

JOINT SUBMISSION

THE SITUATION OF THE ENJOYMENT OF THE RIGHT TO HEALTH IN INDONESIA

Submitted to:

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

(Mr. Dainius Pūras)

Submitted by:

Arus Pelangi
Franciscans International
Gugah Nurani Indonesia (GNI)
Himpunan Wanita Disabilitas Indonesia (Indonesian Association of Women with Disabilities)
Human Rights Working Group (HRWG) Indonesia
Ikatan Perempuan Positif Indonesia (Association of Positive Women Indonesia)
Indonesian Planned Parenthood Association (PKBI)
Institut Kapal Perempuan
Jaringan Buruh Migran (Migrant Workers Network)
Koalisi Perempuan Indonesia (Indonesian Women Coalition)
Lembaga Bantuan Hukum Jakarta (Jakarta Legal Aid Institute)
Lembaga Bantuan Hukum Masyarakat (Community Legal Aid Institute)
Migrant Care
Organisasi Harapan Nusantara (OHANA) Yogyakarta
Organisasi Perubahan Sosial Indonesia (Indonesia Social Change Organization)
Persaudaraan Korban Napza Indonesia (Indonesian Drug Users Network – PKNI)
Sekretariat Nasional Perhimpunan Bantuan Hukum dan Hak Asasi Manusia Indonesia
(National Secretariat of the Association of Legal Aid and Human Rights of Indonesia)
Solidaritas Perempuan (Women's Solidarity)
The Agency of Social Security (BPJS) Watch
The Institute of the Ecosoc Rights
Yayasan Lembaga Bantuan Hukum Indonesia (Indonesia Legal Aid Foundation)

Collected and Coordinated by

**HUMAN RIGHTS WORKING GROUP (HRWG): Indonesia's NGO Coalition for
International Human Rights Advocacy**

Yarnati Building, 2nd Floor (Room 207D), Jl. Proklamasi No. 44, Pegangsaan, Menteng,
Jakarta Pusat, Indonesia 10320, Phone: +62 21 390 2579/+62 21 299 22459, Fax: +62 21
390 2579, Website: www.hrwg.org, Twitter: @HRWG_Indonesia

I. GENERAL OVERVIEW

1. This report developed by several civil society organizations which focus on the health issues and civil society organizations that focus on the human rights in general in Indonesia.

2. In 2015, with total population 257,564,000, Indonesia have life expectancy at birth for female 71 and for male 67, which makes Indonesia is the fourth-most populated countries in the world.¹ The Government of Indonesia recognizes 1,128 ethnic groups. At the national level, there has been some challenges that face in Indonesia, in terms of provision of health care, lack of transportation, infrastructure, energy and isolation are the most common barriers to health sector development and services in villages. Most of the times, goods and services are not equally distributed between urban and rural areas due to poor transportation, insufficient infrastructure and information illiteracy.

II. LEGAL AND POLICY FRAMEWORK OF RIGHTS TO HEALTH

3. Indonesian law recognized the rights to health as a human rights. It mentioned in the Constitution (1945) of the Republic of Indonesia on Article 34 paragraph (2) and (3): “(2) *The state shall develop a system of social security for all of the people and shall empower the inadequate and underprivileged in society in accordance with human dignity;* (3) *The state shall have the obligation to provide sufficient medical and public service facilities*”.

4. The 1945 Constitution of Indonesia includes a special chapter on Human Rights, namely; Article 28A up to Article 28I and several articles also regulates Human Rights, such as: Article 27 concerning equal status before the law and in government and the right to live with dignity, Article 28 concerning freedom of association and freedom to express an opinion, Article 29 concerning freedom of worship, Article 31 concerning the Right to Education, Article 34 concerning the Right to live a Healthy Life, the obligation of the state to implement a universal Social Security System, and the responsibility of the state to provide health services and other public services. Through the Law Number 11/2005 Indonesian has ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) that recognized the rights to the health as basic human rights (Article 9 (3)).

5. **Article 62 Human Rights Law:** “*Every child has the right to access to adequate health services and social security as befits his physical, emotional and spiritual needs.*” **Article 64 Human Rights Law:** “*Every child has the right to protection from financial exploitation and from doing any work which is dangerous and/or which could interfere with his education or his physical, mental, or spiritual health*”. **Article 49 (2) Human Rights Law:** “*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.*”

6. Law No. 24 of 2011 also stipulated that The Implementing Agency of Social Security (BPJS), consisted of BPJS for Health and BPJS for Manpower, would implement National Social Security. Operationally, National Health Insurance (JKN) implementation is specified in Government Regulation and Presidential Decree, inter alia, Government Regulation No. 101 of 2012 concerning Recipient of Premium Aid for Healthcare Benefits Premium (PBI); Presidential Decree No. 12 of 2013 on Healthcare Benefits; and JKN Roadmap.

III. ISSUES IN FOCUS

A. Universal Health Care Coverage

7. Started with Law No. 40 of 2004 on National Social Security System, Indonesia now has social security policies as one form of social protection to ensure that everyone can fulfill their basic needs properly. Those who are unable or poor can freely access health services since their premium are paid by the state through State or Regional Budgets (APBN or

¹ World Health Organization (WHO), Country Profile: Indonesia, <http://www.who.int/countries/idn/en/>

APBD). The program was named Community Health Insurance (Jamkesmas), which later changed to Healthy Indonesian Card for PBI (KIS-PBI).ⁱ

8. JKN with Healthy Indonesian Card (KIS) is an universal program for each citizens, whether it is individual (the premium is paid individually/KIS-Mandiri), working citizens, or every citizens (Article 16, Presidential Decree No. 12 of 2013 on Health Care Benefits)

9. According to survey done by PT Swasembada Media Bisnis, BPJS for Health satisfaction index reached 78,9 percent (Dec. 2015), higher compared to the surveys done by National Social Security Council (DJSN) which is amounted around 66,33 percent (28 Dec. 2016).ⁱⁱ Nevertheless, BPJS Watch's notes asserted that those surveys did not begin with the questions on what rights that are supposed to be received by the participants. Surveys supposed to open facts on participants' knowledge on BPJS services, so that the satisfaction answers can be equated with the quality of services given, including the amount of healthcare facility access done by the participants.ⁱⁱⁱ

10. Amidst the BPJS services problem a while ago, the Government issued Presidential Decree No. 19 of 2016 concerning the Second Amendment of Presidential Decree No. 12 of 2013, which increased the amount of premium paid by BPJS members. Meanwhile, audit result of Audit Board of the Republic of Indonesia (BPK RI) shows that there are problems in BPJS implementations, and BPJS is not giving its best service to the members.^{iv} In accordance with the situation, as it was asked in the House of Representatives meeting, the Government supposed to do a comprehensive investigaton audit, including to capitation fund, BPJS for Health operational costs, Social Security Fund from APBN, and PBI membership.^v

11. Generally, according to BPJS Watch, the arising problems are related to member's data, unfinished regulation, and medicines, which are not covered by BPJS for Health. The existing regulations also implemented ineffectively, such as the establishment of BPJS Monitor Board in each hospital as mandated by Presidential Decree No. 49 of 2013 on Hospitals' Monitoring Board.

12. Furthermore, weak monitoring also hindered by the unavailability of complaint mechanism that can be accessed by public. PATTIRO, a civil society organization, reported from their research that *"from 20 members of BPJS for Health surveyed by PATTIRO in two kelurahan (village) in Semarang City and two villages in Semarang Regency, all of them have not yet or do not know how to deliver their complaints to BPJS or cooperating Healthcare Facilities."* According to the report, BPJS for Health have not yet provides enough participation room for members, so that members cannot give their opinion in policy making or improvement. The channel/ways to deliver complaints provided on internet and call center, which cannot easily be accessed by public, especially poor, marginalized and/or difable people. Meanwhile, Article 48 Law No. 24 of 2011 on BPJS for Health stipulated that to settle complaints, BPJS for Health has to create service quality control and members' complaints handling units.

13. A survey conducted by PKBI (Indonesian Planned Parenthood Association) and GKIA (Maternal and Child Health Movement), from March to April 2016 in Jakarta, involved 815 respondents, found out that there remains a significant share of respondents who have yet to be the JKN members (39%).^{vi} The survey also found out that while most non-JKN member respondents want to be the JKN members (69%), a complicated administration procedure remains the main reason of not being registered to the JKN scheme.

14. Related to medicines, up until now the national formulations for regulations is not finished yet, resulting complaints from hospitals on difficulties to attain quality generic medicines because of the unavailability of guidance. BPJS Watch found that patients often asked to buy medicines and bloods, which supposed to be covered in BPJS scheme.^{vii} Moreover, the improvement of tariff system INA CBGs (hospital payment system by BPJS for Health) is not implemented, so that many BPJS for health member patients are not

served optimally by the hospital. Services received by members oftentimes stagnated, for example waiting list format for service (have to wait for days to be admitted as inpatient). Another frequent practice received by the members is rejection from care by hospitals to BPJS members.^{viii}

15. Rejection from the hospital happened to Rizky Akbar, a 2,9 years old child, who passed away in one of BPJS implementing hospital. Rizky was first brought to hospital on July 11st, 2016 and rejected by 6 hospitals – including BPJS providers – and passed away on August 27th, 2016. Although debated by hospitals and the Government, BPJS Watch saw Rizky's death as hospital's neglect to one's life.^{ix}

Determination of Recipients of Health Care

16. On the implementation, the recipient of KIS-PBI is based on 14 poverty indicators made by Central Bureau of Statistics (BPS)^x that often creates problem in the field, mainly on the access to vulnerable and minority populations, such as women, children, people with disabilities, migrant workers, religious or beliefs minorities, and people with HIV.

17. Law No. 13 of 2011 on the Handling of the Poor and in Needs, Home Affairs Minister Circular Letter, Government Regulation No. 76 of 2015 on the Amendment of Government Regulations No. 101 of 2012, and Government Regulations No. 76 of 2015 on Recipient of Premium Aid for Healthcare Benefits Premium (PBI) explained the verification and validation of poor people in Target Households (RTS) which is routinely done every six months by Head of Village/Lurah. Head of Village/Lurah can register RTS in need and unlist non-suitable RTS. Nonetheless, data updates are not done routinely, resulting in KIS-PBI given to deceased and migrated people. On the contrary, those with KIS-Mandiri who become poor that cannot pay the premium cannot move to KIS-PBI. Moreover, if the member has unpaid bill in KIS-Mandiri and cannot move to KIS-PBI, they have to pay the bill in full.^{xi} Data update rejection also done by Social Office of Depok with the excuse that KIS-PBI data was final and cannot be updated with new members. To add new data, the proposing institution should sign Memorandum of Understanding (MoU) so that the fund will be obtained from the institution, not APBD.

18. KIS-PBI members get discriminative treatment, such as: a) the issuance of KIS-PBI card takes 3-6 months while KIS-Mandiri can be obtained in one week maximum in Kelurahan Rawa Jati, South Jakarta; b) Budi Asih Hospital East Jakarta, RSCM Central Jakarta, have quota limitation for patient service, causing those who already queued cannot be served and have to repeat the process the next day; c) Sari Asih Hospital Ciputat guide KIS-PBI or KIS-Mandiri patients to upgrade class since being admitted to Emergency Room to get better facility; d) Budi Asih Hospital East Jakarta did not receive KIS-PBI patients in Emergency Room because of full room; e) Pelabuhan Hospital North Jakarta separates waiting room and pharmacy between KIS-PBI and KIS-Mandiri patients; f) KIS-PBI members has to buy medicines outside the hospital with the reason of unavailability of medicines in Kupang Hospital and Kupang Regency; g) Koja Regional Hospital North Jakarta ends KIS-PBI members; h) RSCM did not give certainty for operation schedules; i) Indonesian Cancer Foundation did not receive pap smear, IVA for women who have not married j) Siloam Hospital Kupang told KIS-PBI patients to go home after five days admitted to the hospital, despite the patients' ill condition; k) Leona Hospital and Yohanes Hospital Kupang did not serve KIS-PBI patients because there was no reference letter.^{xii}

Vulnerable Populations' Access to BPJS

19. BPJS service was formulated to ensure the fulfillment of rights to health for every citizens given free of charge through PBI and different classes in BPJS according to the premium paid.

20. Recipients of Premium Aid (PBI) are members of Health Insurance for people in need and living in poverty, as mandated by National Social Security System Law, in which the

premium paid by the Government as the member of Health Insurance. PBI members are poor people as stipulated by the Government and regulated through Government Regulations. According to Social Affairs Minister Decree No. 146 of 2013, poor people category covered: 1) registered, and 2) have not yet registered.^{xiii}

21. **Women:** the establishment of poverty indicators by BPS did not touch gender and women needs issue, such as whether poverty happens because of violence against women, domestic violence, the amount of children in one Family Card (KK), female-headed household, or work hour for women which is more than men in a family. On the field, 14 indicators also only refer to physical appearance of a family to measure their poverty. In reality, there are many permanent and apparently good houses, but it might be inherited while the occupants are unemployed, daily or seasonal labour, or laundry worker.

22. JKN does not cover women patients who are victims of violence because it does not considered as an illness or not a health service, particularly women victims of domestic violence, and police report letter (SKTL) as obligatory. As found in the assistance and monitoring result of Institut Kapal Perempuan, women victims of domestic violence have to pay Rp. 300.000,- to get visum in Tarakan Hospital, West Jakarta.

23. **Migrant workers:** although clearly stated that migrant workers are included as one of the group rightful to attain Health Insurance, in practice the service cannot be accessed by migrant workers abroad. BPJS only applied in Indonesia, while migrant workers abroad are insured with cost as much as Rp. 400.000,- each year, paid by the migrant workers. In spite of that, migrant workers cannot easily access the insurance because of several hindrances; one of them is that the insurance can only be accessed in Indonesia. There is even tendency to complicate access to insurance from government-appointed consortium companies. According to the Law No. 39 of 2004, migrant workers are obligated to be a part of that private insurance. On the other hand, there is no monitoring, evaluation, or audit on the insurance implementation, so that failed claims percentage from migrant workers are so high. SP data on 2016 shows that from 66 cases, only one case that can be claimed and cashed.^{xiv}

24. **People with HIV/AIDS:** discrimination happened to people with HIV when they want to access BPJS, even in practice the officer often act unfriendly in serving HIV positive BPJS members. Other than that, up until now there is no national referral system for antiretroviral (ARV) medicines and as a result BPJS members with HIV can only obtain the medicines in their respective areas, which cannot fully be accessed by them, while the ARV retrieval should be done every month.

25. **People with Disability (PwD):** BPJS did not include PwD as vulnerable population that has to get special assistance such as wheelchair, special healthcare costs, therapy for intellectual and psychosocial disability, children with cerebral palsy, and other services which almost all should be paid individually by families and/or PwD. There are only several areas that can give tools aid, for example Yogyakarta.^{xv} In Aceh, there are special card to access the disability services in hospital. In Cianjur, West Java, the local government issued County Health Insurance Card for psychosocial assistance. More than that, most BPJS services cannot be accessed for PwD's special needs. Furthermore, PwD in social facilities with BPJS (around 800 PwD in each facility) have to go to hospital to access the service. Healthcare workers supposed to deliver service to the respective locations.

26. **Religious Minority or Indigenous Beliefs:** indigenous believers oftentimes cannot access healthcare and other social services because of the unavailability of citizenship documents. The unavailability of legal documents happen because indigenous beliefs are not recognized by the State, hence they chose not to get identity cards which affecting the attainment of the other rights, such as Marriage Certificate, Family Card, and social services. Health services are very strict with identity cards. National Commission for Women stated that there are at least three cases of women indigenous believers that were obstructed in accessing Government's assistance, both in social security or health insurance. In two cases

the women indigenous believers were elders and very in need of health and social assistance, and are pushed to write “Hindu” in the religion column just to get the assistance, each for Regional Health Insurance and Social Security Card. ^{xvi}

Recommendation:

- a. Ensure the enjoyment of health services for vulnerable population who are not included in 14 poverty indicators, in the form of services such as tools aid and therapy for PwD, migrant workers abroad, and other minority and vulnerable groups.
- b. Revise several regulations, inter alia Health Minister Decree No. 59 of 2014 on INA CBGs packages, and BPJS for Health such as Directorial Decree No. 1 of 2015 that oblige 14 activation period, and ensure the health insurance services are not hindered by technical procedures, and eradicate discrimination for PBI recipients.
- c. Develop monitoring and evaluation model that are gender responsive, inclusive, and participative and involved many people, particularly poor women whose voice have never been heard before.
- d. Create complaint system that can be accessed related to BPJS services, maximizing the role and functions of BPJS Monitoring Board, and establish Monitoring Board in each Hospital, including complaint handling and monitoring mechanism socialization, and evaluation involving BPJS members and civil society.
- e. Emphasize sanctions for BPJS provider hospitals that are proven violating BPJS members’ rights, with maximum quality and non-discriminative service, and maximizing the monitoring role of Monitoring Board in each hospital.

B. Maternal and Children’s Health

27. Based on the 2012 Demography and Health Survey Indonesia (SDKI) 2012, the percentage of teen girl aged 15-19 years who had given birth and first pregnancy reaches 9.5%. While the birth rate by Age Group (ASFR) showed 48. About 11.1% of teen girl aged 15-19 years had married, at an average age of 10-14 years. Teen girl who who have given birth at the age of 15-19 years old, reaches 59% and the average age of giving birth under 18 years old and they are susceptible to bleeding and death in childbirth. Babies born to teenaged 15-19 years generally experience: stillbirth, premature and low birth weight. ^{xvii}

28. One of the factor of this phenomenon is socio-economic barriers which made it hard for a women to decide what she wants for herself. Most of the decisions related to women's reproductive health is determined by others, which impacts women's health, education and life sustainability. Data from PKBI from more than 10 years of consultancy services, showed that on average, 25 women per day experiencing unwanted pregnancies and it mostly occurred experience by married women (between 73% to 86%), with family planning failure (on contraception and children planning). This findings highlight the fact that the majority of unwanted pregnancy in women who are not married is not true (only between 10-20%). Data also shown that women will make various efforts to terminate their pregnancies (40 -60%). This act is potentially threatening women's life and their reproductive health.

29. According to the Institute for Ecosoc Rights, Indonesia is not fully implement their obligation to fulfill the right to review health differences, both subscribe to health care or who subscribe to the basic prerequisites for health basis. This is illustrated by the issue of the prevalence of malnutrition-malnutrition and stunting, as showed in the previous research conducted by the Ministry of Health (2013). The prevalence of malnutrition among children under five old years illustrates fluctuating, from 18.4 percent (in 2007) decreased to 17.9 percent (in 2010) and then increased again to 19.6 percent (2013). Provinces that the prevalence of malnutrition is very high (above 30 percent) is the East Nusa Tenggara and West Papua. Indonesia also faces serious problems with problems of stunting due to chronic malnutrition. National figure reached 37.2 percent, the highest rate was East Nusa Tenggara (50 percent). Among the 33 provinces in Indonesia, there are 18 provinces that have a

prevalence of malnutrition-less above the national average, ranging from 21.2 percent to 33.1 percent.

30. The research conducted the Institute for Ecosoc Rights in NTT (2005 and 2009) showed that the government did not committed in addressing the problem of nutrition. It could be analysed by the allocated budget and curatives programs than prevention. Moreover, in addressing the problem of malnutrition, Indonesia is also facing the problem of data accuracy, with the considerable of margin between the official data and field data due to the lack of complaint from the people.

31. There are no national data on the prevalence of the most relevant nutritional problems in Indonesia. However, cases of malnutrition and infant mortality due to malnutrition emerging and occurring evenly across the various regions. In NTT, for example, in 2014 recorded 2,100 severely malnourished children and 15 of them died and 3,121 children under five are malnourished. In 2015, recorded 1,918 malnourished children (under 5 old years) and 11 of them died. During 2016 there were 200 people malnourished (majority were children under five). In West Nusa Tenggara (NTB), until mid February 2016 there were 55 cases of malnutrition and two of them died. 2015 found 337 cases of malnutrition and there were 486 cases in 2014. In Blitar, East Java (2016), found 232 children suffer from malnutrition. In the same year in the rice granary areas in West Java province, such as Indramayu, 40,000 children under five suffering with malnutrition. In Karawang, West Java, 164 infants suffered with malnutrition, 1,797 of children under five in Purbalingga suffer from malnutrition and 54 of them are malnourished.²

32. **Children with HIV and/or of People with HIV:** not many Pediatricians who understand the care or treatments for children who live with HIV or affected by HIV. Children who are positive is hard to access children's antiretroviral (ARV), but using adult's ARV with children's dosage or service for mother and child is not usually available in one hospital. Oftentimes, different standard operational procedure related to immunization of babies born from mothers with HIV occurs. In practice, pickup place for ARV is different it becomes inaccessible and hard for children.^{xviii}

Sexual and Reproductive Health

33. Under the Penal Code, Arts. (299; 347; 348 & 349), health and education providers who give information and advice about contraception and abortion services are criminalized and risk imprisonment with a minimum of 4 to a maximum 15 years. The draft amendment of the Penal Code Arts. (481) & (483) states that any person who gives direct written information or offers contraception risks imprisonment.^{xix}

34. The article 481 and 483 of the proposed revision of Indonesia's Penal Code (RKUHP) are highly counterproductive to the attempts of various parties (government, private sectors and civil society) at reducing the number of maternal and infant death and improving family's welfare by implementing the Family Planning (KB) and Reproductive Health (KesPro) programs. Therefore, Yayasan Cipta Cara Padu (YCCP), Institute For Criminal Justice Reform (ICJR), Perkumpulan Keluarga Berencana (PKBI) and Aliansi Nasional Reformasi KUHP unite to reject the restriction of information provision and education on Family Planning as suggested by the draft.

35. At this moment, the House of Representatives is holding a discussion to review Article 481 and 483. Article 481 of the draft threatens to impose criminal sanctions on anyone promoting the sale of "tools to prevent pregnancy." The article also prohibits a person from openly exhibiting, with or without being asked, information on obtaining contraceptive tools. The phrase "unlawfully" in Article 481 RKUHP reinforces the idea that information on contraception can only be given by those mentioned in the article 483 of RKUHP, which are

² Report by The Institute of the Ecosoc Rights

authorized officer. In other words, this doesn't apply to civil society or those of family planning workers and volunteers.

36. If the Article 481 and 483 of RKUHP is ratified, they will be highly counterproductive to the attempts of various parties (government, private sectors and civil society) at reducing the number of maternal and infant deaths and improving family's welfare by implementing the Family Planning (KB) and Reproductive Health (KesPro) programs. Today, the provision of information and services on contraception are carried out not only by the state but also by all parties including private institutions and civil society. Meanwhile, the enactment of article 483 of Indonesia Penal Code (Criminal Code) could potentially lead to overcriminalization of service providers and kiosks that sell contraceptive tools openly.^{xx}

37. From the data mentioned above, it is obvious that if information dissemination could only be done by the health workers, people will have limited access of Family Planning and Reproductive health-related information and will not be able to protect themselves. Moreover, people will also be reluctant to participate in providing Family Planning and Reproductive health-related information and education for fear of the criminal sanction. Without people's clear and active involvement in family planning information and education provision, Family Planning and Reproductive health information program in Indonesia is bound to failure.

38. Female Circumcision is still practice in Indonesia. The survey of UNICEF in 2013 to 300,000 households in 33 provinces and 497 cities in Indonesia indicates that, more than 10 girls were circumcised before they reach the age of 12 and the Circumcision starts from type 1 until type 4. Female circumcision is also a health service commodity offered by Hospitals, Maternal and Child Health Clinics, and Public Health Centers. This service is usually offered as a package, circumcision and ear piercing. This is an indication that institutions that provide health services and health workers consider female circumcision as a business opportunity, even though they are aware that this is not beneficial to health and the doctors and midwives did not obtain education and/or training on female circumcision.

Recommendations:

- To urge the government of Indonesia to take strategic steps in the field of education in order to eliminate gender-based discriminations, thoroughly implement 12 year compulsory education, end violence in education, and integrate the material of Sexual Right and Reproductive Health (SRHR) in the curriculum of the different levels of the national education.

C. Disability and Mental Health

39. Disability with the mental health still facing multiple discriminations and insufficient treatment from the government or health services agencies. Based on the DPOs monitoring, there are many cases of women with psychosocial and intellectual disabilities are experiencing serious violation of rights such as receiving contraception, either tablet or spiral, without any consent. Many of them are forced to receive the program to prevent them to get pregnant. Moreover, the program is conducted in many temporary shelters, both public and private shelters, without any supervision and evaluation of the program. This violence is still continuously enforced because there are lack of understanding, awareness and capacity to cope with the problems of women reproductive health of the temporary shelters' management, family, neighborhood and other relatives. (*Monitored Jiwa Sehat [The Health Soul] Association, 2016*).

40. Violation of the Law No. 18 of 2014 on Mental Health is still occur. Deprivation of liberty such as shackling creates unfavorable condition for their mental health development. Children with *Cerebral Palsy* or CP; who unable to stand, unable to sit, and only stays inside their house, is not paid serious attention to be independent. Education and therapy provided by the government is not directly addressed to the their home. From the aspect of services,

there is uncertainty on health facilities for their needs of therapy, and moreover this expensive service is not included in their Social Security Provider Agency (BPJS).

41. **Shackling**^{xxi}: Indonesian government prohibit the act of shackling since 1979, but up until now the act is still happening on the ground. Once Ministry of Health arranges a program to prohibit the act of shackling, but it's unsuccessful. Approximately, 57.000 people in Indonesia are experience being schakled or even still on shackle. Basic Health Research Survey stated that 14% of families who have member with mental health problem are doing shackle.

42. Mental Health Law emphasizing the shackling is prohibited, but the regulation is not supported by facilities and measures -such as village level services, eliminating stigma, consultation services, etc., to stop the act. Related to the shackling in the social temporary shelters, there is no regulation available to authorize monitoring and evaluation of the shelters, even though for the establishment of the shelters needs a license from the local government. Two of the private-run shelters which use shackling as their treatment is Bina Lestari Shelter located in Brebes, Central Java and Jasono Alternative Medicine located in Cilacap, also Central Java.^{xxii}

43. Indonesian Government has planned the MoU on Handling Persons with Mental Disabilities between four ministries and two Police Institutions and BPJS on May 2016. This MoU aimed to stop the act of shackling with tagline "Stop Shackling Movement 2017." But up until now there is no concrete action frame agreed and published. On the other side, the civil societies are not invited to participate in the process of the establishment of the program.

Recommendations:

- a. Synergizing psychosocial and intellectual disability services in public hospitals and ensure the mental hospital services are in accordance with the principles of CRPD, including also to adopt a regulation on licensing, monitoring, evaluation and sanction of private and public shelters on the basis of interest and rights of the persons with disabilities.
- b. Ensure the participation of DPOs and civil society on the program of "Stop Shackling Movement 2017" and ensure all the actions of the program could be implemented on the ground, including also the regular monitoring of progressiveness of the program.

D. HIV/AIDS

44. Indonesia is one of country in the world which increasingly high of HIV infection within the last few years. The estimates data has shown there are 660,000 people with HIV/AIDS in Indonesia. There is the three key populations are adolescents aged 15-24 years, the key population **that** are at high risk for contracting HIV/AIDS. HIV infection in Indonesia is concentrated in key populations, namely injecting drug users, sex workers, men who have sex with men (MSM), and transgenders. In Papua, HIV transmission has ocured in the general population. Based on data from the Integrated Biological and Behaviour Surveys (IBBS) in 22 cities, the prevalence of HIV among key populations have declined, except among MSM and transgender.

45. There are still high prevalence of HIV in Indonesia which influenced by several factors, among others are still high stigmatization and discrimination against people living with HIV and the key populations, as well as the number of legal obstacles that make people living with HIV has difficulty or reluctant to access of HIV services. The key to success of HIV prevention programs is necessary accomplishment of conducive environment, which enables people living with HIV and key populations to access the services.

46. Misunderstanding on HIV as immoral disease strengthens stigma and discrimination in the society of people with HIV (ODHA) and key population. Stigma and discrimination suffered by ODHA and key population in many aspects of their lives, including when they access health service, apply for jobs, and pursue education. The fear of stigma and

discrimination has made the key population reluctant to check their status, and ODHA unwilling to tell their status and access services, including health service.^{xxiii}

47. Among policymakers, HIV misunderstanding contributed to the establishment of discriminative, even punitive, regulation to ODHA and key population. For example, Bali Province Regional Regulation No. 3 of 2006 on HIV/AIDS Countermeasures and Cilacap Regency Regional Regulation No. 2 of 2015 on HIV/AIDS Countermeasures in Cilacap Kabupaten, which both criminalized transmission and undisclosed HIV status. Another discriminative policy are the obligation to get HIV test in military and compulsory requirement to get married, as regulated in Cilacap Regency and Bogor City.^{xxiv}

48. There is still a lot of homework related misconception to HIV/AIDS. The newest issue came from LPDP's Beasiswa Indonesia Timur (East Indonesian Scholarship) which request health certificate of health care unit who state registrants free from HIV/AIDS, Tuberculosis and Drug, as the requirement for applying scholarship. This regulation stigmatize and discriminate in two way, firstly for ODHA, and secondly for East Indonesian People.

49. Stigma and poor health service also occurred on Indonesian migrant workers (BMI). Guarantees the fulfillment of the basic rights of migrant workers are still weak. One of the basic right for BMI that oftenly been dismissed related to women's health & reproduction are; the right to sexual and reproductive health of women migrant workers (menstruation leave, working while being pregnant, not being dispatched or deported due to pregnancy), the right to marry, the right to work for migrant workers infected with HIV / AIDS.

50. HIV testing and counseling for BMI should include protection of migrant workers from stigma and discrimination and the right to obtain guaranteed access to integrated prevention, treatment and care service in the principle of confidentiality, counseling and informed consent, in addition of standardized procedure, supervision, and service.

Recommendation: Give easier facility and access to HIV treatment in detention facilities, starting from police to detention centers or prisons. It should be conveyed as fulfillment of health service related to HIV-AIDS. HIV treatment has become government regulation, can be accessed by drug user when going through legal procedures in every detention facility. Currently, there is no detention facility in Regency/City that accommodate the needs.

E. Drug/Substance Use and Dependency

51. Since 2009, Indonesia introduced policies required to report for drug addicts. This obligation is further stipulated in the Government Regulation No. 25 of 2011 regarding on Report Obligatory Recipient Institutions (IPWL). With the policy of compulsory report, drug addicts who have reported themselves to be placed in rehab, both medical and social rehabilitation.

52. With the compulsory reporting, drug user who already reported them will be admitted to rehabilitation facility, both medical and social rehabilitation. Parents or guardian to IPWL can report underage drug user. Drug user who already reported, or reported by their parents or guardian cannot be criminally charged (Article 128 Law No. 35 of 2009 on Drugs). In practice, compulsory reporting is not in line with rights to health principles because it contains coercion. Compulsory reporting policy often ends in placing drug user in rehabilitation facility against their will. The implementation of compulsory reporting already condemned by many institutions and UN Special Rapporteur.^{xxv}

53. Compulsory reporting policy makes drug user position more vulnerable to exploitation and other human rights abuses. Research done by LBH Masyarakat successfully unveil unjust practice including involvement of money and other dishonest practices done by several IPWL institutions in 'filtering' drug user so that they would report to their institutions.^{xxvi}

54. Other than compulsory reporting policy, Indonesian government also tries to implement other diversion policy for drug user. One of them is by giving authority and guidance for judges to put convicted drug user in rehabilitation facilities instead of prisons.^{xxvii} Unfortunately, according to LBH Masyarakat report, only 41 out of 151 eligible cases where the convicted really placed in rehabilitation facility.^{xxviii} The main issue in narcotics policies in Indonesia is criminalization of the drug users.

55. The reasons several outreach officers discouraged to reach teenage key population under 18 years old are the fear of abusing child protection rules, legalize trafficking if reaching underage sex workers, or teaching improper behaviours early. From Region 1 Global Fund findings in Sumatera and DIY, it was found that 300 teenage drug users under 18 was not reached by field officers.

56. Another law barrier for ODHA and key population in fulfilling rights to health is unclear policy on age limit to give consent for health measures. Health Minister Decree No. 290/menkes/per/III/2008 on Health Action Consent, which regulate that consent, can only be given by competent patients, which are adults and married patient.^{xxix} Underage patient has to get consent from parents or guardian to have medical action, including HIV test, which sometimes hinders HIV service access for children under age.

57. In Indonesia, freedom to access service, one of them HIV service that cannot be accessed freely by teenage key population under 18. Compulsory informed consent form from parents makes teenagers reluctant to access the service. On the other hand, when we talk about teenage key population (sex workers, gay, drug users, transgenders), they are, on average, did not live with their parents anymore. If they do, it's clearly not easy for them to ask for HIV test because of the stigma to those who do HIV test, they are afraid that their status which can be categorized as key population is known by their parents.

Recommendations:

Drug users should be rehabilitated and not incarcerated. With several available therapies, it will be most appropriate if Drug users can access rehabilitation therapy service, according to their needs, which refers to the integrated assessment result, compared to getting criminal sentences. Of course it's heavily depend on investigation process.

IV. The Situation of Specific Groups and Populations in Situations of Vulnerability

A. Children

58. 1945 Constitution of Republic Indonesia, Article 28B paragraph (2) and Article 28H paragraph (1) guarantee children's rights. Law No. 36 of 2009 on Health. It is said that: Children's healthcare efforts are done since they are in the womb, baby, infants, until their teenage years; including efforts to nurture children with disability and children who are in need of protection.

Children rights issues in Manggarai, East Nusa Tenggara (NTT)

59. The district of West Manggarai with its capital, Labuan Bajo, is one amongst 21 districts of East Nusa Tenggara province. The district is augmented as administrative region of Manggarai District in West Manggarai District covers 10 sub districts, 116 villages and 5 urban administrative communities. GNI works in the area with focusing on two sub districts namely Kuwus and Macang Pacar. Kuwus subdistrict consists of 15 villages and 2 urban administrative communities with the capital of Golowelu, while Macang Pacar consists of 13 villages with capital of Bari. There're several issues related to the rights to health in Manggarai, such as the malnutrition, unhealthy environment, water and sanitation (*for details, see Annex I*).

- a. *Malnutrition*: for this case it show increase level every year, unfortunately the up data from related government institution are many varian. Civil society (the Gugah Nurani

Indonesia) have their own data and if percentage around 32 % that occur in our project site area;

- b. *Unhealthy environment*: The link between the behaviors of open defecation on malnutrition is not directly visible and tangible. However defecation will pollute the river water and water used for everyday purposes. The dirty water contaminated with feces is used to irrigate the fields and plantations. As a result, food sources become contaminated and hazard when consumed. Danger bacteria is going to happen because the 'help' of insects. Insects such as flies will be settled on the careless disposal of feces that spread filth and disease. Food will be dangerous when the insects that carry the germs from these stools perch on the food that will be consumed. Because of unhealthy food to be consumed this will lead to children so malnourished that the body needs. About nine million children in Indonesia have a short body.
- c. *Water and sanitation*: In the period up to 2016, there are still many families who have not been paying attention to the health condition and their family environment. This is especially on clean and healthy lifestyle behaviors. There are still many residents who don't have toilets and conduct personal dumps carelessly. Awareness to have family toilet is still very low, it is also due to water access that far enough from the community area; many citizens are reluctant to build the toilets because the water had to transport to the toilet. It is daily huge work, mostly for children and women, who considered to responsible on domestic work.

Table 1: Summary of Situation in Manggarai, NTT

Malnutrition	32 % of Manggarai Population
Infant mortality	71/1000
Toilet	20 %

Source: Gugah Nurani Indonesia, 2016.

B. Rights to Health of Papuan People

In the case of the right to health, especially in Papua and other Eastern area of Indonesia, facing more serious problems than other Indonesian people because of lack of access to health care and lack of basic prerequisite conditions, such as nutrition, water, sanitation and others. Poor levels of health in Papua, among others, includes four things, namely maternal and child health and public nutrition, infectious disease of malaria, tuberculosis (TB), and HIV-Aids,^{xxx} the Special Autonomy since 2002 does not solve the problem of the lack of fulfillment of the right to health.

Deaths due to disease and malnutrition still occurring. In Yahukimo, for example, in 2005 and 2009 there were 220 people died because of diseases and malnutrition. In 2008, Justice and Peace Commission of the Synod of Papua Kingani reported in Dogiyai District 239 residents died of cholera and diarrhea. From November 2012 to March 2013 Indigenous Peoples' Alliance reported, there were 95 deaths in the District Kwor, Tambrau district, West Papua, and 61 people died in the District Samenage, Yahukimo, Papua, due to malnutrition and illness. In 2015 there were 225 cases of malnutrition and malnutrition in Sorong, West Papua. In 2015 at least 41 children in the District Mbuwa, nduga regency, Papua, died of the disease unknown.^{xxxi}

Related cases of death due to disease and malnutrition, the government is considered slow in responding so the impact on the high number of victims. Until now, Papua and West Papua is a province of the worst in terms of the right to health. According to national and regional health research conducted in 2013 the mortality rate of mothers and children in Papua and West Papua is the highest in Indonesia. Director General of Disease Control and Environmental Health, Ministry of Health, stating that the cases of malaria in eastern

Indonesia such as Papua, West Papua, Maluku and East Nusa Tenggara, is still fairly high with Annual Parasitological Index (API) of more than 20 per 1,000 inhabitants (Master, Malaria in Papua Top, 2013). Programs of the local government has not been able to resolve health problems that exist in Papua (Loen, 2013).

Meanwhile, in the case of TB disease, in the year 2012, according to a report Jayapura District Health Office, there were 306 cases of TB in Jayapura,^{xxxii} but in other news reports, mentioned that there were 477 cases, in which 417 patients can be cured, 15 patients died, and 45 others are cases of failure.

Report by the Ministry of Health has shown that there are 13,942 cases of HIV-AIDS in Papua province, and has an increasing tendency in the past 10 years (Dagur, 2012). For the case of sectoral HIV-AIDS itself, the sample locations in Jayawijaya, Department of Health and AIDS Commission (KPA) Jayawijaya explained that by September 2013, HIV-AIDS cases in the region reached 3,655 cases. (Adisubrata, 2013).³

C. Indigenous Peoples

60. Despite several remote indigenous community programs already initiated by the Government (Ministry of Social Affairs) as an effort to ensure the community's rights to life, it does not include every aspect needed. Ministry of Social Affairs' programs only cover fulfillment of indigenous people's right to development, and did not touch other basic rights such as right to health.

61. Community also do not have access to many available aid program, rice for the poor, PKH, Community Health Insurance (Jamkesmas)/Regional Health Insurance (Jamkesda) that was renewed to become BPJS for Health, School Operational Aid (BOS), and other development programs such as Association of Farmer Groups (Gapoktan) and Small and Medium Enterprises (UKM). (Inkuiri, Book III, p. 87)

62. According to National Commission for Human Rights' (February 2016) study on health situation of Orang Rimba (jungle people) community in Jambi,^{xxxiii} it shows that 4 of 10 Orang Rimba are contracted with contagious Hepatitis B. The study also found high prevalence of Malaria on Orang Rimba, which is 24,26 percent.^{xxxiv}

63. Beside that, Indonesian indigenous community is impacted heavily from business practices and corporations, including health situation, healthy environment, and access to traditional medicines that all this time is obtained from the forest. Natural resources exploitation in indigenous sites, legally or illegally, not only affected environment, pollution, violence threats, physical conflicts, tortures, and terrors, but also indigenous community health condition, mainly women reproduction health. Business operations near indigenous site oftentimes creating environment pollution because of chemical materials usage (in gold mines and palm plantations maintenance). Destroyed environment and ecosystem causing indigenous population, particularly indigenous women, troubled to find clean water and contracted with diseases because polluted water consumptions.^{xxxv}

64. Destroyed indigenous forest because of corporations also caused plants rarity for indigenous community's traditional medicines, lower clean and healthy environment enjoyment, and extinction of inherited traditional knowledge. Punau Dulau indigenous community (North Kalimantan), for example, currently is hard to get materials for traditional potions in their indigenous forest. As a result, they have to spend huge amount of money to get health services and medicines that are only available in the city or puskesmas. Moreover, Punan Dulau community was once plagued by itchy skin diseases because of gummy trees' logs that are floated through the river in Punan Dulau indigenous area. This corporate's act also causing the death of fishes in the river, which is one of indigenous community's food resource.^{xxxvi} Similar thing also happens in Kampung Muara Tae indigenous population in East Kalimantan, that becomes place for waste disposal – causing

³ Report by The Institute of the Ecosoc Rights

Nayan river pollution, despite the fact that the river is used by indigenous people as life source.^{xxxvii}

65. Indigenous women and children also seriously affected by the destroyed environment and/or irresponsible business operation. Women reproduction health getting lower, indigenous women get weaker health protection when the forest which to date provides daily needs and health disappears. Herbal plants are destroyed and exposed with environmental pollution because of chemicals used massively by companies (particularly for plantations), inexistence or minimum facilities from the Government to serve reproduction health.^{xxxviii} (See, ANNEX I)

66. Another rising issue is livelihood shift in some Matteko indigenous people (Gowa, South Sulawesi). To stay alive in between pine trees and lowering harvests because of narrowing lands, they are pushed to become pinesap tapper in PT Adimitra Pinus Utama. Salary obtained is not enough for a proper living, especially because the company did not provide health services for the workers that health needs couldn't be covered.^{xxxix}

D. Refugees, Asylum Seekers and Migrants

67. **Refugee/Asylum Seekers:** Indonesian government provides health care services of the refugees in the hospitals that work together with IOM. However, there were obstacles encountered by refugees in accessing health services. This guarantee is given outside of the meager monthly allowance given by IOM to refugees each month. As an example of the Rohingya refugees who were in Jakarta.^{xl}

68. **Migrant workers:** Health test for migrant workers are not effectively implemented because of the minimum access to information for migrant workers, especially women, that supposed to be given as mandated by Article 48 Law No. 39 of 2004. Migrant worker recruits are often do not get information on purpose of the tests, what kind of diseases examined and counseling services and facilities they can get before and after the examination. Migrant workers also not directly get their examination test, but through PPTKIS. Migrant workers recruit who passed the test will be processed for departure. Some also get pending status, which means they have curable disease so their departure is pending, but can only be given available medicines.

69. Several violation practices happen in medical check up process, while sanctions only bestowed upon PPTKIS that placed migrant workers recruit that did not fulfill health and psychological requirement, not for health institutions who did medical examinations. Many female migrant worker recruits who have heavy diseases have their test manipulated to turn the unfit to fit by PPTKIS to process their departure, so that migrant worker recruits are departed in ill condition.

70. Discrimination for female migrant workers (with health status HIV positive, pregnant, sexually transmitted infections, TBC, etc.) so that they cannot be departed to destination country, are sent home without referral mechanism to healthcare facilities. Whereas the protection of migrant workers with those statuses not supposed to be discriminated, but to be given protection as stipulated in Minister of Health Decree No. 21 of 2013 on HIV and AIDS Countermeasures.⁴

71. Violation to rights to health of housemaid migrant workers that can be documented by Solidaritas Perempuan from case handling and research activities are, inter alia, rights to get treatment and care when sick, rights to get health rehabilitation after physical and psychological violence, sexual and reproductive rights, and voluntary test rights. Most housemaid female migrant workers did not have access to insurance claim and other health insurance while working.

⁴ Regulating confidentiality, agreement, counseling, registration, report, and referral as principles that has to be obliged in HIV/AIDS examination.

72. Female migrant workers' vulnerability to health impediment risks started from recruitment and on waiting period in the shelter. The shelters are in inappropriate situation, not enough sanitation and health facilities, limitation of communication with families that have confinement tendency so that often implicate to psychological breakdown in female migrant workers.

73. Child domestic migrant workers and ship crews are the most vulnerable group. The vulnerability is caused by working situation and protection for the working situation that are provided by Indonesian government and destination country are not sufficient, including:

- a. Inavailability of protection for migrant workers including child migrant workers in Law No. 39 of 2004, including children. In Malaysia, up until October 2016, there are 3.600 child migrant workers that are following their parents working as migrant workers in palm oil plantations in Sarawak, and only 860 of them get access to education.⁵
- b. Domestic workers and ship crews' rights to health are not fully maximized because their working space that almost fully do not have access to public services. With improper and vulnerable working condition, such as bad sanitation, minimum access to health, and social security in workplace. Besides, rehabilitation for housemaid and ship crews are minimally provided despite the work situation which are very potential to psychological disturbance such as stress and depression.

Recommendations:

- a. The Government has to guarantee protection and fulfillment of rights to health, access to healthcare facilities, health facility without discrimination to child migrant workers, housemaid, and ship crew.
- b. The Government has to ensure that information on purpose of the tests, what kind of diseases examined and counseling services and facilities they can get before and after the examination, and build independent monitoring mechanism from every kind of violation, discrimination and sexual harassment potential.
- c. The Government have to take insurance scheme of migrant workers from profit oriented to providers of health insurance, ensuring that there is access of those health benefits in the destination country.

E. Persons with Disabilities

74. Health Ministerial Regulation No. 5 of 2014 on Guideline of Clinical Practice for Doctors in Public Health Services is a power for the society to do advocacy and correspond with the situation on the ground. Even though there are less and limited health services in certain areas for the leprosy disability.⁶

75. Health Ministerial Regulation No. 5 of 2014 on Guideline of Clinical Practice for Doctors in Public Health Services is a power for the society to do advocacy and correspond with the situation on the ground. Even though there are less and limited health services in certain areas for the leprosy disability.⁷

76. On 2014-2015, Himpunan Wanita Disabilitas Indonesia (HWDI) studied how far teenage PwD's understanding on reproductive health, result shows that most of them have

⁵ Kompas.com, October 16th 2016. [Pemerintah Malaysia Akhirnya Merestui Sekolah untuk Anak TKI di Sarawak](#)

⁶ Law Nr. 24 of 2011 on Social Security Provider Agency; Indonesia Government Regulation No. 76 of 2015 on the Amendment of Indonesia Government Regulation No. 101 of 2012; Social Ministerial Decree No. 146/HUK/2013 on Determination of Criteria and Data Collecting of the Poor and the Unable.

⁷ Law Nr. 24 of 2011 on Social Security Provider Agency; Indonesia Government Regulation No. 76 of 2015 on the Amendment of Indonesia Government Regulation No. 101 of 2012; Social Ministerial Decree No. 146/HUK/2013 on Determination of Criteria and Data Collecting of the Poor and the Unable.

no understanding on how to keep reproductive health, and it was found that in panti X, the headmaster instructed forced sterilization with the reason to protect the students.

77. Ministerial Regulation on Health No. 75 of 2014 oblige the Community Health Center or Puskesmas to do home visit, but not under BPJS scheme. Persons with disabilities in temporary shelters are not enjoy the services. They have to go to hospital by themselves under the BPJS scheme. While number of people in each shelter can reach 800 persons.

78. In Kupang, East Nusa Tenggara, false diagnosis happened to seven leprosy patients in which spots in their body diagnosed as allergy, and ulcers diagnosed as diabetes. As a result, unsuitable medicines are given with possibility to cause permanent disability.^{xii} In some areas such as Sitanala Hospital, Tangerang, Banten Province, leprosy patients are put behind the hospital, isolated. In village areas in Central Java, people with leprosy are still excommunicated, exiled to the other place so that they will not blend with the community, strengthening the stigma.

79. In Sukoharjo, Central Java, Regency Regulation No. 1 of 2012 which is always revised annually emphasizing the county health insurance that not include poverty category to be able to access the services. Persons with disabilities could received the services with the recommendation of Social Welfare Department.⁸

80. Children with cerebral palsy needs are not understood fully by the government. Whereas families of children with CP needs huge cost for medicines and routine care, around IDR 3.800.000,- (see end note for details).^{xiii}

Recommendation:

- Centralizing and correcting the data of Persons with Disabilities (Article 22 Law No. 8 of 2016), as well as include them in the health and social security scheme without including the poverty category.
- Providing physical and non-physical accessible accommodation (disabled people friendly environment), and proper infrastructures in whole health service facilities in village, *Puskesmas* and hospital.
- Synergizing psychosocial and intellectual disability services in public hospitals and ensure the mental hospital services are in accordance with the principles of CRPD.
- To adopt a regulation on licensing, monitoring, evaluation and sanction of private and public shelters on the basis of interest and rights of the persons with disabilities.

F. Sexual Orientation, Gender Identity and Gender Expression (SOGIE)

81. Public ignorance towards sexual orientation, gender identity expression and sexual characteristic (SOGIESC) it caused and considered as abnormal. The Indonesian Psychiatrists Association (PDSKJI) has classified homosexuality and bisexuality as mental disorders or psychiatric problems while transsexualism included in people with psychiatric disorders.⁹ It is definitely contradict with the American Psychiatric Association (APA) back in 1987 and the World Health Organization (WHO) in 1992, which issued homosexuality category from mental disorders. In addition, that statement is also contrary with the Guidelines specified in the Psychiatric Diagnosis of Psychiatric Classification (PPDGJ), which no longer classify homosexuality as a person with psychiatric problems (ODMK).

82. Rejection from environment creating violence, most of the cases happened to LGBT happen in a form of school bullying which affected study performance, skipping school, and thing or even try to kill themselves. Arus Pelangin in their report on 2013 found that 17,3

percent of LGBT population have tried to do suicide, and 16,4 percent have tried it more than once. Mental disorders on differences are not taken care well in our professional psychiatry institution. They tend to judge those with different gender and sexual identity is against their nature. This is why religious-based conversion therapy institution established.

83. Conversion therapy is something often spoke about in the community on LGBTI groups. People still believe that LGBTIQ has to be “cured” and they believe that this therapy can be curative medium. Increasing discriminative statements and hate speech to LGBTI community in Indonesia causing therapy efforts discussed again. One of the conversion therapies using religious approach is *Peduli Sahabat*, which claimed that they could cure sexual orientation, from homosexual to heterosexual with religious approach.

84. Indonesia has access to health that categorized as gender confirmation treatment (hormone therapy, silicon injection) that supposed to be accessed by transgender community, both transmen and transwomen. Nevertheless, this service only available in big cities such as Jakarta, Surabaya, and Malang. The cost is also high because this service is not covered by insurance, including BPJS insurance. Moreover, healthcare worker and health institution is still bias and do discriminative action because of biased understanding. It caused many community member accessed hormones through dark market, using medicine that supposed to be used for different purpose (such as birth control pills), and through senior transgender. It was documented that one case in 2012 and four cases in 2015 in which transgender women dead because of silicon injection treatment without doctor supervision.

Recommendations:

- Encourage medical workers to diagnose people with sexual and gender diversity without bias to those who are in need of medical treatment, and applied non-discriminative health service on every basis, including SOGIESC,
- Encourage the Government to provide informations related to access to healthcare, particularly on SOGIESC for every citizens equally, and;
- Demand the State to illegalize every conversion therapy for LGBTI community.

V. Other Concern Issues

Water and Satination

85. The documents of the Health Research created the Ministry of Health showed, still high proportion of households do not have access or sources of drinking water, which is 33.2 percent (36 percent urban and 30.6 percent rural). There are 5 provinces a very high proportion of households do not have access to drinking water sources, namely Riau Islands (76.0%), East Kalimantan (64.8%), Bangka Belitung (55.7), Riau (54.5%) and Papua. In the physical qualities, there are households with quality drinking water turbid (3.3%), color (1.6%), taste (2.6%), foamed (0.5%) and smelled (1.4 %). By province, the highest proportion of households with drinking water is murky in Papua (15.7%), colored in Papua (6.6%), taste in South Kalimantan (9.1%), foaming and smelled in Aceh (1, 2%, and 3.8%).

86. In addition to the availability of drinking water, Indonesia is also still facing the problem of access to sanitation. There are still 12.9 per cent of households that do not have the facilities to defecate (BAB) and therefore defecation. There are five provinces fairly high proportion of households that do not have the facilities BAB, namely West Sulawesi (34.4%), NTB (29.3%), Central Sulawesi (28.2%), Papua (27.9%) and Gorontalo (24.1%).

Legal access and rehabilitation for malpractice victims

87. There are several malpractice cases happened, even though most of it did not arose in public. Patient as victims of neglectful doctors or hospital always have hardships in suing

hospital or doctors' responsibility, because patient oftentimes don't have strong evidence that shows the responsibility of hospital or to evaluate whether the suffering was indeed malpractice.

88. Complaints basically can be admitted to Doctors' Honor and Discipline Assembly in Indonesia (MKDKI), but patients is often get hardships because of slow response and MDKI's investigation is non-adjudication and closed from public. According to the LBH Jakarta experience, slow response from MDKI was caused by very little honor assembly members in handling complaint cases, and not every province has MKDKI so that every complaint and its settlement is still centralized in DKI Jakarta.

89. Patient can submit a civil action or go through criminal justice system with police report. However Indonesian court still refers to MKDKI assessment before deciding if patient have rights for settlement or rehabilitation of loss because of medical neglect.

Tobacco Control

90. Indonesia currently is number three countries with the most cigarette smoker, after China and India. With less than 90 millions cigarette smoker, Indonesia has the highest prevalence of adult male smoker in the world (66 percent), in which 1 every 3 adult man are smoker.¹⁰ Meanwhile, the amount of cigarette-smoking adult woman also tripled in the last 12 years, from 1,3 percent in 2001 to 6,7 percent in 2013.¹¹ More than 58,4 percent people started smoking when they were under 15 years old.¹²

91. Trend shows that the smoking age is getting younger, where 10-14 year age category of smoking initiation rose from 9,5 percent in 2001 to 17,6 percent in 2010.¹³ Every year, smoking pandemic kills more than 244 thousand people and affecting millions of smokers' families.¹⁴

92. Ministry of Health noted the loss because of cigarettes reached IDR 378 trillions, which comes from money spent buying cigarettes IDR 138 trillion and the loss of productivity because of illness, disability, and premature death in young age as much as IDR 235,4 trillion, and the treatment cost for tobacco related illnesses IDR 5,35 trillion.¹⁵

93. To date Indonesia is the only Asian country that have not access Framework Convention on Tobacco Control (FCTC). Nevertheless, Indonesia already regulated tobacco issue in many domestic regulation, inter alia, Law No. 39 of 2009 on Health and Government Regulation No. 109 of 2012 that regulate seven non-smoking areas, 40 percent health warning with pictures, and limited cigarette sponsor regulation. Other regulation are Law No. 32 of 2002 on Broadcasting and Law No. 40 of 1999 on Press that regulate limitation of cigarette ads in broadcasted and printed media. Advertising in broadcasted media cannot shows cigarette or cigarette-smoking person and the broadcast is limited from 10.30 at night to 05.00 in the morning. Indonesian government also routinely regulate the policy on cigarette price through Fiscal Policy Agency (BKF) and Ministry of Finance that raise the price of cigarette and cigarette tax.

Recommendations:

- Recommend to Indonesian government and parliament (DPR) to ratify the FCTC
- Encourage total banning to every kind of promotion and advertising of cigarettes and its derivative.
- Increase cigarette price and tax, increase health warning pictures and provide service to stop smoking

¹⁰ Tobacco Atlas Fifth Edition, 2015

¹¹ SKRT 2001 and Riskesdas 2013

¹² Riskesdas 2013

¹³ SKRT 2001 and Riskesdas 2010

¹⁴ Global Burden of Disease (GBD) 2013. Seattle, WA: Institute for Health Metrics and Evaluation (IHME), University of Washington; 2015. Available from: vizhub.healthdata.org/gbd-compare/

¹⁵ <http://health.kompas.com/read/2015/12/18/161900223/Kerugian.akibat.Rokok.3.7.Kali.Lebih.Besar.Di>

- Stop the development and establishment of Bill of Tobacco

ENDNOTE:

ⁱ Recipient of KIS-PBI is free according to Ministry of Health Decree No. 903/MENKES/PER/V/2011 on Health Benefits Program Implementation Guidance (Preface and Implementing Agency Chapters), the Ministry of Health Decree is in accordance with Government Regulation No. 101 of 2012, the state's contribution for poor groups and Presidential Decree No. 111 of 2013 that state's contribution has to be increased for health subsidy.

ⁱⁱ <http://posstore.com/2016/12/28/survei-cepat-djsn-peserta-jkn-baru-mencapai-6633/>

ⁱⁱⁱ BPJS Watch (“Temuan BPJS Watch, dari Pasien Disuruh Beli Obat Hingga Darah”, *Republika*, January 6th 2016, <http://nasional.republika.co.id/berita/nasional/umum/16/01/06/o0hrck330-temuan-bpjs-watch-dari-pasien-disuruh-beli-obat-hingga-darah>)

^{iv} “BPK Menyerahkan Laporan Audit Kinerja BPJS Kesehatan”, March 30th 2016, <http://www.bpk.go.id/news/bpk-menyerahkan-laporan-audit-kinerja-bpjs-kesehatan>; “Layanan BPJS Kesehatan Buruk Sesuai Hasil Audit BPK”, *Inilah.com*, April 13th 2016, accessed from <http://ekonomi.inilah.com/read/detail/2287750/layanan-bpjs-kesehatan-buruk-sesuai-audit-bpk>; look also, “Hasil Audit BPK, BPJS Kesehatan Bermasalah”, June 15th 2014 accessed from <http://www.jpnn.com/news/hasil-audit-bpk-bpjs-kesehatan-bermasalah>

^v Minutes of Hearing Indonesian Parliament (DPR) year 2015 – 2016, p. 35

^{vi} “Survey of the Implementation of Indonesia’s National Insurance Scheme: Knowledge, Perception and Experiences of the Poorest Households related to Maternal and Child Health” Survey of the Implementation of Indonesia’s National Insurance Scheme: Knowledge, Perception and Experiences of the Poorest Households related to Maternal and Child Health. PKBI-GKIA. 2016

Figure 1 Respondents profile

City	Frequency	Percentage
West Jakarta	140	17.2
Central Jakarta	170	20.9
South Jakarta	178	21.8
East Jakarta	152	18.7
North Jakarta	175	21.5
Total	815	100

^{vii} BPJS Watch (“Temuan BPJS Watch, dari Pasien Disuruh Beli Obat Hingga Darah”, *Republika*, January 6th 2016 <http://nasional.republika.co.id/berita/nasional/umum/16/01/06/o0hrck330-temuan-bpjs-watch-dari-pasien-disuruh-beli-obat-hingga-darah>)

^{viii} <http://www.jpnn.com/news/hasil-audit-bpk-bpjs-kesehatan-bermasalah>

^{ix} <http://infopublik.id/read/169509/bpjs-watch-kasus-rizky-akbar-adalah-kelalaian-rs.html>

^x Those 14 indicators are 1) residential area less than 8 m² per person; 2) the floor is dirt/bamboo/cheap wooden floor; 3) the wall is made from bamboo/sago palm/low quality wood without plaster; 4) no bathroom; 5) no electricity; 6) water came from unprotected water source; 7) cooking fuel from wood/charcoal/kerosene; 8) only consume meat/milk/chicken once a week; 9) only buy one set of clothes a year; 10) can only eat two or three times everyday; 11) cannot pay for health

services; 12) family head's livelihood is farmer with 500m² farming area, farm labour, fisher, construction worker, plantation labour, and/or other work with salary lower than IDR 600.000 each month; 13) family head highest education is unfinished elementary school/junior high school; 14) do not have savings or easy to sell belongings with price as high as IDR 500.000 such as gold, motorcycle, or anything else. If 9 out of 14 indicators are fulfilled, the family is categorized as poor family.

^{xi} The findings were found in Jakarta, for example BPJS Rawamangun rejected data updates for KIS-Mandiri members that became poor and have unpaid bills. Local government, for example Puskesmas Kelurahan Cililitan, Kramat Jati District, East Jakarta; and BPJS Pancoran, Pasar Minggu, South Jakarta; data update rejection also happens to officials in Kampung Pitara RW 013 Kelurahan Pancoran Mas, Pancoran Mas District, Depok City, West Java Province, and Bogor. So that many people cannot access JKN-KIS.

^{xii} Research on National Health Insurance in 5 villages, 3 provinces, also done in 2014; AGBK research Phase I in 6 villages/kelurahan and 6 provinces; and assessment of JKIN in North Lombok Regency.

^{xiii} Poor and in need people categories are:

• **Registered poor and in need people.** The criteria for poor and in need people that registered according to Minister of Social Affairs Decree No. 146 of 2013 is households who:

1. Do not have livelihood and/or have livelihood but cannot fulfill basic needs;
2. Expenses mostly spent for very simple staple food consumption;
3. Cannot or unable to go to health workers, except Puskesmas or other subsidized facility;
4. Unable to buy clothes once a year for every family member; and
5. Can only educate their child until Junior High School;
6. House's wall is made from bamboo/wood/cement with bad condition/low quality including woen or unplastered wall;
7. Floor is made from dirt or wood/cement/ceramic with bad condition/low quality;
8. Roofs are made by straws/sago palm or roof tile/iron sheeting/asbestos with bad condition/low quality;
9. Have lightning but not from electricity or electricity without gauge;
10. House's are less than 8 m²/orang; and
11. Have water that came from unprotected water source/river/rain water/other

• **Unregistered poor and in need people** in Social Welfare Institutions or outside, which are:

1. Homeless;
2. Beggar;
3. Individuals from remote indigenous community;
4. Socially and economically vulnerable women;
5. Victims of violence;
6. Migrant workers with social problems;
7. Poor people because of natural and social disaster after the emergency until 1 (one) year after the disaster;
8. Individual recipient of Social Welfare Institutions benefits;
9. Detention centers/prisons residents;
10. Thalassaemia major patients;
11. Adverse Events Following Immunization patients;

^{xiv} Migrant Workers Network (JBM) Indonesia and Solidaritas Perempuan (SP) data

^{xv} Governor of Yogyakarta Regulation No. 51 of 2013 on Health Insurance for the Persons with Disabilities is implemented with the Governor Decree which stated names and data of the persons with disabilities who are entitled to receive services.

^{xvi} Komnas Perempuan, *Laporan Hasil Pemantauan tentang Diskriminasi dan Kekerasan Perempuan dalam Konteks Kebebasan Beragama atau Berkeyakinan*, (Jakarta: Komnas Perempuan, 2016), h. 45 & 58

^{xvii} The research of the Gender Study Center of Universitas Indonesia in 2015 states that the number of child marriages in Indonesia ranks second in Southeast Asia. Approximately 2 million of the 7.3 million female children in Indonesia get married under the age of 15 years old and their

dropping out of school follows this. The 2014 data of the Central Bureau of Statistics recorded 911,644 child marriages and it is estimated that this number will go up to 3 million in 2030. Indonesian Coalition to Stop Child Marriages (Koalisi 18+) identified 377 marriage dispensation petitions in the Religious Courts in the District of Bogor- East Java, Tuban-East Java, and Mamuju-West Sulawesi in the period of 2013-2015. A Total of 367 of the 377 applications for obtaining dispensation approved by the Religious Courts for marriage of girls at the age of 10 -15 years. Most of these marriages are forced marriages

^{xviii} Ikatan Perempuan Positif Indonesia (IPPI)

^{xix} Article (481) RKUHP stated that, *"Any person who unlawfully and explicitly demonstrate a tool to prevent pregnancy, explicitly or unsolicitedly offers, or explicitly broadcast writings without being asked, showing to be able to obtain birth control, shall be punished by a fine of Category I "*.

While Article (483) RKUHP stated that *"Not convicted, any person who commits acts as referred to in Article 481 and Article 482 if it was committed an authorized officer in the implementation of family planning and prevention of infectious diseases"*.

^{xx} If the articles remain unrevised during the review by the House of Representatives, it will interfere and threaten: Firstly, the philosophy of family planning and reproductive health programs in Indonesia. It is important for all of society's elements, starting from the government, private sectors, NGOs, religious leaders and public figures to take part in supporting the family planning and reproductive health programs. Therefore, the reduction of this element will lead to program failure in general. The importance of people's involvement in Family Planning and reproductive health programs has already been acknowledged by the government through Law Number 52 / 2009 on Population Development and Family Development, Chapter X on People's involvement.

Secondly, the articles will threaten and interfere with the access to Family Planning and reproductive health information. The use of contraceptive tools in Indonesia has increased more than two-fold since 2006. This shows not only that awareness in using contraceptive tools has been improved but also the knowledge on the use of contraception. The increase also gives a significant support to Family Planning and reproductive health programs in Indonesia. In Indonesia, Family Planning and reproductive health program implementation has been supported and stipulated by Health Law Number 36 / 2009, in particular reproductive health chapter and the Presidential Regulation (PP) 61 / 2014 which states that everyone is entitled to communication, information and education on family planning in accordance with the needs based on the human life cycle. The presidential regulation also mentions that the provision of contraceptive services including the provision of human resources, logistics, funding and contraceptive tools is no longer the government's sole responsibility.

Thirdly, the article will also interfere with the contribution of modern contraception use. Whereas the number of contraception use especially modern contraceptive tools becomes an important factor in measuring the success of Family Planning and reproductive health programs in Indonesia.

Lastly, in relation to HIV and AIDS as well as STDs, the articles will threaten the life of Indonesian people. As we know, Indonesia still has to work hard in preventing STDs. IDHS 2012 shows that people gained information on reproductive health mainly from private institutions such as television, radio, magazines, newspapers. Meanwhile, people only gained 17% information on reproductive health and 8% information on HIV AIDS from health workers.

^{xxi} Shackle: is the act of physical deprivation which mainly done for those who have psychosocial disabilities. Physical deprivation can be in a form of hand or foot cuffing with wood beam, chain, or put into isolated room. This act can be lasted for weeks until decades even more for a lifetime. Shackled person shall eat, drink, sleep, urinate and defecate on the same place. Shackling can be done by the family in their home, by the private or public shelter management, or in the traditional medicine stalls. In the context of Indonesia, shackling could be happened because of; a) almost no access of proper medical, social and economic services for the person with psychosocial disability; b) this also caused by the lack of information dissemination for public on the issue of psychosocial disabilities; c) stigma on mental health problems which cause the family feels ashamed to cope with the problems; d) medical services, medicines with the low-side effect is not available on the level of Puskesmas/village. While, most of the people who were shackled is on villages. In order to be able to access medics, the victim should go to hundreds kilometer regency hospital. Even if it available in Puskesmas or village, it will be the high-side effect drugs and plentiful tablets, which person with mental health problem will

refuse to use it; e) social services such as rehabilitation, assistance for education and jobs, is not available at all; f) Public or private psychosocial shelters in Indonesia are still using the prison approaches. The occupants are isolated and not allowed to go outside. Inhuman treatment such as shaving hair is a common even for the women with psychosocial disabilities; g) myths that person with mental health disabilities is caused by mysticisms.

xxii *Monitoring Data of Galuh Foundation in Bekasi, West Java and Human Rights Watch on 2015*

xxiii <http://www.cnnindonesia.com/gaya-hidup/20161201085012-255-176502/jalan-panjang-odha-meretas-stigma-dan-diskriminasi/>

xxiv Bali Regional Regulation No. 3 of 2006 on HIV/AIDS Countermeasures Article 27, and Cilacap Regency Regional Regulation No. 2 of 2015 on HIV/AIDS Countermeasures Article 21 and 20, and Bogor City Regional Regulation No. 4 of 2016 Article 13

xxv ...

xxvi LBH Masyarakat, 'Trip to Nobody Knows Where: Examining the Effectiveness of Indonesia's Compulsory Report Program for Drug Users and Its Compliance to the International Human Rights Standards', March 2016, pp. 18 – 20. Available here: http://lbhmasyarakat.org/wp-content/uploads/2016/04/310316_IPWL-Research-Report_LBHM_Mainline.pdf

xxvii Supreme Court Circular Letter No. 7 of 2009

xxviii LBH Masyarakat, 'Di Ujung Palu Hakim: Dokumentasi Putusan Rehabilitasi di Jabodetabek', March 2016, p. 19, http://lbhmasyarakat.org/wp-content/uploads/2016/04/Di-Ujung-Palu-Hakim-Dokumentasi-Putusan-Rehabilitasi-di-Jabodetabek-2014_LBH-Masyarakat.pdf.

xxix Ministry of Health Decree No. 290/Menkes/Per/III/2008, Article 13 jo. 1 (7)

xxx <http://www.suarapembaruan.com>, October 11, 2013

xxxi Based on the The Institute of Ecosoc Rights Institute, 2016.

xxxii <http://www.suluhpapua.com>, August 29, 2013; (<http://bintangpapua.com>, February 18, 2013)

xxxiii National Commission on Human Rights, referring to Molecular Biology Institute (LBM) Eijkman Institute together with Indonesian Conservation Community (KKI) Warsi.

xxxiv "Komnas HAM: Kesehatan Masyarakat Adat Tak Terjamin", June 14th 2016, <http://www.cnnindonesia.com/nasional/20160614144110-20-138096/komnas-ham-kesehatan-masyarakat-adat-tak-terjamin/>

xxxv National Commission on Human Rights, National Tradition Inquiry, p. 65, book I

xxxvi National Commission on Human Rights, National Tradition Inquiry, p. 241, book III; Quotes from one of indigenous community:

"Traditional medicines is harder to get. Traditional medicines for deep wound and neutralizer for venomous animal bites. Many other medicines are very useful for Punan indigenous community. Meanwhile, our settlement was 50 km away from the puskesmas. Now, the village is 7 km away from the puskesmas," he adds. "Health officers actually exist in Punan Dulau villages, but they are not active everyday, but only twice a week. The facility is also very minimum. Alternatively, if villagers are sick and bought medicines from nearby kiosk with IDR 1000/tablet. It is too pricey for Punan people."

xxxvii "My infant child was once have skin issues, ulcers and itchy skin after they took a bath in the river despite the water looked clean when I was there. After that I never took my child to bathe in Nayan River," Ibu Layen said. This pollution also indicates environmental changes. River water is not eligible to be drunk like it was in the past. (book III 197)

xxxviii National Commission on Human Rights, National Tradition Inquiry, 40-41

^{xxxix} National Commission on Human Rights, National Tradition Inquiry, p. 541, book III, look also, "Masyarakat Adat Matteko, Berjuang Mengembalikan Hutan yang Terampas", *Mongabay Indonesia*, July 30th 2013 accessed from <http://www.mongabay.co.id/2013/07/30/masyarakat-adat-matteko-berjuang-mengembalikan-hutan-yang-terampas/>

^{xl} Based on SUAKA and HRWG's research on the situation of Rohingya communities in Indonesia (2016).

^{xli} PerMaTa Indonesia assistance result, leprosy disability organization in Kupang, NTT.

^{xlii} According to the survey of *Cerebral Palsy* Family Association or Wahana Keluarga Cerebral Palsy (WKCP) in 2013, treatment cost for children with CP in a month are:

	Mininum/ month(IDR)	Satisfying minimum requirement (IDR) / month (IDR)	Minimum necessary tools (IDR)
Doctor consultation	60.000	100.000	
Topomak, trileptal, noprenia medicines	600.000	1.200.000	
Therapies: - Physiotherapy - Sensointgrasi - Occupation - Tw	60.000x8 60.000x8	60.000x4 60.000x4 60.000x4 75.000x4	
Supporting tools for therapy: - wheelchair - walker - avo - matrass - backsleep - bolster pillow			1.200.000 600.000 400.000 1.000.000 400.000 200.000
Total	1.620.000/month	2.320.000/month	3.800.000

Source: WKCP Yogyakarta, 2013