**Call for submissions**

***Women’s and girls’ sexual and reproductive health and rights in situations of crisis***

The Working Group on discrimination against women and girls will present a thematic report on women’s and girls’ sexual and reproductive health and rights[[1]](#footnote-0) (SRHR) in situations of crisis to the 47th session of the Human Rights Council in June 2021. The report will examine women’s and girls’ SRHR within an overarching framework of reasserting gender equality and countering roll-backs.

The Working Group will take a broad approach to crisis. In doing so, it intends not only to look at humanitarian crises, typically understood as encompassing international and non-international conflicts and occupied territories, natural disasters, man-made disasters, famine and pandemics, but it will also examine long-standing situations of crisis resulting from structural discrimination deeply embedded in histories of patriarchy, colonization, conquest and marginalization (such as in the case, for example, of indigenous women, Roma women and women of African descent), as well as other types of crisis based on the lived experiences of women, such as those induced by environmental factors, including the toxification of the planet, land grabbing, political, social and economic crises, including the impact of austerity measures, refugee and migrant crises, displacement crises, and gang-related violence, among others. The Working Group will examine how existing laws, policies, and practices can contribute to negative reproductive health outcomes for women and girls in situations of crisis and restrictions on their autonomy during their life-cycle, using an intersectional approach.

In order to inform the preparation of this report and in line with its mandate to maintain a constructive dialogue with States and other stakeholders to address discrimination against women and girls, the Working Group would like to seek inputs from all stakeholders. Submissions should be sent **by 31 August 2020** to [wgdiscriminationwomen@ohchr.org](mailto:wgdiscriminationwomen@ohchr.org) and will be made public on the Working Group's web page, unless otherwise requested. The Working Group is particularly interested in receiving information about challenges faced in ensuring that women’s and girls’ sexual and reproductive rights are respected, protected and fulfilled in times of crisis, and are adequately prioritized, as well as examples of good practices.

**Questionnaire**

Concept/definition of crisis

1. Please provide information on the legal and policy framework used by your State to manage situations of crisis and on how the concept of “crisis” has been defined or framed.

*The Law No. 24, the Year 2007 on the Disasters Management utilizes the terminology of disaster or incident to describe the crisis as the threatening, and disturbing situations caused by human-made or natural factors to the lives of people in Indonesia so that it causes death, environmental damage, loss of properties, and psychological impact. The government determines the status of disasters based on the following indicators: i) the number of victims; ii) loss of belongings; iii) infrastructure and structure damage; iv) impacted areas, and v) social-economic impacts by the disaster.*

1. Please list the type of situations that would fit the concept of “crisis” in your State and indicate what situations are excluded.

*The Law No.24, the Year 2007 classifies three disasters or events compatible with the crisis, namely:*

1. *Natural disasters such as earthquake, tsunami, floods, landslides, volcanic eruption, hurricane, and drought.*
2. *Non-natural disasters caused by non-natural series of events such as technology and modernization failure, epidemic, and the plague.*
3. *Social disasters induced by several incidents by men such as the social conflict between groups and social community, as well as terror.*

*Those events excluded from the categories mentioned earlier in the Law No.24, the Year 2007 are civil and military (war) emergencies. The decision for such situations articulated in the Government Regulations in Lieu of Laws No. 23, the Year 1959 on the Emergency Situations according to three conditions, namely:*

1. *Order and security in Indonesia are threatened by a rebellion or disturbance caused by natural disasters or social unrest.*
2. *War or any threats lead to war in the scope of Indonesia’s territory.*
3. *Endangering situations towards the Indonesian people and region.*

*Also, the government of Indonesia adopted Law 6, the Year 2018, on the Health Quarantine that defines the emergency of public health. The public health emergency is an extraordinary event impacts public health indicated by potential contagious disease, nuclear radiation, biological pollution, chemical contamination, bioterrorism, and food that spread to other areas across Indonesian territory.*

1. What institutional mechanisms are in place for managing a crisis and how are priorities determined?

*As mentioned above, the priority to determine measures in emergencies is based on the following criteria: i) the number of victims; ii) loss of belongings; iii) infrastructure and structure damage; iv) impacted areas, and v) social-economic impacts by the disaster.*

*The government of Indonesia has formed a non-department or ministerial level institution called the National Disasters Mitigation Agency (BNPB) based on Law No. 24, the Year 2007 consisting of two parts: the director and implementer of disaster management. The director board members require specific qualification and selected by Indonesia’s legislative body. Nonetheless, the implementer team composes of technical ministries or institutions that include civil society organizations.*

*In civil or war emergencies, the President and ministries are responsible for directing any instructions, management, and other strategies to recover the situation. Likewise, the public health emergency also needs the role of central and local governments, as mentioned in the adopted laws above.*

Challenges and good practices

1. Please highlight any challenges faced in the provision of SRH services and good practices in ensuring women’s and girls’ SRHR in situations of crisis, including, for example, measures concerning timely access to the the following types of services and aspects of care:
2. Access to non-biased and scientifically accurate information about sexual and reproductive health matters and services;

*Scientific and non-biased information is most commonly available and accessible in urban areas, particularly in modern or high-level healthcare facilities and hospitals. Also, an adequate information and services to women’s and girl’s SRHR in emergencies are limited and rare since the government of Indonesia allocates medical and humanitarian assistance in general. Consequently, the SRHR services are not well-planned and built in a decent manner because such services and the mechanism to manage the situations are typically ad-hoc, decided after the emergency management team assesses the victims' situation and needs.*

The healthcare providers and hospitals, to some extent, are lacking in delivering the non-biased information even though the SRHR’s services accessibility are located in urban and rural areas since women and girls in sexual violence cases are often doubted and victimized multiple times. For instance, female genital mutilation is prohibited nationwide, but the practices still happen in the healthcare providers or hospitals both in urban cities and rural areas.

1. Access to medical professionals and health service providers, including traditional birth attendants, with adequate provision for their training and safety including personal protective equipment;

Due to the vast geographic region, Indonesia has 34 provinces nationally with different topography, socio-economic, and cultural characteristics. People living in the eastern part of Indonesia encounter more adversities than those in western or mid regions to access employment, health, SRHR information, and services because of the development gap. As a result, medical or healthcare providers, professionals, including equipment for the birth attendant, are accessible in urban regions, especially in the capital cities in the western part. The training and distribution of personal protective equipment in remote and rural areas face a rough challenge, such as budget, infrastructure, equipment, and training material.

1. Access to essential medicines as prescribed by the WHO, equipment and technologies essential for the quality provision of sexual and reproductive health services;

*Women and girls living in remote or rural areas hardly find advanced technology and services related to SRHR, as qualified and certified health providers are outnumbered. Therefore, women and girls in rural regions rely on traditional treatment and remedies for seeking birth attendants and curing other reproductive diseases. Potent or high quality medicines is not affordable for women and girls living in vulnerable situations, especially those living in poverty and other barriers in rural areas.*

1. Prevention of HIV transmission, post-exposure prophylaxis and treatment for HIV/AIDS as well as the prevention and treatment of sexually transmissible infections;

*The management and prevention budget for HIV/AIDS in Indonesia increased gradually in a significant number from 2012 to 2014. In 2012, Indonesia's government spent USD 29 million to the highest number of about USD 60 million in 2014, considering HIV/AIDS is an epidemic disease in Indonesia. Nevertheless, the challenges for people with HIV/AIDS remain alarmed. The universal health coverage (UHC) in the national healthcare and social security scheme (BPJS) is not yet cover HIV/AIDS. It caused by the BPJS payment system that requires all family members to register the health care scheme with the hope government would increase the healthcare scheme subscription and revenue.*

*Unfortunately, that practice turns as barriers to the specific group of women and girls, namely those who use drugs and different gender identities (trans women or trans men) as they cannot register such a scheme without birth and family certificate; in fact, they live outside the house. Therefore, they are inaccessible to use the BPJS healthcare scheme to receive adequate treatment and remedy for HIV/AIDS. Also, p*eople with HIV/AIDS face discrimination in accessing treatment and remedy since they are mostly rejected by the healthcare providers by self-claiming that the BPJS healthcare scheme does not cover HIV/AIDS. However, HIV integration and national health insurance include HIV/AIDS as covered diseases.

1. Pregnancy-related health services, including pre- and post-natal care, assistance during child-birth, and emergency obstetric care;

The Ministry of Health Affairs issued regulation No. 97, the Year 2014 on the Pre and Post-natal care, child-birth, contraception service administration, and sexual health services. The central, provincial, and local governments take into account healthcare facilities for women and girls before and after pregnancy, including birth delivery, contraception, and sexual health care. The governments should utilize comprehensive and sustainable services with promotive, preventive, curative, and rehabilitative approaches.

The administration of healthcare services has to be delivered following the standardized procedure. However, in practice, the group of women and girls with disabilities come across sexual health violations, noting multiple barriers surrounding them. Women and girls with disabilities hardly access education and healthcare facilities due to inaccessible infrastructure and not an inclusive environment. Also, they are lingered by poverty and stigma in society that causes them unable to reach information and services to the SRHR. Some cases in rehabilitation institutions show that women and girls with psychosocial disabilities are sexually violated, raped, molested, and forced to use contraception or get sterilization to hinder them from pregnancy.

1. The full range of modern contraceptive information and services, including emergency contraception, as well as family planning information and services related to the number, timing and spacing of pregnancies and infertility treatments;

*Similar to the above information, the information and services to contraception should be provided in healthcare providers and facilities according to Regulation of the Ministry of Health Affairs No. 97, the Year 2014. The essential provisions in the regulation assert two matters that should be done beforehand contraception use, namely counseling, and issuing an informed consent. Therefore, the information and accessible facilities are vitally needed to define the necessity of women and girls in contraception, fertility, and pregnancy choices. Nonetheless, an ideal implementation is not yet upheld due to inappropriate healthcare facilities, providers, and lack of monitoring from the government; hence the gender-based violations are still happening in Indonesia, such as early marriage.*

1. Safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion;

*According to the National Statistic Agency (BPS), the number of age-specific fertility rate of young people aged 15-19 decreased slightly from 41 births per 1,000 women in 2010 to 36 births per 100,000 women in 2017. It indicates that the number of Indonesian pregnant women or gave birth ranged 15-19 years old is quite high.*

*The Indonesian government issued Government Regulation No. 61, the Year 2014 on Reproductive Health, that refined by the Health Minister Regulation No. 3, the Year 2016 on the Training and Abortion Services for Emergency Medical Indication and Pregnancy caused by Raping for addressing SRHR issues.*

*Women and girls, particularly those with disabilities who need abortion services, should require a counseling confirmation letter from a competent counselor. The dedicated team in hospitals or healthcare facilities provided for such services should require a counseling letter describes any steps taken pre and post the abortion. It means that women and girls in need may accept or reject abortion services after receiving timely and vivid information.*

The reports from the National Human Rights Institution and National Commission on Violence Against Women in Indonesia reveal that women and girls with disabilities have high risks of sexual violation, including the adversities to access justice and rehabilitation services. The cases reported by the organization of persons with disabilities show that the divorce, raping, forced sterilization, and abortion mostly happening to women and girls with disabilities.

1. Treatment for pregnancy-related morbidities such as obstetric fistula and uterine prolapse, among others;

Law No.61, the Year 2014 on Reproductive Health, ensures the rights to the health of reproductive organs for women and girls. Article 30 asserts the standardized healthcare services of reproductive organs aimed to protect women and girls from infectious diseases and disorders by treating women cycles effectively. However, the regulation does not breakdown the pregnancy-related morbidities and its treatment for women, and girls need it. Therefore, detailed information and any medications related to pregnancy should be provided more in the local healthcare facilities to reach out to women and girls throughout the Indonesian region, and not only the hospitals in urban cities.

1. Screenings and treatment for reproductive cancers;

The national health scheme (JKN) guarantees Indonesian citizens' universal health care, including screening and treatment for reproductive cancers. Women and girls who have registered the national healthcare and social security scheme (BPJS Kesehatan) entitled the rights to access the treatment and services in the first level of healthcare facilities. They appointed healthcare institutions by the BPJS Kesehatan, such as the Indonesian Cancers Foundation. Nevertheless, women and girls with disabilities hardly access the services as they are difficult to obtain a birth certificate and citizen card. Not only those problems, the accessibility of transportation, information, and infrastructure facilities also hampering them to access the healthcare facilities. Consequently, they cannot be registered and enjoy the treatment in the BPJS Kesehatan scheme, albeit they extremely need those services.

1. Menstrual hygiene products, menstrual pain management and menstrual regulation;

The needs for information regarding a menstrual cycle, products, management, and regulation are essential for women and girls, especially the parents and families of girls during puberty. The parents of girls with disabilities often challenged to explain the concept of reproductive organs and menstruation information. Neither the families nor schools can inform the menstrual practice properly and effectively. Top of the problems, reproductive health, and menstrual knowledge discussions are deemed taboo in public, both at the family and educational institutions. Therefore, the National Population and Family Planning Board (BKKBN) proposed the SRHR curriculum to the Ministry of Education to disseminate the rights to reproductive health among students in primary schools, such as in religion lesson.

1. Prevention, investigation and punishment of all forms of gender-based violence, and access to timely and comprehensive medical interventions, mental health care, and psychosocial support for victims and survivors;

In Indonesia, there are several mechanisms to address and support victims' and survivors' needs, both from the government and civil society organizations. The collaboration of government and civil society organizations, mostly women-led and legal aid organizations, contributes significantly to the timely and comprehensive case management, psychosocial support, and medical interventions for the victims and survivors. However, the Indonesian government just revoked the bill of sexual violence elimination from the Indonesian legislative body's priority bills discussion. Women and girls in Indonesia exceptionally need the law amid high risks and cases of sexual violations across the regions. The civil society organizations urge the government to pass the bill as it covers prevention, investigation, and punishment aspects. Also, the bill contains an article to support the victim and survivor's needs for rehabilitation.

1. Measures to prevent and prohibit practices such as female genital mutilation and child, early and forced marriage;

*UNICEF Indonesia asserted that 13,4 million Indonesian women aged 11 or below might have had female genital mutilation (FGM). The FGM practice can be carried out by these following acts: 1) holding a symbolic ceremony; 2) grazing; 3) cutting; 4) removing part of the woman's clitoris.*

*These regions in Indonesia have the highest rate of female circumcision cases according to 2013 UNICEF data, namely, Gorontalo 83,7%, Bangka Belitung 83,2%, Banten 79,2%, South Kalimantan 78,7%, and Riau 74,7%. Besides, the same data stated that Indonesia is the third country in the world with the highest rate of female circumcision after Gambia and Mauritania.*

*The government of Indonesia, through the Ministry of Health, issued regulation No. 6, the Year 2014 to revoke the Health Ministry Regulation No.1636, the Year 2010 on Female Circumcision. The later regulation issued to call-of the female circumcision practice endorsed and legalized by the Indonesian government, as healthcare services providers interpreted the regulation as the state's endorsement or acted to control the country's citizens.*

Other measures taken by civil society groups pushed the discussion of The Elimination of Sexual Violation Bill in the Indonesian Legislative Body. However, the bill was drop out due to invalid or unreasonable information from the member of the Indonesian Legislative body. As a result, the draft law can not be issued this year and should be proposed next year in the plenary discussion. However, the Indonesian government and legislative body agreed to raise the minimum standard of marriage from 18 to 19 years old to decrease child and forced marriage practices in rural areas.

1. Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements;

*Article 22 of The Government Regulation No. 61, the Year 2014 on the Reproductive Health, ensures that every woman and girl entitled the right to choose the contraception methods without force from any parties. Also, the article requires each couple to participate in the discussion and decide the contraception use for their partner.*

*Additionally, the Health Ministry Regulation No. 97, the Year 2014* on the Pre and Post-natal care, child-birth, contraception service administration, and sexual health services*, indicates two steps for administering contraception: the informed choice and informed consent. The informed choice refers to the condition of women who wants to choose any contraception methods with adequate information through intrapersonal communication or counseling. The informed consent, as defined by the regulation, is consent from the client or their family based on the information from healthcare providers to take any medical acts or contraception.*

*The referral mechanism to level-up services and treatment is available based on the Regulation of Health Ministry No.97, the Year 2014. The referral system's purpose is to enhance an integrated, quality, scope, and efficiency of contraception services. Confidentiality and privacy are part of the quality service in contraception and SRHR. Thus, any acts that might harm or endanger the confidentiality and privacy of women and girls will be sanctioned through different laws, such as Law No.11, the Year 2008 on the Internet, and Electronic Transaction.*

1. The affordability of SRH services especially for those in situations of vulnerability; and

The SRHR services and treatment in state-owned local healthcare facilities called Puskesmas are affordable for most Indonesian people, yet, the quality of healthcare providers and equipment might be varied among regions due to budget and other factors. Aside from affordability, women and girls with disabilities need accessibility and reasonable accommodation for all types of disabilities to access the treatment and services without barriers. However, the accessibility for women with disabilities is challenging as there are no sign language interpreters in the Indonesian justice system or healthcare facilities and hospitals for those deaf or deafblind (moreover in local regions). Disability-friendly infrastructure and design building also cause women with physical disabilities are left behind. However, the BPJS Kesehatan guarantees that the registered participant can access services and treatment as prescribed by doctors and healthcare providers in designated hospitals or healthcare institutions.

1. Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information.

Indonesian women and girls often discriminated against multiple times because of numerous factors. They might become victims of sexual violations and inaccessible to the provided healthcare services and treatment because of the legal status such as birth or family certificate and citizenship, poverty, disabilities, and other identities belonging to Indonesian women and girls.

Experiences of crisis

1. Please list the situations of crisis experienced by your State in the last five years.
2. *29th July 2018, earthquake with 6,4 magnitude was hitting the West Nusa Tenggara island, which affected the Lombok, Bali, and Sumbawa Islands. The quake caused a couple of people dead, hundreds injured, and thousands of property broken. Later, 5th August 2018, the second earthquake in North Lombok of West Nusa Tenggara happened with 7 magnitudes, which also felt in the Java and Madura Islands. The BNPB recorded a hundred people dead, thousands in severely injured, and thousands of people loss houses.*
3. *A seven magnitude earthquake broke Donggala and Palu on 28th September 2018, not long after that, the government announced the tsunami warning 0,5 to 3 meters. However, the worst thing was 8 meters wave hit Palu city at the end of Palu bay. Coincidentally, it happened approached to the celebration of Palu city anniversary. In another part of Palu city, in Petobo district, the soil changed into mud suction towards anything on the ground, such as houses, vehicles, trees, and even humans. Recorded by BNPB, 2.101 people dead, 1.373 people lost, 206.219 people had to move in the shelter.*
4. *Tsunami wave from Sunda Strait devastated coastal along West Java and Southern Sumatra Island on 22nd December 2018. The record showed 430 people death, 159 people lost, 1.500 thousand injured, and 22.000 thousand people had to be evacuated—the tsunami caused by an avalanche of the Krakatao's Child Mount.*
5. *Several demonstrations happened on 21-23 May 2019 in Jakarta to protest the presidential election result that was naming Joko Widodo and Ma'ruf Amin as the President and Vice President of Indonesia. The demonstration point was concentrated in front of the Election Supervisory Agency (Bawaslu). The demonstration resulted in 8 civilians dead, 730 injured, and 257 people suspected as the rioters.*
6. *Demonstration from 24-30 September 2019 from civilians and students triggered by the Indonesian government's willingness to issue several problematic laws, among others, are penal code and the law of eradication of corruption. The demonstration happened across several Indonesian regions at the local level but the largest one was in Jakarta. The Police of the Indonesian Government caught 1.489 people and 380 among them determined as suspects.*
7. What was the impact of those crises on women and girls? Please provide information in particular on the following aspects:
8. Which groups of women and girls were most affected and how, taking into account different factors, such as age, geographic location (including urban and rural areas), ethnic and social origin, disability, marital status, migratory status, citizenship status or other status?

Generally, the victims in Palu, Lombok, and West Java were women and girls from the Muslim group in rural areas. Those natural disasters devastated in rural areas far away from the central government, whose limited access and infrastructure. Hence, the equipment and services for women and girls’ necessities are very limited in the evacuation areas such as toilet. Therefore, women and girls in Palu and other cities reported some sexual violations, such as raping and toilet peeking.

Two political demonstrations in Jakarta last year (as mentioned earlier) had causalities to the protester’s women and girls student who has become the victim of sexual violence during the protests such as catcalling and shouted impolitely. Also, the women and girls of street sellers affected by the election result’s rally as the rioters looted their goods and broke their vehicles.

1. What was the impact on their SRHR? Were any specific risk factors and needs identified? Do you have data and/or qualitative information disaggregated by the factors listed under question 6(a)? If not, please explain why.

*Unfortunately, we did not have quantitative data describing the number and information of women and girls’ characteristics in those events. However, the BNPB and related agencies might have collected data on women and girls affected by disasters and demonstrations.*

*The aids and assistance from other parties were not identified and appropriately provided for women and girls. Also, women and girls were afraid to receive sexual harassment and violations in the shelters due to unavailable security, services, facilities, and equipment to the SRHR.*

*In some extent, the BNPB and the Military of the Indonesian government does not belong to adequate gender-perspective and knowledge to women and girls victims. Thus, services to SRHR (pregnancy, menstruation, psychosocial or mental health, and complaint mechanism) were not upheld unless there was assistance from the women-led organization and international agencies, such as UNICEF, UN WOMEN, etc.*

1. What were the main obstacles encountered by the State, if any, in identifying and addressing the impact of the crisis on women’s and girls’ SRHR?

*1. Lacking gender knowledge and perspective from the state or government’s apparatus and the Military or Police of Indonesia’s government in mapping and identifying the SRHR needs.*

*2. A limited number of women’s roles in the decision-makers team within the Indonesian government (BNPB, central, and local governments).*

*3. Inadequate strategy and plan to address and provide SRHR’s services to the women and girls both in disasters and social unrest situations.*

*4. Heavy causalities surrounding the evacuation areas to send in SRHR equipment, tools, and competent apparatus so the services might be handicapped for several days.*

*5. Unavailable complaint mechanisms to file sexual violations happened to women and girls in the shelter. If any complaint procedure and machinery, the police and military of the government of Indonesia might abuse the process and discriminate against women and girls; thus, they doubled victimized.*

1. What measures were adopted during and after the crisis to ensure women and girls’ access to sexual and reproductive health services? Please indicate which SRHR services are recognized as essential services in the health policy or laws of your State and are funded through the health system. What steps were taken to ensure the continuity of services and access during the crisis?

*Some measures were adopted to tackle the obstacles, namely:*

*1. Included the appointed government agency to address and handle the sexual violation cases in the local areas across Indonesian regions such as the Integrated Care Center for the Empowerment of Women and Children (P2TP2A).*

*2. Opened and coordinated humanitarian assistance and aids from international organizations, other states, civil society organizations, private sectors, etc.*

*3. Allocated budget for women and girls’ SRHR primary needs in the shelters.*

*4. Provided sufficient and timely health-are equipment and providers for women and girls in the shelters and healthcare facilities.*

*5. Coordinated with the local healthcare facilities in the nearest evacuation areas to provide necessary SRHR services to the women and girl victims. The menstruation, post mortem test, counselor, psychologist, SRHR, and other women’s rights should be guaranteed though those rights are not stipulated in the Law No.24, the Year 2007 on the Disaster Prevention thus the steps should be taken soon.*

1. What other protocols or systems were put in place to prevent adverse reproductive and sexual health outcomes due to the common risks triggered by crisis including, for example, gender-based violence and child marriage? Were any special measures adopted for specific groups of women and girls?

Specific protocols or systems under P2TP2A are taking places such as timely, effective, standardized, gender perspective, confidentiality, and referral mechanisms are part of the measures taken within the protocol. The women-led and humanitarian organizations in central and local levels that wanted to help specific groups of women and girls such as disabilities, ethnic, and other identities might contact and coordinate with the Indonesian government, local government, and P2TP2A necessarily. In doing so, special measures to specific groups of women and girls might be addressed well and effectively.

1. Were women’s rights organizations[[2]](#footnote-1) involved in the needs and impact assessments and the recovery policies? If not, please indicate why.

Yes, the women’s rights organizations whose members at the local level might organize help or assistance to women and girls victims faster than those without local members. Besides, they work closely with the P2TP2A and other human rights organizations to disseminate and coordinate further the needs of women and girls in the evacuation zones and shelters.

Furthermore, when it possibles, the women’s rights organization provided funds, equipment, and services to the women and girls such as clothes, menstruation products, psychiatric or mental health providers, and other needs identified by the government. Being that said, the government of Indonesia was supported to deliver women and girls’ demand in the evacuation areas. More importantly, the implementation, recovery process, and need assessment also helped by women organizations, although unfortunately the impact has not yet applied to a legal framework.

1. Which actors or institutions played a role in the provision of emergency responses? Please describe their role and explain what roles were played, if any, by national women’s rights or human rights mechanisms, or other similar bodies as well as civil society organisations.

*Some institutions have been mentioned earlier. However, these institutions and their roles were identified as follows,*

*1. The government of Indonesia represented or led by BNPB as the director and coordinator of emergency management, recovery, aid distributions, and other related tasks until the mission is done.*

*2. The Military and Police of the Indonesian government safeguards the security and safety, help the aid distributions, build temporary infrastructure, and equipment for victims, including women and girls.*

*3. National Human Rights Institutions and the National Commission on Violence Against Women (Komnas HAM and Komnas Perempuan) help in providing complaint mechanisms to human rights and SRHR violations to victims, including women and girls. If needed, the officers of those institutions may investigate the cases and report them to the police.*

*4.Women, human rights, humanitarian organizations, international organizations, and other countries contribute to providing funds, delivering goods, services, and other collaboration needed to disseminate or inform the situation and needs of the women and girls.*

1. How were the emergency responses funded and to what extent did they rely on foreign aid or assistance, if any? Please also indicate how in your State adequate financing of women’s sexual and reproductive health is ensured more generally on an ongoing basis.

The budget of emergency responses is allocated from the national budget with assessment and approval from the President and counseled by the Ministry of Finance Affairs. Besides, the local government may spend the provincial budget expenses for the victims with additional support (loans, funds, aids, goods) from other parties, both national and international fora. In the COVID-19 emergency, the funds not only allocated by the government but generated from crowdfunding from private sectors, communities, and online fundraising platforms. However, specific budget extracted for women's and girls' needs, especially SRHR, is hardly found and socialized by the government as the aid and assistance generally were primary daily needs.

1. What obstacles have civil society organisations encountered in their efforts to deliver sexual and reproductive services?
2. *The civil society might inaccessible to the evacuation areas and reach out to the victims in delivering sexual and reproductive services or equipment because of the heavy damage in the infrastructural sectors so they have to coordinate with government as the main coordinator beforehand.*
3. *Limited information and rough connection of the situations and identified needs of women and girls in the evacuation. Mostly, phone connection and valid information is troubled during the couple hours after the events.*
4. *Limited sources to the high and specific needs of women and girls unless they can collaborate with other women and humanitarian organizations.*
5. *Overlapping, ineffective, and inefficient aid distribution to SRHR caused by limited coordination with government or closed space for the CSOs’ participation in delivering the SRHR needs.*
6. *Inadequate gender knowledge and perspective within the Indonesian government apparatus, the Military and Police of the Indonesian government, and other related institutions.*
7. Could you identify any lessons learned? Please indicate if and how these lessons have been applied in preparedness strategies or in subsequent situations of crisis.

*The participation of women organizations was constructive and contributive to the recovery phase; thus, they coordinated closely with the government to ask the situation, information, and precise needs of women and girls. The women organizations with their members at the provincial level may work faster and effectively since they can assess the requirements before preparing and delivering the aids. The collaboration between women and humanitarian organizations is also accommodating as the humanitarian assistance in Indonesia usually do fundraising through their registered members and society nationwide.*

*The government of Indonesia continues to coordinate the assistance and aids from various parties collected by all means (online platform, fundraising, loans, aids, etc.) in one gate system to hinder wasted distribution and unnecessary aid delivery in the field. Besides, the one gate system might be more useful to monitor an overlapping and abuse of aid distribution to the victims, including women and girls. In recent COVID-19 emergencies, the government of Indonesia does this method and publishes the data on aids and assistance through a daily press conference and the national COVID-19 management website.*

1. If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.

*Indonesia has the highest rate and possibility of natural disasters, as indicated by the World Risk Report (2016). The Indonesian National Medium Term Development (RPMN) 2020-2024 also showed that 75% of primary connectivity and industry infrastructural are built within vulnerability zones. Therefore, the RPJMN sets forth several strategies to enhance the resilience towards natural disasters and climate change through three measures, namely:*

*1. Increase the quality of the living environment or green environment.*

*2. Enhance the resilience towards natural disasters and climate change.*

*3. Low carbon development programs or approaches.*

*Nevertheless, the RPJMN does not explicitly mention how it addresses and prioritizes the strategy to fulfill women's and girls’ SRHR during the disasters and other events indicated as a crisis.*

1. Please indicate the main challenges, if any, encountered by women and girls to access justice and obtain reparations for violations of their SRHR, including any procedural barriers, and the types of assistance available to access legal and other remedies. Please also indicate the groups of women and girls most affected. Where applicable, please indicate the role played by a national truth and reconciliation commission (or a similar body) in ensuring the recognition of human rights violations in relation to women’s and girls’ SRHR and reparations.

*The main challenges encountered by women and girls are limited facilities and services related to SRHR available in the evacuation areas and shelters. They hardly access immediate and adequate services due to unavailable healthcare providers, advanced equipment, and medications unless they are brought into appropriate hospital or healthcare centers. Women and girls are dominantly led by the men's leadership and coordination during the evacuation process and within the shelters because of relation gap inequalities and patriarchy approach. Thus, women's and girls' roles are challenged and rare in the emergency response, even more the role of women in decision-maker panels.*

*Generally, women and girls in rural areas were affected, but those more severe were women and girls with disabilities and related other factors (migratory or ethnic status). Multiple discrimination happened to women and girls with disabilities during the crisis. Moreover, they are challenged to access and participate in aid and service distributions without reasonable accommodation such as ramps, portable beds, spacious toilets, sign language interpreters, wheelchairs, etc. The complaint mechanisms and reparation of women's rights and SRHR are commonly addressed and handled by the National Human Rights Institutions or the National Commission on Violence against Women (Komnas HAM dan Perempuan). However, other specific human rights violations might address the SRHR matters to newly formed and particular institutions such as the Commission on Truth and Reconciliation in Nangro Aceh Darussalam for human rights violations during the armed conflict in Aceh from 1976 to 2005.*

Preparedness, recovery and resilience

1. Is there any preparedness or risk management strategy/plan/policy in your State? If so, please provide information on the following aspects:
2. To what crisis does it apply? What situations are excluded?

The government of Indonesia issued Government Regulation No. 21, the Year 2008 on the Disasters Mitigation Organization. The regulation addresses the need to mitigate natural disasters indicated as the crisis. The disaster defined in the regulation as “..the threatening and disturbing events or series of events towards the society living caused by both natural and non-natural factors that affect causalities, death, environment damage, property loss, and psychological impact”.

1. Does it contain a definition of crisis? If so, please indicate the definition used.

As mentioned, disasters is“..the threatening and disturbing events or series of events towards the society living caused by both natural and non-natural factors..”. Thus, determining factors from non-natural incidents might also be included in the definition of disasters Government Regulation No. 21, the Year 2008. Disaster, the used terminology in the regulation is not precisely similar to the crisis, but the“natural and non-natural factors”are open for improvement and consideration for other types of emergencies such as social unrest, pandemic, and other incidents.

1. Does it include measures concerning women and girls’ SRHR? If so, please describe the measures included and any special measures envisaged and/or adopted for specific groups of women and girls concerning both preparadeness and recovery.

The regulation does not include accurately the measures and basic needs concerning women and girls’ SRHR. Nonetheless, Article 52 (1) Government Regulation No.21, the Year 2008, categorizes the primary needs of victims, namely, sanitation, foods, clothes, healthcare services, psychosocial services, and evacuation areas. The fulfillment and implementation of those needs are coordinated and provided by the BNPB on behalf of the Indonesian and local governments, society, private sectors, women and human rights organizations, and other organizations. Being that said, the government of Indonesia should develop more comprehensive and integrated SRHR facilities and healthcare as identified and ensured by Government Regulation No.21, the Year 2008.

Furthermore, the protection of vulnerable groups also recognized by this regulation, although Article 53 does not explicitly mention the types of vulnerable groups who might become the victims. However, the priority measures are given to the severely injured and those in vulnerable situations, although the article does not indicate types of vulnerability. The priority measures for these categories are included rescue, evacuation, security, healthcare, and psychosocial services.

1. How were the risks related to women and girls’ sexual and reproductive health and rights, in urban and rural areas, identified and assessed?

*The risks of women and girls’ SRHR in urban and rural areas are identified and assessed by various factors classified into socioeconomic and cultural sections. The social factors may be captured and evaluated to determine whether the social status, social living environment, morals, values, and other factors affect the risks and challenges of women and girls’ SRHR. The economic factors also play a pivotal role in the dangers of women's and girls’ SRHR as poverty, unemployment, and related issues may put more adversities on the lists. Similar to previous factors, cultural or beliefs among women and girls in urban and rural areas will generate different risks to SRHR, such as traditional practices, science, and information.*

1. Were women’s rights organizations involved in: i) the development of the strategy/plan/policy; ii) assessment of the risks concerning SRHR; iii) the design of the measures implemented; and iv) the monitoring of the strategy/plan/policy? Please indicate the steps taken to ensure their participation and to include a gender-perspective in crisis preparedness, management and recovery.

*Lesson learned from the involvement of women-led organizations can be constructive engagement and point for the development of the national strategy for women’s and girls’ SRHR. Nevertheless, the government of Indonesia has not included a meaningful engagement and participation of the women-led organization in the development of government regulation or strategies. However, the women and environmental organizations contributed to provide feedback and inputs regarding assessment and risks concerning SRHR that implemented in their projects. The projects may be varied from pre-implementation (assessment, survey, research, etc.), implementation (aid distribution, fundraising, monitoring, etc.), and post-implementation (recovery, empowerment, and evaluation). The efforts taken to include a gender perspective and mainstreaming in the preparedness, management, and recovery are included human rights and CEDAW training, capacity building, dissemination, FGDs, and other means.*

1. Please indicate if the strategy/plan/policy has undergone any assessments to date. If so, what were the main findings and recommendations concerning women’s and girls’ SRHR?

*There is no specific assessment of the existing strategy/plan/policy to date, yet, the draft bill of the elimination of sexual violation has been proposed to the Indonesian legislative body. Unfortunately, the proposal was rejected after the plenary discussion with all members of the Indonesian legislative body couple of months ago. As a result, the draft bill should be resubmitted and rediscussed in the plenary session next year. This bill is essential for the SRHR needs that can be addressed and utilized in the crisis context. Other potential matters are monitoring the RPJMN implementation as the RPJMN and national human rights plan (RAN HAM) imply the main substances from SDGs and other UN treaty bodies’ reports.*

1. If your State does not have a plan that can immediately go into effect in a time of crisis, please explain why it is so.

*Law No. 24, the Year 2007 on Disasters Management used as the main legal framework to address the emergencies and crises in Indonesia. Besides, the government of Indonesia has issued Government Regulation No. 21, the Year 2008 to mitigate the disasters caused by both natural and non-natural factors. To compliment such regulations, the RPJMN and RAN HAM also relevant to the management of the crisis and related human rights issues, especially SRHR for women and girls.*

Indonesia's government seemed reluctant to issue a new legal framework (draft bill of the Elimination of Sexual Violations) and strategy. Thus, the government has not yet developed a new plan despite the absence of such a plan, and the services of SRHR. Even more, the sexual violation cases should be addressed urgently. Otherwise, Indonesian women and girls in an emergency in urban and rural areas will be left behind and becomes more vulnerable than previously without any suitable and timely measures to respond to women's rights and SRHR services. 

1. Are there specific ways in which international human rights mechanisms can support States in their efforts to address a crisis?

*The international human rights mechanisms may support the crisis in any state through their existing tools, namely, the charter and treaty-based mechanisms. The state parties to the UN Charter may utilize the variant support system within this mechanism, such as Universal Periodic Review (UPR), Human Rights Council (HRC), UN General Assembly (UNGA), and Special Procedures or mandate holders. If the UPR, HRC, and UNGA cycle may take time, state parties may use the mandate holders or special procedure to address the situation of women’s and girls’ SRHR.*

*Another international mechanism that can be used constructively is a treaty-based in which the state parties have ratified the conventions. This mechanism is more commonly used and familiar for civil society organizations, including women’s rights organizations, concerning the CEDAW implementation in their respective states.*

*Also, other conventions can be referred and used by women’s organization to address and monitor the SRHR during an emergency with suitable intersections such as migratory status and disabilities that can be linked into the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) and International Convention on the Rights of Persons with Disabilities (CRPD). Besides, the International Criminal Court (ICC) mechanism can be explored and used for further support in delivering SRHR needs and violations, if any, in-state parties that have ratified the convention.*

1. SRHR include women’s right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health, as well as entitlements to unhindered access to a whole range of health facilities, goods, services and information on sexual and reproductive health, such as maternal health, contraceptives, family planning, sexually transmitted infections, HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancer. Women’s right to sexual and reproductive health further encompasses the “underlying determinants” of sexual and reproductive health, including access to safe and potable water, adequate sanitation, adequate food and nutrition, and adequate housing, among others, and effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health. Moreover, it covers social determinants, notably social inequalities in society, poverty, unequal distribution of power based on gender, ethnic origin, age, disability and other factors, systemic discrimination, and marginalisation, which affect people’s patterns of sexual and reproductive health. [↑](#footnote-ref-0)
2. The expression women’s rights organizations should be understood as encompassing organizations of women of different ages, backgrounds and identities. [↑](#footnote-ref-1)