and 16 villages during 2005.[279] Before a village was approach for socialization, the village head received a letter asking him which area of human rights the village wanted to be socialized on. The socialization has thus been on different topics, *e.g.* basic human rights introduction, violence against women and children and reproductive health.[280] The definitions of human rights used in the socialization have been based on international instruments and national law, provided the definitions of human rights have not been contrary to the local understanding of moral.[281] The Provincial Department of Law and Human Rights additionally had the mandate to process complaints of human rights violations, but as victims arguably prefer to report to the NGOs, the Department has not received many cases.[282]

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[276] Interview with Mary, Head of Human Rights Division, Provincial Department for Law and Human Rights, 4 August 2005.
[277] *Ibid.* At the time of the interview, the enactment of regulation was scheduled to 6 August 2005, but the formation of the working teams was not completed on the district level.
[278] The Department has submitted a request to the provincial government to be granted 500 million rupiah (50 000 USD) per year to implement all activities in the future provincial RAN-HAM. Interview with Mr. Slamet Martawardaya, Head of Provincial Office for Law and Human Rights, Provincial Department for Law and Human Rights, NTB, 4 August 2005.
[279] Interview with Mary, Head of Human Rights Division, Provincial Department for Law and Human Rights, 4 August 2005 and Ms. Ani Suryani, Lecturer, Mataram University Human Rights Center, Mataram, 21 July 2005.
[280] *Ibid.* The fact that the village heads get to choose which area of human rights the village should be socialized on has according to Ms. Mary not been problematic, as they have always been well received.
[281] *Ibid.*
[282] *Ibid.*

The Provincial Law Bureau also has a mandate to collect data on reported cases of human rights violation and to socialize and suggest human rights policies to the district governments.[283] Many reported cases regard domestic violence and denial of alimony to women after a divorce, which are defined as human rights violations by the Provincial Law Bureau.[284] So far, there have been no reported complaints involving violations of reproductive rights.[285] The cases are not solved in court but through negations between the stakeholders in the community. Found violations are not subject to legal sanction, but to social sanction within the community.[286] The definition of human rights violations used by Provincial Law Bureau is determined by definitions in the Human Rights Act and various international conventions, with adjustments to local religious conceptions of human rights.[287] When there is a conflict between the definition of a right in the international or national instrument and the local interpretation of that right, the local interpretation prevails.[288]

6.4 Access to Educational Information on Sexual and Reproductive Health

The level of knowledge about reproductive and sexual health issues is generally low among women in Lombok. Married women who supposedly have access to information on reproductive and sexual health through the national family planning program, still have little knowledge of *e.g.* STIs. Only 34.8 per cent of ever-married women in West Nusa Tenggara have ever heard about HIV/AIDS and only 18.9 per cent believes that there is a way to avoid contracting HIV/AIDS.[289] 87 per cent of the ever-married women in West Nusa Tenggara have never heard about STIs.[290]

As unmarried women are excluded from the government-sanctioned family planning services, there are no statistics available on the level of knowledge on reproductive and sexual health among unmarried women. It is however

[283] Interview with Mr. Agus Patria, Head of Law Bureau (*Biro Hukum*), Nusa Tenggara Barat, 25 July 2005.
[284] *Ibid.* These cases are commonly submitted through the Legal Aid Office of the Indonesian Women Association for Justice of West Nusa Tenggara, (LBH-APIK).
[285] *Ibid.*
[286] According to Mr. Agus Patria, social sanctions can involve temporary social isolation of the family or payment of a fee to the community. Social sanctions involving punishment through violence are not accepted.
[287] There is no regulation for determining the adjustments human rights as it is said to be common knowledge which type of rights are acceptable and which are not. *Ibid.*
[288] Mr. Agus Patria gave the example of a woman who wants to go on *Haji*, the Muslim pilgrimage to Mecca and Medina. Under the local interpretation of human rights, she is not allowed to travel on her own and must therefore go with her family.
[289] *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 255.
[290] *Ibid.* p. 260.

probable that the level of knowledge is low, as there are few adequate sources of information available.[291]

There is no local regulation providing for sex education in public schools in Lombok. Educational information on reproductive and sexual health is considered as already covered in the biology course. The subject is however commonly limited to merely one lesson taught during the second year of high school.[292]

In the year of 2000 there was an NGO initiative sponsored by University of Amsterdam to raise awareness of the specific reproductive health needs of adolescents.[293] The one-year program involving 80 high schools and Muslim boarding schools in Lombok ended with a presentation where parents, teachers and pupils demanded for sex education to be included in the high school curriculum. The response from local government was positive at first, but was later altered by the Provincial Department of Education, with the explanation that the subject would not fit into the curriculum.[294]

According to the Head of Family Planning and Reproductive Health at BKKBN West Nusa Tenggara, BKKBN has also requested that education on adolescent reproductive health should be included in school curriculum.[295] However, BKKBN is still waiting for a response from the Department of Education and the Department for Religious Affairs (*Agama*).[296] BKKBN is currently co-sponsoring three information posts on reproductive health for adolescents in three high schools in Lombok: one in Central Lombok and two in East Lombok.[297] Arguably, there is no need for one in Mataram, since young people there can seek information from IPPA.

IPPA is currently lobbying for permission to provide educational information on adolescent reproductive health as an extra-curriculum subject, but has so far not succeeded. The reason is arguably the difficulties to get the local BKKBN to be involved and to get permission from the Provincial Department of Education.[298] IPPA additionally offers educational

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[291] According to the conclusions of Linda Rae Bennett's extensive fieldwork in Mataram, unmarried women are unlikely to discuss reproductive and sexual health with their family members. Government censorship additionally limits images of sexual character in the media. The main source of information is likely the peer-group and in some cases pornographic films, which commonly lead to misconceptions about sex and reproduction. *See* Linda Rae Bennett, *Women, Islam and Modernity – Single Women, Sexuality and Reproductive Health in Contemporary Indonesia,* pp 132-134.

[292] *Ibid.* p. 134.

[293] Interview with Ms. Zubaeda, Head of Mataram Clinic, Indonesian Planned Parenthood Association, 21 July 2005.

[294] *Ibid.* The explaination given was that so many new subjects had already been included and that the curriculum was now full.

[295] Interview with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005.

[296] *Ibid.*

[297] BKKBN is cooperating with midwives, student organizations, NGOs and the district health authorities to provide these information posts. *Ibid.*

[298] Interview with Ms. Zubaeda, Head of Mataram Clinic, Indonesian Planned Parenthood Association, 21 July 2005.

information on reproductive rights in their facilities in Mataram. The consulting facilities are open to married as well as unmarried persons. Most consultations concern unwanted pregnancies, but also issues like STIs and homosexuality. There are plans to extend the services to adolescents by making the facilities look less like a clinic and more of a 'youth friendly environment', with a garden and a café.[299]

6.5 Access to Contraception

Since the transfer of the decision power over public services to the district level, three districts in West Nusa Tenggara have adopted regulations on family planning.[300] However, there is not yet any such regulation enacted in Lombok.[301] The reason is arguably that reproductive health is not an issue of high priority for the district governments.[302]

The official unmet need for contraceptives is high in West Nusa Tenggara compared to other Indonesian provinces. In the province, 16 per cent of the married women say that they would like to limit the number of children and/or space their pregnancies, but are currently not using contraceptives, while the percentage is 8.6 per cent in the rest of Indonesia.[303]

The explanations why there is a significant unmet need for contraceptives in West Nusa Tenggara vary. At the provincial branch of BKKBN, the answer is that cultural believes make people reluctant to use contraceptives and that a lack of knowledge on where to turn additionally adds on to the high unmet need.[304] Others argue that the local religious leadership disapproves with certain contraceptive methods, *e.g.* the IUD, which influences the choices made by individuals.[305] Another reason is arguably that the providers are badly organized and that there is a shortage of supply.[306]

Midwives providing contraceptives in Lombok face problems because of the generally low level of education. Lack of understanding of how a method works may lead to failure or discontinuation of contraceptive use.[307] One midwife in Mataram gave the following illustrative example:

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[299] *Ibid.*
[300] Interview with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005
[301] The three districts are all situated on the neighboring island of Sumbawa. Signed mandate for creating and adopting the regulations are already in place. *Ibid.*
[302] *Ibid.*
[303] NTB has the second highest unmet need after Nusa Tenggara Timor (NTT), with an unmet need of 16.8 per cent. *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 226.
[304] Interview with Ms. Aladhiana Nurhayati, Staff working with contraceptive distribution in the Family Planning and Reproductive Health Section, BKKBN in NTB, 25 July 2005.
[305] Interview with midwives in Mataram.
[306] *Ibid.*
[307] *Ibid.*

> "Many men don't understand how to use the condom. We can't show them exactly how to do it, but we show them by putting it on our thumbs. But the men don't always understand and they also put the condom on their thumbs…. And that won't work!"

As in the rest of Indonesia, the government-sanctioned family planning program and services in Lombok are only available to married couples. As stated above, the social acceptance for *kawin* marriages is high in Lombok due to its association with the practice of polygamy.[308] It is disputed to what degree the high prevalence of *kawin* marriages has affected the statistics on unmet need. According to some stakeholders, women married *kawin* can have difficulties accessing contraceptives, as they are officially unmarried.[309] According to government officials and midwives at the *Puskesmas* in Lombok, there is no difference made between officially and unofficially married women in terms of access to contraceptives.[310] When in doubt, a midwife will interview the woman seeking service at a *Puskesmas,* in order to determine her marital status.

> "There is no need to provide any documentation to prove that she is married. We can often tell from the body language if she is faking it, but that doesn't happen very often. Sometimes these women are prostitutes and need condoms, but we will not help them with that here."[311]

Women have the responsibility for family planning in Lombok in terms of being the party using the contraceptive method.[312] Only 0.49 per cent of married contraceptive users are men.[313] Married women in Lombok can access contraceptives via *Puskesmas* and *Posyandu* and through the village midwives (*bidan di desa*). BKKBN is supplying contraceptives for free for the poorest people provided they have a card from the Social Insurance Bureau.[314] The deliveries of contraceptives from BKKBN to the *Puskesmas* are however not entirely reliable in terms of timing and quantity.[315]

The majority of women in West Nusa Tenggara do not get their contraceptives from the government-supported clinics, but from private

[308] Interview with Mr. Sahan, Staff working with violence against women, Division for Women's Empowerment, Provincial Department for Social Welfare and Women's Empowerment, 23 July 2005.
[309] Interviews with Dr. Ramona Sari, Head of Family Planning and Reproductive Health, IPPA, Jakarta, 27 June 2005 and Ms. Raldiastuti Koestoer, Deputy Assistant of Private and Professional Organization, Ministry for Women's Empowerment, Jakarta, 18 July 2005.
[310] Interviews with Mr. Ida Bagus Permana, Director of Program Policy Integration, National Family Planning Coordination Board, BKKBN Jakarta, 13 July 2005 and Ms. Aladhiana Nurhayati, Staff working with contraceptive distribution in the Family Planning and Reproductive Health Section, BKKBN in NTB, 25 July 2005.
[311] Interview with a midwife in a *Puskesmas* in Lombok.
[312] The man still has an influence of the choice of method and is sometimes the one making the decision on which method to use.
[313] Interview with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005.
[314] Interview with midwives.
[315] Interview with midwives.

entities.[316] The majority of women pay for their contraceptives, but there are special programs that provide the poorest people with free contraceptives.[317] In an effort to increase the male participation in family planning, condoms are distributed for free by BKKBN. There is however no formal regulation or policy on male participation from the provincial government.[318]

Condoms can be bought in pharmacies and since 12 July 2005 in the *Kondom ATM*, a condom vending machine.[319] The machine was installed by BKKBN after consultation with local and religious leaders who were concerned that the *Kondom ATM* might be taken as a sign of acceptance of free sex and illegitimate sex (*zinah*).[320] The Teachers' Association in West Nusa Tenggara (PGRI) has demanded for the machine to be removed. According to the head of PGRI, installing the machine is sending the message to young people that they that can have pre-marital sex without the consequence of unwanted pregnancy.[321] The compromise reached was to place the machine within the premises of the West Nusa Tenggara provincial police headquarters in Mataram. The opening hours are limited to 8-12 a.m. in order to prevent that unmarried persons buy condoms for 'immoral purposes'.[322]

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[316] *See* 'Indonesia Demographic and Health Survey 2002-2003', Badan Pusat Statistik, 2003, Jakarta, p. 224.

[317] Midwives explained in interviews that the *Puskesmas* sometimes have to cover the shortage of stock with additional purchases of contraceptives. The shortage limits the options for women seeking contraceptives and the midwives have to provide them with what is available at the moment. One midwife I interviewed estimated that BKKBN supplied them with approximately 50 per cent of what they should.

[318] BKKBN has made efforts to encourage the provinces to adopt regulations on male participation in family planning. The rationale is that a couple consists of two parties with equal responsibilities. Furthermore, the male methods (condoms and vasectomy) are basically without side effects. In April 2005, twelve provinces have adopted programs on male participation. Interview with Dr. M. Tri Tjahjadi, Director for Male Participation, National Family Planning Coordination Board, BKKBN, Jakarta, 13 July.

[319] The *Kondom ATM* is part of a project to increase male participation and is carried out through the installation of eight condom vending machines in different cities in Indonesia. Interview with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005. After the request of a mining company in Batu Hijau, there are plans to install a second condom vending machine in the neighboring island of Sumbawa. *See* 'Wary Villagers in NTB to Get Condom ATMs', *The Jakarta Post*, 22 November 2005.

[320] *Ibid.* The *Kondom ATM* has been the subject of controversies and protests in Mataram during the summer of 2005. Interview with Ms. Zubaeda, Head of Mataram Clinic, Indonesian Planned Parenthood Association, 21 July 2005. *See also.* 'Kondom Bebas di Kota Ibadah' (Free Condoms in a Religious City), *Lombok Post*, 26 July 2005. According to *The Jakarta Post*, protests were silenced after a massive information campaign undertaken during the fall of 2005 on how condoms prevent unwanted pregnancies. *See* 'Wary Villagers in NTB to Get Condom ATMs', *The Jakarta Post*, 22 November 2005.

[321] *See* 'PGRI Tuntut ATM Kondom Ditutup' (PGRI demands closing down of the Kondom ATM), *Lombok Post*, 29 July 2005.

[322] *I.e.* pre-marital sex or sex with commercial sex workers. Interview with Mr. Soeharmanto, Head of Family Planning and Reproductive Health, BKKBN in NTB, 25 July 2005.

Pre-marital sex is not socially accepted in Lombok and unmarried persons have limited access to contraceptives.[323] As unmarried persons cannot access the government-sponsored services, the options are to buy condoms in the pharmacies or to visit an NGO clinic. The IPPA clinic is quite well-known and provides condoms to those seeking their consultation, regardless of marital status.[324] IPPA can also provide the clients with other forms of contraceptives, but it is less common.[325] Additionally, the clinic run by the Midwives' Association provides contraceptives to women without asking about their marital status, as one midwife explained:

> "These are issues of women's rights. We won't ask if the women are married, we are not here to judge. A person is only responsible to God."[326]

The fees for the private services are 30-50 per cent higher than the prices in the *Puskesmas*, and the clinic only serves 10 clients per month compared to about 140 per week in a *Puskesmas*.[327]

The Midwives' Association Clinic receives limited financial support from the local governments. The Midwives' Association Clinic used to receive one million rupiah (100 USD) per year before decentralization, but has not received any money since 2003, when the association was granted one million rupiah from the provincial government.[328]

6.6 Unmarried Women and Unmet Need

Officially, there is no need for contraception services for unmarried women in Lombok as they are not sexually active. Arguments presented in the recently fierce debate over the *Kondom ATM* even suggest that access to contraceptives for unmarried persons will in itself create immoral behaviour and should therefore be banned.[329]

However, recent studies on adolescent sexual behaviour suggest that unmarried persons are sexually active to a larger extent than is officially

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[323] Extra-marital sex has been called "the most evil act and greatest taboo". *See* 'Wary Villagers in NTB to Get Condom ATMs', *The Jakarta Post*, 22 November 2005.
[324] The reason the clinic is well-known is that the former doctor in charge provided abortion services to unmarried women. Interview with Ms. Zubaeda, Head of Mataram Clinic, Indonesian Planned Parenthood Association, 21 July 2005.
[325] *Ibid.*
[326] Interview with midwives at the Midwives' Association Clinic in Mataram, 29 July 2005.
[327] Interviews with midwives at the Midwives' Association Clinic and in a *Puskesmas.* The number includes all clients seeking reproductive health services, from purchase of contraceptives to deliveries and post-natal care. *Ibid.*
[328] The Midwives' Association is financied by monthly membership fees of 3000 rupiah (30 US cent) and private sponsores such as Nestlé. *Ibid*.
[329] *See e.g.* 'Kondom Bebas di Kota Ibadah' (Free Condoms in a Religious City), *Lombok Post*, 26 July 2005 and 'PGRI Tuntut ATM Kondom Ditutup', (PGRI demands closing down of the Kondom ATM), *Lombok Post*, 29 July 2005.

recognized.[330] As stated above, virginity until marriage is still highly valued in the Indonesian society, particularly for girls. However, in contrary to public perception it is not the category of well-educated, urban women who are the most positive to premarital sex – it is the category of women with less than completed primary education.[331]

The prevalence of pre-marital sex among unmarried women in Lombok cannot be easily measured. An interesting fact is that Lombok stands out in the results of an IPPA study comparing client profiles of women seeking 'menstrual regulation'[332] in clinics in nine different cities during the years 2000-2003.[333] Although relatively few women per year sough menstrual regulation service in Mataram (less than 500), compared to Denpasar, Bali (around 4000 women), the number is still in level with the number of women seeking this service in Jakarta.[334] The vast majority of women (77 per cent) seeking menstrual regulation in Mataram were unmarried, which was not the case in any other city in the survey.[335] No other clinic reported more than 47 per cent (Denpasar) of the patients as unmarried and several reported the percentage of unmarried to be less than 10 per cent (Medan, Bandung, Surabaya, Semarang).[336] In the study it is concluded that:

> "This could be one of factors that make maternal mortality rate in Mataram is very high. If safe abortion could be provided maternal mortality rate could be decreased."[337]

It should be added that the IPPA clinic in Mataram does no longer provide menstrual regulation services.[338] There are thus limited options for unmarried women to have a safe abortion in a clinic in Lombok.[339] In an interview, one health worker described this frustrating dilemma:

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[330] *See e.g.* 'The Indonesian Population, Reproductive Health, and Family Planning Programmes: Confronting Challenges', National Family Planning Coordination Board, Center for International Training and Collaboration, 2003, p. 24.

[331] The difference is quite small, but not un-significant: 99 per cent of the girls and women between age 15-24 with completed secondary education believes that a woman should stay a virgin until she is married, compared to 93.8 per cent of the girls and women without completed primary education. The percentage is 98.1 per cent and 96.7 per cent for urban and rural areas respectively, calculated on all levels of education. *See* 'Indonesia Young Adult Reproductive Health Survey 2002-2003', Badan Pusat Statistik, 2004, Jakarta, pp. 79-80.

[332] 'Menstrual regulation' is the less stigmatizing term commonly used for abortion.

[333] *See* 'Client Profile, Menstrual Regulation', Retrospective Study Result on Menstrual Regulation in 9 Cities year 2000-2003, published by IPPA.

[334] *Ibid.* p. 1.

[335] *Ibid.* p. 2.

[336] *Ibid.* p. 2. Information given in interviews suggest that women from Lombok wanting an abortion often travel to Bali to seek the service there.

[337] *Ibid.* p. 2.

[338] The policies were changed when Ms. Zubaeda recently took over as Head of Clinic. Interview with Ms. Zubaeda, Head of Mataram Clinic, Indonesian Planned Parenthood Association, Mataram, 23 July 2005.

[339] The Midwives' Association Clinic does not provide abortion service to unmarried women. Interview with midwives at the Midwives' Association Clinic.

> "The sad thing is that I see that some of the girls we deny an abortion become sex workers. I have a very hard time dealing with the fact that my decision creates this situation for many of the girls. This is really a non-win situation."

Unmarried women seeking abortion services at one of the public hospitals in Lombok are often advised to go to Bali and have the abortion at the IPPA clinic in Denpasar, as safe options in Lombok are basically non-existent.[340] The procedure cost 750 000 rupiah (75 USD), which makes this option a theoretical one for most unmarried women who cannot afford a safe abortion.[341]

The facts and figures on abortion services in Mataram and Denpasar are evidently not sufficient background material to draw conclusions on the prevalence of pre-marital sex in Lombok. However, the fact that on average three unmarried women per week during 2000-2003 sought abortion service in a small clinic in a town of 300 000 inhabitants, is an indicator of an unmet need for contraception services and educational information on reproductive and sexual health among unmarried women.

6.7 Conclusions

After decentralization of the decision power over public services, the districts are responsible for enacting regulations and provide services such as education and healthcare. As concluded, there are not yet any local regulations enacted on family planning in Lombok.

Educational information on family planning and sexual and reproductive health is available for married women through the projects of BKKBN and the Department of Health. Access to the same information is more restricted for unmarried women and adolescent girls as sex education is not part of intra- or extra-curriculum in schools.

Married women have access to contraceptives as provided by BKKBN or available through private clinics. Although the *de facto* access and opportunity to make informed choices might be limited due to societal subordination of women, there are no legal constraints. As for unmarried women and adolescent girls, the situation is difficult as they are by law excluded from the government-sponsored services. These categories of women have to rely on services provided by NGOs such as IPPA or the Midwives' Association.

[340] Interview with an obstetric and gynecology specialist at a public hospital in Lombok, 2 August 2005.
[341] *Ibid.* As a comparison, a young women working as a housekeeper or maid earns about 150 000 rupiah per month. According to various interview respondents, the price for an illegal abortion in Lombok varies between 200 000 - 300 000 up to a few million rupiah, depending on who is providing the service. A midwife is generally less expensive than a doctor.

7 Concluding Remarks

7.1 Introduction

The right to reproductive choice represents a difficult area of international human rights law. The content and scope of this right remain ambiguous and there seems to be as many definitions as there are scholars. What can be concluded with certainty is that some rights sometimes presented under the banner of reproductive rights are not (yet) recognized as rights under international human rights law, based on the sources of international law. The most significant example is the right to abortion. Another conclusion to be drawn is that the right to reproductive choice closely linked to the most sensitive and personal elements of being human: sexuality, bodily functions, procreation, love relations etc. Thus, the stakes are high, which is reflected in the passionate manner in which the issue is addressed from various viewpoints in the debate.

7.2 The Right to Reproductive Choice in International Human Rights Law

In this thesis, the ambition was to stay as true to the provisions in positive international law as possible. This has not been an easy task. There are different interpretations of the treaty articles I presented, and there are additional articles that could have been used and elaborated on, an effort that has been undertaken by various scholars. However, in such attempts, the line is often fine between *de lege lata* and *de lege ferenda*, especially considering how strongly most authors in this field feel about gender equality and human rights of women.

What can be concluded is that CEDAW provide a protection for the right to reproductive choice, *i.e.* the right to decide freely and responsibly on the number and spacing of children and to have access to the information, education and means to enable them to exercise these rights. CEDAW also provides for the rights to access family planning information and health services. Under CRC, parents are entitled to information on family planning and health services and all persons under the age of 18 years have the right to freedom to seek, receive and impart information and the right to the highest attainable standard of health.

7.3 The Right to Reproductive Choice in Lombok

Indonesia is a state party to CEDAW and CRC. The ratifications do not include any reservations to substantive articles of the treaties. Hence, the Indonesian government is obligated to implement the treaty provisions in

national legislation and to respect, protect and fulfil *e.g.* the right to reproductive choice.

From studies of the 1945 Constitution, one can deduct that discrimination on the basis of sex and marital status is prohibited, as discrimination "on any basis whatsoever" is illegal. Consequently, all legislation which discriminate against women on the basis of marital status is contrary to the wording of the Constitution. However, as have been exemplified with provisions from Act No. 10/1992 Concerning the Development of Population and Happy and Prosperous Families and Act No. 23/1992 on Health, laws related to the right to reproductive choice still discriminate unmarried women.

The Human Rights Act with its extensive and inclusive definition of human rights violations provides a broad basis for human rights protection. The right to reproductive choice is however not explicitly protected. Although there are rights to marry, found a family and bear children, other related rights as the right to obtain medical care or to adequate health services are not protected. As the life of a foetus is protected under the right to life, except in abortion cases where the woman's life is in danger, it is obvious that the right to reproductive choice in Indonesia does generally not include a right to abortion. Furthermore, considering that *Komnas HAM* has not dealt with any case on violations of the right to reproductive choice, it is fair to conclude that the right to reproductive choice is not currently an issue on the Indonesian human rights agenda.

Moving over to the situation in Lombok, it is apparent that the local regulations are not more progressive than the national legislation. Despite the decentralization of health care to the provincial and district level, there is not yet any regulation on family planning in Lombok. Following from the official national census and reports from *e.g.* IPPA, it is clear that the need for improved reproductive and sexual health information and services is urgent among Indonesian women. In equivalence to the rest of the country, information and services to unmarried women related to reproductive and sexual health are limited. Unmarried women have to rely on private providers, which are generally more expensive, and for the most part run by NGOs. Initiatives such as the *Kondom ATM* and extra-curriculum sex education even seems to be obstructed by local leadership, which complicates the situation for groups that fall outside of the state sanctioned family planning program.

7.4 Areas of Interest for Further Studies

The limited format of a master thesis prevents from in-depth studies of the root causes and deep structures of the law resulting in the current legislation and policies.

Some subjects of interest for future studies in this field are *e.g.* the relation and division of mandate between BKKBN and the Ministry of Health. The

decentralization process and governmental control over compliance with national guidelines in *e.g.* family planning is another topic that could be relevant for further understanding of the issues at stake. From a perspective of human rights law, it would furthermore be interesting to study how local human rights regulations, interpretations and institutions relate to the national system.

7.5 Some Final Considerations

Considering the Indonesian national legislation, the lack of local regulations, the policies of BKKBN and the public debate in Lombok, it is fair to conclude that the right to reproductive choice as provided in international law binding upon the Indonesian government is not considered as a human right in this context.

Evidently, in order for the Indonesian government to comply with its international obligations, laws like Act No. 10/1992 Concerning the Development of Population and Happy and Prosperous Families need to be amended to include services to unmarried women. Interestingly enough, the CEDAW Committee in the Concluding Observations did not address this issue in the 1997 Concluding Observations. To secure that women's right to reproductive choice is respected in the implementation of the national family planning program, the needs and views of the individual woman should be the center of attention and the prevailing interest.

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