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Stakeholder Submission

Jointly submitted by

The Civil Society Coalition

on

Sexual and Reproductive

Health and Rights (SRHR)

Represented by the following organizations:

Institute for Women's Human Rights (IHAP); Women's Health Foundation (YKP); Women's Health Education Foundation (YPKP); Samsara & Women on Web.

Key Words/ Phrases: Sexual and Reproductive Health and Rights (SRHR); Women's Rights; The Right to Basic Health; Gender Discrimination; Access to contraception; Abortion; Criminalization of health, education & service providers.

A. Executive Summary

1. This submission of the Indonesian Civil Society Coalition on SRHR addresses concerns about Indonesia's compliance with its international human rights obligations related to SRHR. This report focuses on three key issues: 1) Lack of access to contraception for married and unmarried women; 2) Criminalization of abortion services; and 3) Criminalization of education and service providers who provide information, education, or advice related to contraception and abortion. All issues are interrelated to each other as lack of access to contraception leads to unwanted pregnancies which then leads to unsafe abortions. Criminalization of professionals who provide education, information or advice relating to contraception compromises the ability of professionals to disseminate appropriate information and provide services on sexual and reproductive health. The impact of denied access to SRHR to girls and women can be detrimental and is pervasive. We recommend that the Indonesian government revise the legal provisions governing access to information and services related to contraception and abortion.

B. Methodology

2. This submission is drafted by the Indonesian Civil Society Coalition on SRHR consisting of 5 national and international NGOs in Indonesia. These include: Women's Human Rights (IHAP); Women's Health Foundation (YKP); Women's Health Education Foundation (YPKP); Samsara & Women on Web. All the organizations in this coalition work in the area of SRHR in Indonesia. The data and supporting evidence for this report have been compiled using three key primary sources: 1) Database and yearly reports of NGOs in this coalition; 2) Focus group discussions and interviews with professionals, community health workers and other small scale grass roots organizations working in SRHR in Indonesia; 3) Case studies of human rights violations documented by the organizations in this coalition. The secondary sources used for this report range from statistics and publications issued by government Ministries in Indonesia, articles published in the mainstream national and international media and reports published by NGOs.

C. Progress and gaps in the implementation of recommendations

3. This coalition acknowledges the efforts of the Indonesian government for taking a number of steps to implement some reforms relating to SRHR which it committed to in the previous UPR. However, the government has yet to work towards implementing these recommendations.
4. During the previous UPR cycle, the government of Indonesia accepted recommendations made by Spain[i] to completely eliminate all legal and political provisions which discriminate against women and violate their sexual and reproductive rights. The recommendation made by Belgium[ii] to provide universal access to education, family planning and reproductive health for young women was also accepted. The recommendations made by Cuba[iii] to strengthen programs and initiatives aimed at guaranteeing the right to health and in particular reducing maternal

mortality were also accepted. There were a total of thirteen recommendations relating to the three key issues discussed in this report that were made to Indonesia during the previous UPR cycle. The government of Indonesia has accepted all of these recommendations. However, many of the key recommendations that Indonesia committed to implement have remained largely unaddressed.

5. In line with Spain's recommendation[iv], the Ministry of Women Empowerment and Child Protection, in their 2015-2019 Strategic Plan mention that they will draft, review, correct and harmonize nine policies. The Ministry focuses on the establishment and strengthening of institutions and mechanism to handle cases of violence against women and children from the national to the local levels. Unfortunately, they have not mentioned anything about abolishing the 389 policies that discriminate women.
6. In line with Belgium's recommendation[v], the National Family Planning Board, in their 2015-2019 Strategic Plan mentions: 1). Provision of contraception information and services to married couple as strategy to control population growth, 2). Decreasing the birth rates in adolescent girls aged 15-19 years old in order to prevent abortion, and, 3). Decreasing unwanted pregnancy rates among married couples. However in their strategic plan, The National Family Planning Board did not mention anything related to the provision of information and contraception access for unmarried couples or teenagers. Regarding adolescent reproductive health issues, the National Family Planning Board focusses on their "GENRE" programme through the tagline "say no to early marriage, no sex before marriage and no drugs."
7. In their 2015-2019 Strategic Plan, the Ministry of Education guarantee education to all, with particular emphasis on children with special needs, children in the outer, rural and remotes areas, ethnic minorities and children in post-conflict areas. The Ministry of Education did however not mention anything about sexual and reproductive health education and also doesn't guarantee continuous education for girls of school going age who become pregnant or get married.
8. In line with Cuba's recommendation[vi], the Ministry of Health in their 2015-2019 Strategic Plan aims to make 45% of all health services youth friendly. However the Ministry of Health did not mention anything in their Strategic Plan, on guarantee of the provision of information and access on contraception for young people as well as the information and services on safe abortion for women and girls under medical emergency and pregnancy due to the rape, as mentioned in the Government Policy No.61/2014 on Reproductive Health.

D. Background: Legal & Institutional Framework

9. The sexual and reproductive health and rights of women and girls have been recognized and guaranteed as human rights by the government of Indonesia in The Constitution, Art (28)(H)(10) and in the Human Rights Law No. 39/1999, Arts. (45) and (49)(3). These rights are in line with The Universal Declaration of Human Rights, Art. (2); ICPD Cairo 1994 Plan of Action and The Beijing Platform (1995), Arts. (14), (17) and Arts. (29) – Arts. (31). However, the rights guaranteed under the Constitution of Indonesia and the Human Rights Law are thwarted by other legislation and regulations which violate the rights of women and girls to access basic health and to be free from discrimination.

Issue 1: Restrictions on access to contraception.

10. Currently, married women in Indonesia cannot legally access contraception without the permission of their husband. For unmarried women, access to contraception remains illegal. The Health Law No.36/2009 Art. (72), states that access to sexual and reproductive health services may only be given to 'legal partners' under religious norms. 'Legal partners' refers to married heterosexual couples. Art. (78) states that a health service provider is only permitted to provide contraceptives to married couples. The Ministry of Health Regulation no61/2014, Art. (22) states that contraception can only be given to married women with the consent of husband. The Law on Population and Family Development, Art. (21) states that only married women can have access to contraceptives. Arts. (21-25) of this legislation further emphasize that the duty of the state to provide SRHR services only applies to married persons.
11. The Health Law 36/2009, Art. (72) states that every person shall be entitled to obtain information, education and counselling on sexual and reproductive health; to have healthy and safe reproductive and sexual lives; to determine their reproductive life; to determine on their own when and how often they want to reproduce; be medically healthy; be free from discrimination, compulsion and/or violence from legal partner under religious norms. However, The inclusion of *'religious norms'* in this legislation is used as a blanket excuse to deny women's and girls access to health services and justify violations of the rights of women to basic health.
12. There are also contradictions between the Ministry of Health Regulation 61/2014, Art. (11) & Art. (26) and Arts. (22) & (23). Art. (11) states that youth friendly services are given to prevent and protect young people from risks related to their sexual and reproductive health. Art. (26) states that every woman has the right to exercise her sexual and reproductive health without discrimination, fear, shame and guilt. However, Arts. (22) and (23) state that contraception is given solely to married women under agreement and permission of her husband. These contradictions and lack of synchronicity between different Articles of the same Regulation fail to recognise the sexual and reproductive rights of women as basic human rights irrespective of their marital status.
13. The existing legal and regulatory framework governing access to contraception is reinforced by vigorous political campaigns which pit religious and moral norms against basic human rights. As a result of the hostile position taken by the Indonesian state towards access to contraception, women and girls across Indonesia face serious obstacles in accessing their rights to basic health. In 2015, the Indonesian government submitted a draft amendment of the Penal Code to Commission III of the House of Representatives recommending the criminalization of condom sales in supermarkets and minimarts[vii]. This proposed amendment has received opposition from Civil Society Organizations (CSOs) and there is currently an online petition to prevent this amendment from being passed on Change.org.[viii] In 2015, the government district of Luwu in South Sulawesi province released a decree which restricts the sale of condoms in supermarkets and minimarts.[ix] In 2016, the *Wilayatul Hisbah* (civil service police responsible for executing Sharia Law) conducted raids on supermarkets and minimarts that sold condoms.
14. In 2013 the Ministry of Health (MoH) launched a national program to promote condom use as a prevention strategy for STI's and HIV aimed at high risk

populations.[x] In opposition to this program, the Vice Chairman of the House of Representatives stated that a national campaign on contraception is not an urgent issue. He also emphasized that this campaign will legitimize premarital sex amongst the youth, which is a violation of religious norms. In response to these political pressures, the MoH revised its position and stated that this program would not provide condoms for young people, despite having previously identified them as a high risk group. Instead, the MoH encouraged religious leaders, civil society and education providers to protect young people by strengthening their religious values.

Issue 2: Criminalization of Abortion

15. The Law on Population and Family Development 52/2009, explicitly states that abortion is illegal. Under the Health Law, Arts. (75) & (76), abortion is only permitted under two conditions: 1) In proven cases of rape; and 2) if the pregnancy poses serious risks to the health of the pregnant woman and the foetus. Outside these two stringent provisions, abortion is illegal in Indonesia. The Penal Code, Art (346) restricts abortion and criminalises women who seek abortion. The Penal code also criminalizes people who assist women seeking abortion information or services under or without her permission, Arts (347) & (348); people who provide information and giving advice on abortion services, Art (299) and health service providers who provide abortion services, Art (349).

Issue 3: Criminalization of information and health service providers.

16. The Health Law, 36/2009, Arts. (135-137) state that it is the government's responsibility to provide information, education and services to young people as long as it is not against moral or religious norms. This prevents NGOs and other grass roots/ community based organisations from providing information, education or advice related to contraception or abortion. Subsequently, health service providers cannot provide family planning services for unmarried women despite the high demand for contraception. 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.

E. International Obligations

17. The existing legislative and regulatory framework in Indonesia prevents women from accessing their sexual and reproductive rights on two key grounds: 1) These laws discriminate against women on grounds of gender; and 2) These laws deny women their right to basic health. Women and girls are disproportionately affected by the state's restrictions on sexual and reproductive rights because they can become pregnant and must bear the negative consequences resulting from unwanted pregnancies. Women and girls are also disproportionately affected by these laws due

to gender based stereotypes on sexuality. Consequently, women are exposed to health and social risks not experienced by men. The existing legislative and regulatory framework in Indonesia governing sexual and reproductive health of women are in direct violation of Indonesia's obligations under numerous international human rights treaties which it has signed and ratified.

18. The right to gender equality is a fundamental tenet of human rights. Denying women access to contraception and abortion is a form of gender discrimination. The right to equality and freedom from gender discrimination is guaranteed under Art 2 of the Universal Declaration of Human Rights (UDHR). These rights are reiterated and further entrenched in Art. 2.1 & Art. 3 of the International Covenant on Civil and Political Rights (ICESCR); and Art. 2.2 & Art. 3 of the International Covenant on Economic, Social and Cultural Rights (ICCPR).
19. The right to health is also outlined under several international human rights instruments. Lack of access to contraception and the criminalization of abortion exposes women to unsafe abortion, thereby placing their physical and emotional health under risk. The right to health is guaranteed under Article 25 of the UDHR. Art. 12 of ICESCR guarantees women the right to highest attainable standard of physical and mental health. The Committee on Economic Social and Cultural Rights has formally recognized the right to health to include access to safe and legal abortion.[xi] The Convention on Elimination of All forms of Discrimination against Women (CEDAW) further grants women the rights to decide the number and spacing of their children in Art. 16. This is also noted down in the Sustainable Development Goals (SDGs) in particularly in goal 3.7 and 5.6 spelling out universal access to SRH.[xii]

F. Impact of these laws

Issue 1: Lack of access to contraception.

20. Lack of access to contraception renders unmarried women more vulnerable to unplanned and unwanted pregnancies and sexually transmitted infections. Married women who are unable to get permission of their husband are denied the right to exercise choice and control over their fertility, the number of children and the spacing between births. The Indonesian Demographic & Health Survey 2012 found that 11.2 percent of those surveyed reported an unmet need for contraception. This figure increased to 14.87 percent in 2014. The National Population & Family Planning Board (BKKBN) stated that there are 2.5 million cases of abortion in Indonesia every year, young and unmarried women account for 80,000 of these cases[xiii]. The MoH stated in 2015 that 5,990 or 19.4% of the population affected by HIV are young people between 15-24 years old.[xiv]
21. Unmarried women in Indonesia experience further discrimination when accessing sexual and reproductive health services. When they do become pregnant unintentionally and the pregnancy is unwanted, women and girls are left with limited choices to either go through with the pregnancy against their will or seek unsafe abortion. The criminalization of abortion in most circumstances perpetuates the stigmatization of women's and girls' sexuality and is rooted in narrow and patriarchal attitudes. This stigmatization can be attributed to narrow and conservative attitudes

towards women's sexuality. Women's sexuality is stereotyped according to gender roles and it is defined primarily in terms of marriage and motherhood. Women who become pregnant and have children are expected to be married. Virginity is highly valued and pregnancy outside of marriage is considered to be a signifier of poor character and low morals. These negative attitudes and perceptions compromise the ability of women to continue education and receive suitable employment and/or marriage prospects. The stigma associated with pregnancy outside of marriage can also stop women and girls from pursuing education. A reported case study that highlights some of these issues is the highly publicized case of an unmarried girl in the province of East Nusa Tenggara who was refused access to counselling and contraception services.[xv] The doctor announced her case to national media, exposing her identity. She was publicly shamed and she dropped out of university due to the stigma and social pressure that she faced in her community and place of education.

22. Unmarried girls and women who are unable to terminate unwanted pregnancies also face discrimination in accessing prenatal, antenatal and postnatal health care. They are vulnerable to discrimination at the hands of community health workers and may not access health care during and after their pregnancy.[xvi] Reducing the stigma associated with premarital sex for women is crucial to ensuring that they receive adequate health care before, during and after their pregnancy. The right of unmarried women to exercise choice and control over their fertility and reproductive health and protect themselves from disease is not protected by the Indonesian state.

Issue 2: Criminalization of Abortion

23. Unsafe abortion exposes women to high risks of maternal mortality and maternal morbidity. Unsafe abortions can render women vulnerable to risks of hemorrhage, infection, sepsis, genital trauma and necrotic bowel. It also makes women vulnerable to risks of non- fatal, long term health complications such as infertility, reproductive tract infections, infertility, internal organ injury, bowel resections, rectovaginal fistulas, etc. Unsafe abortion also leads to loss of productivity and psychological suffering of women and girls which is difficult to measure.
24. As abortion is a criminal activity in Indonesia, there are no reliable and recently published sources which accurately specify the number of women who have abortion and the maternal mortality and morbidity rates associated with it. The Guttmacher Institute estimates approximately two million induced abortions each year in Indonesia. [xvii] The Guttmacher Institute has arrived at this estimation from small scale, urban, clinic based studies documenting women's experiences with abortion in Indonesia. This study does not capture women who induce abortions by themselves or with the help of traditional birth attendants. Keeping these facts in mind, the real abortion rates are likely to be much higher. While the data produced by this study is not nationally representative of the total number of unsafe abortions, the number of abortions that it has been able to document establishes that abortion is a common occurrence and that it often occurs under unsafe conditions. These findings indicate a high demand and the unmet need for safe abortion services.
25. Samsara's database specifies that of the 10,346 women that contacted the organization between 2011 and 2015, 24 percent were married women, 44 percent were unmarried

women and 32 percent did not wish to specify their marital status. Between the period of 2014- 2015, 1221 women accessed post abortion counselling services from Samsara which reflect the unmet need for psychological support and psychological well-being of women which is often overlooked when considering abortion.[xviii] The focus group discussions included other grass roots organizations who wish to remain anonymous due to the threat to their operations and the safety of their staff. One organization reported that it assisted 1493 women with safe abortion in 2015. Another grass roots organization that also took part in the focus group discussions reported servicing 140 women with safe abortion in 2015.

26. While abortion is legal for rape victims, the stringent requirements that must be satisfied in order for women to prove that they have been raped makes it very difficult for rape victims to access abortion. The Ministry of Health issued a new Regulation on abortion service, training and implementation on emergency medical conditions and rape. This regulation is not yet implemented because the government still needs to establish the necessary institutions and mechanisms. The data published by the National Commission on Violence Against Women indicates that rape is prevalent in Indonesia. In 2015 there were 1657 reported rape cases that occurred in the community domain and 2,399 rape cases that occurred in the family domain. This is a huge underestimation of the actual incidence of sexual violence as most goes unreported.
27. The data from *Samsara* and *Women on Web* shows that many rape survivors are looking for information related to unwanted pregnancy. In 2015, 41 of the 5168 women contacted both organization who identified themselves as victims of rape and were seeking information on unwanted pregnancies. While this number is relatively small, it does highlight the need for appropriate information on abortion for rape survivors.
28. The Health Law No 36, 2009 states that legal abortion services (on health grounds and in case of rape) can only be provided to women whose fetus is less than 6 gestational weeks. The problem with this qualification is that it can take longer for victims of rape to realize that they are pregnant. The cycle of menstrual regulation can vary broadly[xix]. The lack of comprehensive sexuality education in Indonesia means that many women are not aware of their cycle and often do not immediately realize that they are pregnant. The data from *Samsara* and *Women on Web* show that all the clients that reported rape and were seeking information about abortion were already over six weeks of gestational age.
29. Furthermore, The Health Law No 39, 2009 states that a rape survivor must report to the police and obtain proof from the doctor that she has been raped. The stigmatization of rape victims in Indonesia further compounds the psychological trauma experienced by rape victims and prevents them from reporting rape. The reporting procedure is not victim friendly and it is common for police officers to open the line of questioning by asking whether the sex was consensual.[xx] The negative and often hostile experiences surrounding the reporting procedure can discourage women from reporting rape. It is also common for victims not to report rape because of family pressure or fear of blame from their community.[xxi] Moreover, women require statement letters from investigators, psychologists and/or other experts related to the alleged rape as well as other documentation relating to counselling processes. These procedures are time consuming and take more than 6 weeks to process. Considering these factors, the 6

weeks gestational time limit required by the law sets an unrealistic legal standard for rape victims to be able to access safe abortion services to which they are entitled.

Issue 3: Criminalization of Information & Service Providers.

30. The criminalization of people who provide information, advice or services related to contraception and abortion prevents NGOs, human rights advocates and other workers outside of the government authorized bodies from supporting the Indonesian government to achieve sustainable and successful public health of the Indonesian people. These draconian laws compromise the ability of professionals working in the health and education systems from disseminating appropriate information on sexuality and reproduction. Moreover, the current legislative and regulatory framework also obstructs the Strategic Plan of the Ministry of Health[xxii] (2015-2019) to increase the public health status of all Indonesian people.
31. The data from the Supreme Court website[xxiii] between the period of 2012- 2016 shows that the Indonesian state has prosecuted 9 people who have helped women to access information about abortion or accompanied them through the process. However, the database system of the Supreme Court is currently still in progress and therefore not all the decisions of the Indonesian court have been published. Furthermore, not all of the courts in Indonesia have a database which publish all the decisions made by lesser Courts. The records that are currently available also show that 14 women have been prosecuted and imprisoned for getting abortion. Considering these facts, the statistics which show the number of women persecuted for abortion and the number of those who assist women with getting abortions are estimated to be much higher.
32. The focus group discussions and interviews of professionals working in the field of sexual and reproductive health and rights stated that they felt at risk of being arrested or their licenses revoked for providing information on contraceptives and abortion. The current legal and regulatory framework governing access to contraception and abortion renders health professionals uncertain about their rights and duties and makes them vulnerable to penalties from the state but also from husbands of clients. The community health workers in the focus group discussions noted several incidents when married women came in with written consent of husband to undergo birth control implants. They were then later confronted by the angry spouse who denied giving permission and threated to report them.

G. Recommendations

1) Repeal all laws including government, district and local regulations restricting unmarried women from accessing contraception.
2) Guarantee access to contraception for all women and girls in Indonesia, regardless of marital status, spousal or parental consent.
3) Decriminalize abortion in all circumstances for all women and girls by repealing all laws, legislation as well as all government, district and local regulations which prevent women from accessing safe abortion services, irrespective of their marital status.
4) Repeal all legislation as well as all government, district and local regulations which restrict women and girls from accessing information and advice related to their sexual and reproductive health.
5) Ensure that this law reform is consistent with Indonesia's obligations under the Constitution, ICPD Plan of Action, The Beijing Platform, CEDAW and other International human rights instruments related to women's rights and sexual and reproductive health & rights.
6) Adopt a national law to provide legal protection to health service, information and education providers so that they are able to disseminate appropriate information, advice and services regarding sexual and reproductive health.
7) Publicly support the work of human rights advocates, NGOs and other professionals and organizations who promote and provide sexual and reproductive health information and services.
8) Enable health workers and other related professionals to provide contraception to unmarried women within the state sponsored family planning programs.
9) Ensure that comprehensive reproductive and sexual health services are based on a rights based approach and a public health approach rather than moral and religious norms.
10) Ensure improvement of universal access to comprehensive sexuality education and reproductive health services for all women and girls in Indonesia inline with international standards by the next UPR cycle.
11) Launch awareness raising programs and campaigns which help to combat the stigma and discrimination associated with the sexual and reproductive health of women. These programs should establish sexual and reproductive health and rights as basic human rights. Special programs and campaigns should be developed and directed towards community health workers, the police and other professionals working with women and girls.
12) Establish government health programs and contribute to existing programs which enable unmarried pregnant women to access prenatal, antenatal and post-natal care free from discrimination and stigma.
13) Establish monitoring mechanisms which ensure that sexual and reproductive health programs are implemented free from discrimination.
14) Extend the time limit of 6 weeks to 12 weeks so that victims of sexual abuse can access abortion services that they are legally entitled to.
15) Strengthen inter departmental coordination and collaboration between government and CSOs including young people, marginalized groups and women in the planning,

implementation and evaluation of programs advancing comprehensive sexual and reproductive health and rights at national, district and local levels.

16) Improve the opportunities for CSOs and NGOs throughout the country to collaborate as equal partners in all stages of Indonesia's preparation for the UPR report. In preparation for its National Report in this review cycle, the government of Indonesia sent invitations to specific CSOs while excluding others from the opportunity to participate in the consultation process. Moreover, the consultation was only held in Jakarta which made it difficult for NGOs and CSOs outside of the capital to participate. In the future, it is recommended that the government hold consultations throughout Indonesia with open invitations to all CSOs and NGOs interested in participation.
17) Recommend that the government accepts all requests for Special Procedure visits to Indonesia and cooperate with the Office of High Commissioner for Human Rights (OHCHR).
18) The Government of Indonesia should request technical assistance from OHCHR to implement the recommendations from the UPR, the Treaty Bodies and other mechanisms to fulfill the human rights of women and girls to be free from discrimination and access basic health.

Annex 1

The Indonesian Civil Society Coalition on SRHR consists of 5 national and international NGOs in Indonesia: Institute for Women's Human Rights (IHAP), Women's Health Foundation (YKP), Women's Health Education Foundation (YPKP), Samsara and Women on Web.

IHAP is a national NGO in Indonesia, founded in 2004 to encourage structural awareness on sexual and reproductive health and rights for young people. YKP is a national NGO established in 2001 to promote universal access to sexual and reproductive health services for women. YPKP is an NGO established in 2003 to provide comprehensive education on sexual and reproductive health for midwives. Samsara is a national NGO in Indonesia established in 2008 to promote sexual and reproductive health and rights for women and young people. Samsara provides counselling services on unwanted pregnancy. Women on Web is an international NGO established in 2006 and works on providing online information and education on women's human rights as well as safe abortion.

Annex 2

CRIMINALIZATION OF HEALTH PROVIDER WHO PROVIDE INFORMATION ABOUT CONTRACEPTIVE AND ABORTION TO YOUNG PEOLE AND UNMARRIED WOMEN[1]

Interview Result

I. Informant A

1. **Did experience challenges/ obstacles when you were providing information about contraceptive and abortion for young people/ unmarried woman both in the community and in your health facility? Please explain!**

   The laws are the biggest challenges and obstacles for me to provide information about contraceptive and abortion for young people/unmarried women both in the community or my clinic. Moreover, the people and the communities also experience challenges and obstacle. For instance, some parents/people/community who feel reluctant/sceptic, protest given the content of information's provided, I could approach them by building good relations and communicating to them the importance of the information provision to young people and unmarried women. I try to build their perspective to be positive, although of course it took time. But, I can manage for that. Therefore, most of the time I forget or even didn't notice that I have a lot of challenges in providing this information. Especially while provided information to some peer groups, my closes friends, and my clients who have been in touch with me for several time.

2. **How are your feeling when you are providing the information to them? Please explain!**

   Overall I always feel alright and helpful towards them. Because, they really need the information and in some cases it helps save their life and their future.

3. **What kind of information/knowledge do you provide to them? Please explain?**

   It depends on their needs. But usually I provide information and education on contraception's and abortions. It always went deeper depend on the client's needs. For contraception's to abortion for example. I gave all the information about the methods, side effect, etc. I let them decided to choose and respect their decisions.

4. **Why did you think that you should provide that kinds of information?**

   Because it is a human rights, as simple as that! This kind of information are attached to the life of people, sexual reproductive life, and it also effects their future. Therefore, there's no reasons not to give these information to them. It's safe people's life!

5. **Have you ever given abortion service to young people and unmarried women who got unwanted pregnancy or refer them to the referral facility? Please explain!**

[1] Interview to 6 midwifes on the barriers that she faces in providing sexual and reproductive health services for women. The Interview conducted by member of The Coalition, during July – August 2016 in Jakarta and Yogyakarta.

I never gave abortion services, I just gave information and refer them to a facility that provides safe and friendly services.

6. **How was your feeling when you gave that kind of service? Please explain**
   I am worried and afraid! I feel like I will also jeopardize my family. I mean, if somehow I get caught or criminalized by the law, it will affect them (my family). But, I have to help these persons to get their rights for high quality services, which means helping to save people's life too. Therefore, I sometime forgot the dangerous of my work. Of course I need to keep myself save and build a very safe system by networking with friends or other professions who have the same frameworks like me around SRHR. Just to make sure to make the world a better place for everyone, especially vulnerable people.

7. **Have you ever heard that there was a health provider criminalized or got in trouble because providing information about contraceptive and abortion to young people and both married and unmarried women?**
   No, I never heard about a heath care provider being criminalized because they gave information about contraceptive and abortion to young people. However, the providers often get negative stigmatized from society and rejection. Even I and my friends (midwives) or NGO's friends are sometimes afraid just to give the information, especially about abortion. Because someone (from fundamentalist) can someday report us to the police. Therefore, we often feel insecure. Other cases, I have heard of some of doctors and midwives who have been criminalized and prosecuted because they help to refer or even help to do the abortion. It was on the news and this often discourages us (care provider) to refer or help women to have a safe abortion.

   About contraceptive, I have experienced one case where my client wanted to have IUD Copper-T as her contraceptive. But, actually she didn't get permission from her husband to use Copper-T as a contraceptive. Then, after I inserted the IUD and the client went home, the problem started. After, a few days, the client had sex with her husband, unfortunately while they had sex the husband felt the string of the IUD. Than the next day, my client's husband came to my clinic and he wanted me to remove the IUD, or if I did not do this he was threatening to report me to be prosecuted. This because I help her wife inserted IUD without his permission. These kind of cases are the obstacles for us as care provider to give the right services to our client. Therefore, some of my friends are reluctant to give contraceptive and abortion information or services, event to do referral.

II. Informant B

1. **Did you experience challenges/ obstacles in providing information about contraceptive and abortion for young people/ unmarried woman both in the community and in your health facility? Please explain!**
   I am often questioned about the reason why I do this. I feel a form of stigma in providing certain information and threated by the underlying the legal procedures.

2. **How are your feeling when you are providing the information for them? Please explain!** I feel helpless when there is no option left I can give for them.

3. **What kind of information/knowledge do you provide to them? Please explain?**
   Contraceptive: the varieties, what to expect, when to use it, sign of pregnancies. Abortion: medical abortion (how to use, what to expect, sign of complication, how to get the pills) and refer them to local help.

4. **Why did you think that you should provide that kinds of information?**
   There is a lot of misinformation about SRHR that risk people there health. It is because of the myths and stigma. Many women have tried unsafe abortion because of this. Moreover, many unwanted pregnancies happened since women and men and other gender do not get any sexual education.

5. **Have you ever give abortion service to young people and unmarried women who got unwanted pregnancy or refer them to the referral facility? Please explain!**
   I gave information about the medical abortion so it easier for them to access in this kind of society. The package of medical abortion can be sent to them as well after they fill in online consultation and approved by the doctor. The instruction is provided as well. If they are more than 10 weeks pregnant or have a sign of complication, they are suggested to go to local facilities.

6. **How was your feeling when you gave that kind of service? Please explain**
   I feel worried and helpless since there is not much that I can do after this procedure. Sometimes, they feel sad and guilty, some of them mentioned to suicide, because of the stigma. They want their story to be silent, so they also feel alone in this kind of situation. I am afraid as well that they get prosecuted.

III. Informant C

1. **Did you experience challenges/ obstacles when you are providing information about contraceptive and abortion for young people/ unmarried woman both in the community and in your health facility? Please explain!**
   I am getting challenges and obstacles on providing information about contraception and abortion for young people or unmarried woman. Related to the contraceptive information, the community tends to judge me as a bad person who is influencing the young people or unmarried women to do the free sex by using a condom or by telling them that contraception can be accessed by every person, married or unmarried. Finally, providing information about abortion has brought me to be judged as a murder. People always say that I am bringing people to the hell, that I am killing babies by providing information on safe abortion.

2. **How is your feeling when you are providing the information to them? Please explain!**
   Personally, I am always feeling good whenever I can provide them with comprehensive information about contraceptive and safe abortion. I can imagine how hard it is for those who are young and unmarried to get that kind of information, so if I can help I will do my best.

3. **What kind of information/knowledge do you provide to them? Please explain?**
   Information I provide starts from with what they are questioning and I try to provide the knowledge that can help in answering that question. If a question is related to abortion I provide information about the methods and I also emphasize a on a woman's right to decide in a case of an unwanted pregnancy. Through this information, I also encourage them that whatever their choices I will support them and provide them with the comprehensive information they need.

4. **Why did you think that you should provide that kinds of information?**
   I think I should provide these kinds of information because I have the knowledge and skill to provide it and because women need it.

5. **Had you ever given abortion service to young people and unmarried women who got unwanted pregnancy or refer them to the referral facility? Please explain!**
   Yes, I refer the women who are willing to get a surgical abortion to a friendly health facility but for medical abortion, I only provide information and counseling.

6. **How was your feeling when you gave that kind of service? Please explain**
   At first, I felt a little bit worried about my security in providing the information on medical abortion and the referral for surgical ones. But, in the end, I can think of the bigger picture that I can contribute to women empowerment by doing this, so I feel courage more than before.

IV. Informant D

1. **Did experience challenges/obstacles in providing information about contraceptive and abortion to young people and unmarried women?**
   There was no obstacle in providing contraceptive information. Patients and the community showed interest in the information. In providing abortion information, I usually merged the information in topic of unwanted pregnancy. I emphasized "abstinence" for young people. At one occasion during my work I met this young men, he said that young people should have ways to prevent unwanted pregnancies but he didn't agree that married couples should have remedies to prevent unwanted pregnancies.

2. **What kind of information/knowledge do you provide to them?**
   On the topic of abortion, safe abortion conducted by trained health provider at health facility, methods of unsafe abortion conducted by community and the danger of unsafe abortion, were discussed. But I never informed people about oral/medical abortion because I feel afraid since there is no legal protection for midwives related to abortion. I prefer to refer my client to referral facility. It is safer for me at least until there is a legal protection. On the topic of contraceptives, I discuss the methods, how they work, and the contraindications. I also inform about emergency contraception.

3. **How is your feeling when you are providing the information?**
   I feel comfortable because I think I should provide that kinds of information to them. Even when there was a teacher with them, the teacher was the person who had more question.

4. **Do you know that based on government regulation that Family Planning program is only for married couple?**
   Yes I know the regulation. So this is why I am careful in peer educations programs I work in.

5. **Had you ever heard that there were health provider criminalized or got in trouble because they provided information about contraceptive and abortion to young people or unmarried women?**
   I have never heard about this. But I had ever heard that there were health providers/midwives criminalized because helping abortion action. That is why I only engage in providing the information. I am also careful in providing the information to clients who are unwanted pregnant so that I don't get in trouble with law.

V. Informant E

1. **Did experience challenges/obstacles in providing information about contraceptive and abortion for young people and unmarried women?**
   Yes I did. Sometimes people misunderstood the information that was delivered to adolescent and unmarried people. Most people in community, even the teachers assume that providing this kind of information mean promoting sex before marriage.

2. **What kinds of information/knowledge do you provide to them?**
   When I was conducting health education for adolescent at schools, I provided information/knowledge about ways to prevent sex before marriage and drugs because of the negative impacts. Related to topic of contraceptive, I informed that contraception was used by married couple to plan their family. Most of information focused on reproductive organ, menstruation, wet dream, maturing age of marriage, ways to

maintain the reproductive organ keep healthy. I didn't deliver information about kinds of contraception.

Related to the topic of abortion, we had video about dangers of abortion so we only explain what are on the video. We also used standard factsheet from BKKBN in providing reproductive health information for young people. The factsheet informed about reasons of abortion, the methods of unsafe abortion and the impacts of unsafe abortion. In informing safe abortion, I only explained that the only one method of safe abortion was abortion conducted by trained health providers.

3. **Why did you only provide that kind of information not the comprehensive information?**

   I felt uncomfortable to provide comprehensive information about contraceptive to adolescents at schools. But if the headmasters/teachers permit me to provide the comprehensive information, I will feel comfortable. Before conducting health education, we made consultation with the headmasters to talk about the material and content of the information that would be delivered to the students. There were constrains determined by the headmaster. The headmaster didn't suggest to giving comprehensive information about contraceptive to the students because he worried that the information/knowledge delivered would be misused an that students would take "prohibited actions".

   I felt more comfortable in providing information about abortion than providing information about contraceptive. I didn't provide information about medical abortion because I was worried that the information would be misused. I had read information on internet that it was easy to get drugs for medical abortion. The website also informed that the drugs for medical abortion was safe to be consumed although with assistance of health provider.

4. **Have you ever heard that there were your colleagues/health providers criminalized or got trouble because they provided information about contraceptive and abortion to young people or unmarried women?**

   I had never heard about that. It may be because we conducted health education based on directions of our boss.

VI. Informant F

1. **Did experience challenges/obstacles in providing information about contraceptive and abortion for young people and unmarried women?**

   There was no obstacle in providing the information to the young people in the previous village. But there was an obstacle in providing the information at Puskesmas (community health center) because there was no counseling room for them. Besides that, there was no support from head of Puskesmas.

2. **What kind of information/knowledge did you provide to them?**
   During peer education sessions, I provided detailed information about abortion including information on medical abortion. I also provided detailed information about contraceptives. In my opinion, girls should know about methods of contraception so that when they get married, they can make informed choices about the reproductive health.

3. **Do you know that based on regulation/law in Indonesia, the Family Planning program is only for couple married.**
   Yes I know, but I don't know exactly the number of the regulation. Until now, I only provide the information not the service.

4. **How do you feel when you are providing the information? Did you feel worried, uncomfortable, etc.?**
   I didn't feel anything because I have recognized the need of the girls for long time. Together with me there are others who see the importance of the information provided in peer education to young people and their parents. Even, when I didn't conduct peer education, there were some parents of girls who asked when I can teach their children again (conduct the peer education). In fact, there was no unwanted pregnancy case in the village. The community trusts me because I am a village midwife.

5. **Have you ever referred your client who was unwanted/unplanned pregnancy to a facility/ clinic? How did you feel?**
   Yes. I had ever referred my client to a clinic in Jakarta because the client had many little children. She was pregnant for 8 weeks. Clients should take their own decision based on their belief, appropriate choice for them, and they should be aware of the risks. I only provide the counseling and I always keep confidentiality of the client.

[i] A/HRC/21/7, pararagraph,108.66/Spain
[ii] A/HRC/21/7, paragraph,108.123/Belgium
[iii] A/HRC/21/7, paragraph,108.122/Cuba
[iv] A/HRC/21/7, pararagraph,108.66/Spain
[v] A/HRC/21/7, paragraph,108.123/Belgium
[vi] A/HRC/21/7, paragraph,108.122/Cuba
[vii] http://www.teropongsenayan.com/16324-tawarkan-alat-pencegah-kehamilan-diancam-penjara-10-tahun
[viii] https://www.change.org/p/stop-kriminalisasi-kontrasepsi
[ix] https://m.tempo.co/read/news/2015/11/25/058721996/larangan-penjualan-kondom-picu-kontroversi
[x] http://news.detik.com/berita/1949886/menkes-tak-ada-program-bagi-bagi-kondom-untuk-remaja
[xi] E/C.12/GC/22/ (2016)the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights
[xii] https://sustainabledevelopment.un.org/sdgs
[xiii] http://www.bkkbn.go.id/ViewBerita.aspx?BeritaID=1789
[xiv] https://www.bps.go.id/index.php/masterMenu/view/id/1#masterMenuTab1
http://chnrl.org/pelatihan-demografi/SDKI-2012.pdf
[xv]http://regional.kompas.com/read/2014/09/18/16053841/diduga.ingin.nyaman.seks.bebas.seorang.mahasiswi.minta.disuntik.kb
[xvi] Focus Group Discussion between community health workers and human rights advocates working in SRHR. The Focus group discussion was organized by the Indonesian Civil Society Coalition on SRHR in preparation for this report.
[xvii] Guttmacher Institute; 2008;
https://www.guttmacher.org/sites/default/files/report_pdf/ib_abortion_indonesia_0.pdf
[xviii] Samsara Hotline Database; 2014-2015.
[xix] *http://www.ourbodiesourselves.org/health-info/variations-in-menstrual-periods/*
[xx] Findings from interviews and focus group discussions with community health workers who have worked with rape victims.
[xxi] http://asiapacificreport.nz/2016/07/27/women-still-not-safe-from-sexual-abuse-in-indonesias-rape-culture/
[xxii] OHCHR Factsheet n.29, Margaret Sekaggya's report to the Human Rights Council (*A/HRC/19/55*) and ILC members' experience.
[xxiii] http://putusan.mahkamahagung.go.id/main/pencarian/?q=aborsi