



June 21, 2012

Committee on the Elimination of Discrimination against Women (CEDAW Committee)
Office of the High Commissioner for Human Rights (OHCHR)
New York Office - Room DC1 - 511
One United Nations Plaza
New York, NY 10017

Re: Supplementary information on Indonesia, scheduled for review by the CEDAW Committee during its 52nd session.

Dear Committee Members:

This letter is intended to supplement the combined 6th and 7th periodic report of the Government of Indonesia, scheduled for review by this Committee during its 52nd session. The Center for Reproductive Rights (the Center), an independent non-governmental organization, hopes to further the work of the CEDAW Committee by reporting information concerning reproductive rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In this letter, the Center would also like to take the opportunity to propose questions to suggest to the state party during the session and recommendations to include in the 2012 Concluding Observations to Indonesia.

During the CEDAW Committee's previous review of Indonesia in 2007, the Committee expressed concern "about the high rates of maternal and infant mortality in Indonesia."¹ The Committee also expressed concern "about the lack of family planning education and the difficulty in accessing contraceptives, which result in a high rate of abortions and teenage pregnancies."² The Committee recommended the state party take the following steps:

- Continue its efforts to ensure that obstetric and maternal health needs are adequately addressed and that maternal mortality rates are reduced;³
- Persist in efforts to ensure that women have equal access to appropriate and adequate health care services, including in rural areas;⁴
- Guarantee effective access of women and girls to information and services regarding sexual and reproductive health, including contraception, in order to reduce the rate of unsafe abortions, teenage pregnancy, and maternal mortality;⁵ and
- Remove family and spousal consent requirements in the area of women's health.⁶

Since the 2007 review, Indonesia should be commended for progress in decriminalizing abortion in cases where the pregnancy is a result of rape or where there is fetal impairment and clarifying

that there is an exception to the criminal abortion ban where a woman's life is in danger.⁷ The state party should also be praised for passing the Domestic Violence Law (No. 23/2004) to address violence against women.

Yet, it is worth noting that several reproductive health-related recommendations made previously by this Committee to Indonesia remain unaddressed. **Indonesia remains amongst the top ten countries accounting for the most maternal deaths worldwide**, with an estimated 10,000 women dying annually.⁸ The state party also has taken **retrogressive steps on a crucial women's rights issue, female genital mutilation (FGM)**. Further, while the state party should be praised for decriminalization of abortion on certain grounds, significant reform is still needed to remove the broad spousal consent requirement and gestational restrictions as narrow as six weeks.

The first part of this letter will provide updated information on three issues highlighted by the CEDAW Committee during the previous review: high rates of maternal mortality and morbidity, lack of access to safe abortion, and the unmet need for contraceptive information and services. The second part of this letter will provide updates on the issues of rural women and teenage pregnancies highlighted by the Committee in its previous review and further discuss where marginalized women and girls in Indonesia, particularly adolescents, unmarried, and rural females, experience discrimination in their enjoyment of their reproductive rights as guaranteed under CEDAW. The letter concludes with suggested questions and recommendations for the Committee's consideration.

I. The Right to Reproductive Health Information and Services (Articles 12, 10(h), & 16)

Reproductive health information and services remain inaccessible to many women in Indonesia due to lack of investment in health programs, spousal consent requirements, legal restrictions on access to reproductive health care for unmarried women, and stigma surrounding contraceptives and abortion. These barriers violate CEDAW Articles 12, 10(h), and 16. Article 12(1) of CEDAW calls upon states parties to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure [...] access to health care services."⁹ Article 12(2) further instructs states parties to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."¹⁰ Article 10(h) requires that women have "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."¹¹ Article 16(1)(e) requires that states parties "take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and...ensure, on a basis of equality of men and women the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."¹² Through General Recommendation 24, Concluding Observations, and more recently in *Alyne da Silva Pimentel Teixeira v. Brazil*, the CEDAW Committee has articulated state obligations concerning pregnancy that support recognition of the right to survive pregnancy and childbirth as a fundamental human right.¹³ Denial of access to appropriate maternal health services constitutes discrimination as it has a "differential impact on the right to life of women."¹⁴

A. Maternal Mortality and Morbidity

Maternal mortality and morbidity are important indicators of women's access to reproductive health care and of a state party's progress in eliminating gender-based discrimination.¹⁵ The CEDAW Committee has framed the issue of maternal mortality as a violation of women's rights to life, health, and to non-discrimination.¹⁶ According to the government's 2007 Indonesia Demographic and Health Survey (IDHS), while Indonesia's maternal mortality ratio (MMR) has decreased in recent years to 228,¹⁷ **high sampling errors in the survey make it "difficult to conclude with confidence that there has been any decline in the level of maternal mortality in Indonesia over the past 10 to 15 years."**¹⁸ The IDHS estimate is lower than the MMR found by external organizations; in 2010, the World Health Organization (WHO) released estimates of maternal mortality that measured Indonesia's MMR as 240 deaths, with the margin of error placing this estimate as high as 380.¹⁹ Under both measures, the state party would have to more than halve its MMR to meet its Millennium Development Goal (MDG) target of an MMR of 102 by 2015.²⁰ In Indonesia's 2010 report on progress to achieving the MDGs, **achievement of the MMR target under Goal 5 is classified as "needs special attention" to be met.**²¹

The Committee has linked high rates of maternal mortality to lack of access to and insufficient availability of comprehensive reproductive health services²² as well as to lack of availability of safe abortion services;²³ lack of access to quality post-abortion care for complications resulting from unsafe abortion;²⁴ and high rates of teenage pregnancy.²⁵ The CEDAW Committee has urged reform where states parties have insufficiently allocated resources to the health system.²⁶ Reform has also been encouraged when states parties fail to address deficient health infrastructure and barriers to access to health facilities, such as poor roads and lack of transportation.²⁷ The Committee has also specifically recognized anemia as a significant cause of maternal mortality and expressed concern.²⁸

1. Maternal Health Services Must Be Expanded and Improved in Order to Reduce Maternal Mortality.

This Committee has emphasized the importance of skilled birth attendants in ensuring safe pregnancy and childbirth,²⁹ and Article 12(2) of CEDAW requires states parties to provide free maternal health services where necessary.³⁰ States parties must also have the facilities and the health infrastructure to provide quality care.³¹

Greater prioritization of maternal health care is necessary and barriers such as cost and poor quality of care must be addressed. The state party should be commended for creating a Delivery Insurance Program (*Jaminan Persalinan/Jampersal*) which it has mentioned in its report to the CEDAW Committee is intended to finance "antenatal services, delivery assistance by health personnel, and post partum services, including maternal care of newborns, postpartum family planning service, as well as exclusive breastfeeding counseling."³² However, this program does not address several key barriers to maternal health care, including those identified by Indonesia itself in its 2010 MDG Report — unequal quality and lack of affordability of basic and emergency obstetric care; lack of adequate referrals from primary health centers to referral hospitals and lack of transportation for women; limited availability of health personnel both in terms of quality and quantity as well as in terms of geographic distribution; and lack of health supplies needed for obstetric emergencies such as blood, medicines, and equipment, particularly in poor or remote areas.³³

Furthermore, although the 2007 IDHS shows that 73% of births were assisted by a skilled birth attendant, **there is a huge disparity between rural and urban areas (25% difference).**³⁴ Indonesia has an extremely high rate of home deliveries (53%) of which more than one third are attended by traditional birth attendants who are not medically trained.³⁵

2. Improvement of Nutritional Status of Pregnant Women Needed to Prevent Maternal Deaths

Nutritional intake is a significant factor in reducing maternal mortality and morbidity.³⁶ In the 2010 MDG Report, the state party recognized that low nutritional and health status of pregnant women is a significant contributor to maternal deaths.³⁷ **The IDHS has identified iron deficiency anemia as the cause of 10% of maternal deaths in Indonesia,**³⁸ and highlighted iodine deficiency as related to numerous adverse pregnancy outcomes.³⁹ In the five years preceding the IDHS, 21% of women who gave birth did not receive iron supplements and only 29% took the supplements for the full time period recommended under medical guidelines.⁴⁰

B. Restrictive Abortion Laws and Barriers to Safe Services Contribute to Maternal Mortality.

In 2009, Indonesia passed Law No. 36 on Health, which affirmed the general prohibition on abortion but expanded the grounds on which abortion is decriminalized to include where the life of the pregnant woman is in danger as well as in cases of severe fetal impairment or where the pregnancy resulted from rape and could lead to psychological trauma if continued.⁴¹ Law No. 36 on Health obligates the government to prevent and protect women from unsafe abortions.⁴² Abortion was formerly criminalized in Indonesia without clear exceptions, although some medical practitioners relied on statements by a former chief justice that interpreted the previous provisions on abortion to allow the procedure in cases of medical emergencies.⁴³ The lack of clarity in the previous abortion law led to significant informal procedural requirements being imposed by providers, including requiring a positive pregnancy test, consent of a husband or family member, and a promise to practice contraception after the procedure.⁴⁴

As will be discussed below, despite recognition of these broader exceptions in the 2009 law, the procedural and gestational restrictions included in the law have severely impeded women's ability to access abortion on these grounds. **Abortion on any other grounds than the three listed above is still wholly criminalized, including where necessary to preserve a woman's health and in cases of incest.** A woman who terminates a pregnancy may face up to four years imprisonment and a health worker who performs an abortion may face up to 12 years imprisonment.⁴⁵ The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has specifically stated "punitive provisions against women who undergo abortion must be removed."⁴⁶ Restrictions on abortion mean that women are unable to access safe services, leading to maternal mortality and morbidity.⁴⁷ While the government has not published official figures, it is estimated that approximately 2 million abortions occurred in Indonesia in 2000.⁴⁸ Of those abortions, nearly half were performed by unskilled providers, and this number is higher in rural areas.⁴⁹ Although specific rates of maternal mortality due to unsafe abortion are unknown for Indonesia, **the WHO estimates that unsafe abortion is the cause of 16% of maternal deaths in Southeast Asian countries with restrictive abortions laws, like Indonesia.**⁵⁰

The CEDAW Committee has consistently criticized restrictive abortion laws,⁵¹ particularly those that prohibit and criminalize abortion in all circumstances,⁵² and emphasized that such legislation leads women to obtain illegal⁵³ and unsafe abortions.⁵⁴ The Committee has affirmed that restrictive abortion laws violate women's rights to life and health.⁵⁵ As such, it has asked states parties to review legislation that makes abortion illegal,⁵⁶ and recommended that states parties remove punitive provisions for women who undergo abortion⁵⁷ in line with General Recommendation 24 (Women and Health) and the Beijing Declaration and Platform for Action.⁵⁸

Moreover, the Committee has expressed concern regarding high rates of maternal mortality due to unsafe,⁵⁹ clandestine,⁶⁰ and illegal abortions,⁶¹ as well as the high numbers of abortions among adolescents.⁶² It has noted that women's need to resort to unsafe abortion is linked to their lack of access to contraceptive services.⁶³ The Committee has recommended that states parties increase access to contraceptives⁶⁴ as well as to sexual and reproductive health information⁶⁵ to reduce the number of unsafe,⁶⁶ clandestine,⁶⁷ and illegal⁶⁸ abortions—and the maternal deaths that result.⁶⁹

The Committee has recommended that Indonesia take measures to “guarantee effective access of women and girls to information and services regarding sexual and reproductive health and contraception in order to reduce the rate of unsafe abortions and teenage pregnancy.”⁷⁰ The Committee has also urged Indonesia to ensure that “women have equal access to appropriate and adequate health services, including in rural areas, that obstetric and maternal health needs are adequately addressed and that maternal mortality rates are reduced.”⁷¹ While legalizing abortion on greater grounds is a step in the right direction, there are specific barriers to access that remain which are discussed in the following sections.

1. Spousal Consent Requirements

Under Indonesian law, women seeking abortions must obtain consent from their husbands except in cases of rape.⁷² **The law recognizes no other exception to the spousal consent requirement, even where a woman's life is in danger.**⁷³ The law is silent on access to abortion for unmarried women, and advocates in Indonesia allege that the law is being interpreted to deny unmarried women abortions even where pregnancy is life threatening because no spousal consent can be obtained.⁷⁴

The Committee specifically recommended in 2007 that Indonesia remove family and spousal consent requirements in the area of women's health.⁷⁵ **In its communications with the Committee for this cycle, the state party defended third party consent requirements,** stating that it requires spousal consent for abortion because it is a procedure which risks the life of an individual and therefore requires mutual consent within the family.⁷⁶ This attitude is discriminatory towards women and implies that women are not capable of making an informed medical choice. Further, the WHO has established that spousal and parental consent requirements are not advised under standards of medical safety; abortion is recognized as one of the safest medical procedures when the procedure is performed by a skilled provider in properly equipped facilities and done in a timely manner.⁷⁷

The CEDAW Committee has emphasized in General Recommendation 24 that spousal authorization requirements are a barrier to women's access to health care⁷⁸ and has urged other

states parties to remove spousal consent requirements in the past.⁷⁹ In 2011, the CEDAW Committee expressed concern to Kuwait about policies requiring consent by a male guardian for medical treatment of women and urged the state party “to abolish, as a matter of priority, the requirement of a male guardian’s consent to urgent or non-urgent medical treatment of a woman.”⁸⁰

2. *Gestational Limits*

It is of significant concern that **abortions are not permitted beyond six weeks since the woman’s last menstrual period, even in cases of rape and fetal impairment.**⁸¹ The only exception permitted to this six week limitation is where a woman’s life is in danger.⁸²

There is no medical reason for a six week gestational limit on abortions.⁸³ Rather, strict gestational limits are known to deter women from seeking safe abortions and are a barrier to access.⁸⁴ Abortions can be safely performed throughout a woman’s pregnancy if proper clinical guidelines are followed.⁸⁵ The CEDAW Committee has previously criticized Lithuania for a draft law that only permitted abortion on three grounds within a limited time frame, emphasizing that such strict gestational limits would lead women to seek unsafe abortions.⁸⁶

3. *Poor Quality of Abortion Services and Lack of Access to Safe Services*

Despite Indonesia’s recognition of the government’s obligation to prevent unsafe abortion and protect women from unsafe providers in Law No. 36 on Health, over half of all abortions occur outside of health facilities in unsafe settings.⁸⁷ Unsafe abortions can lead to many complications, including severe bleeding, infection and poisoning from substances used to induce abortion, genital and abdominal injuries, or uterine perforation.⁸⁸ A study by the Guttmacher Institute has found that women in Indonesia first attempt to induce abortion on their own before seeking assistance⁸⁹ and these **procedures often involve unsafe methods such as ingesting herbal products or receiving an abortive massage.**⁹⁰ Because women are first reaching out to unskilled providers, the Guttmacher Institute estimates that rates of “medical complications and maternal deaths from unsafe abortion are expected to be high.”⁹¹ While the Indonesian government has not systematically gathered statistics on the incidence of unsafe abortion mortality and morbidity in the country, the Guttmacher Institute estimates that for every thousand women in Southeast Asia who obtain unsafe abortions, 130 women are hospitalized for complications.⁹² Because not all women who experience complications seek care in hospitals, the rate of complications from unsafe abortion is considered to be even higher.⁹³

Women of all income levels do not have adequate access to safe abortion in Indonesia, but low-income women especially lack access to abortion services. The unskilled and clandestine services that low-income women rely upon are more likely to cause complications.⁹⁴ Due to cost and distance, many women rely on traditional birth attendants to provide abortion services. Traditional birth attendants charge between 76 cents to 38 USD for an abortion procedure, midwives charge 4-60 USD, hospitals charge 46-96 USD, and doctors in a private practice charge 76-200 USD.⁹⁵ The immense **difference in cost tends to drive women towards seeking a cheaper, unsafe abortion service** which could lead to health complications or death.⁹⁶ Under CEDAW, the state party has an obligation to ensure that women can afford health care services or provide them for free if necessary.⁹⁷

4. *Inadequate Information about Abortion*

In Indonesia, there is a lack of awareness of the legality of abortion in specific circumstances. In a survey conducted by a human rights organization in 2010, health workers were only aware of the exception provided for in the case of complications with a woman or the fetus's health.⁹⁸ Health workers and local government officials were generally not aware that there was also an exception in the case of rape even though it was introduced in 2009.⁹⁹ **The vast majority of women and girls from poor communities continue to believe that abortion is illegal in all circumstances.**¹⁰⁰ The CEDAW Committee has established that states parties must provide information on the legality of the procedure and how to access safe services to ensure that women are aware of their legal right to abortion, including specifically where there has been a change in the abortion law that permits abortion on broader grounds.¹⁰¹

C. **Barriers to Accessing the Full Range of Contraceptives and Related Information and Services**

As has been recognized by the CEDAW Committee, lack of access to contraceptives contributes to maternal mortality by denying women the ability to prevent unwanted pregnancies, including where they have contrary health indications, and by exposing them to the risk of pregnancy complications as well as unsafe abortion complications.¹⁰² Despite Indonesia's legal commitment to ensure women access to information and services related to the full range of contraceptive methods, formidable barriers to access still persist. These barriers – including legal obstacles to accessing contraceptives for unmarried women, inaccurate or inadequate information on contraceptives, and the exclusion of emergency contraceptives from government contraceptive policies – have resulted in stagnation in the contraceptive prevalence rate and a lack of reduction in the unmet need for family planning since the mid-1990s.¹⁰³ The government's 2007 IDHS report found that **the contraceptive prevalence rate for modern methods had remained “virtually unchanged” since 2003** at 54% for ever-married women and 57% for married women.¹⁰⁴ Sixty percent of married women with 2 children, 75% of married women with 3-4 children, and 80% of married women with 5 or more children are not using contraception.¹⁰⁵ Further, **Indonesia has regressed in satisfying the demand for contraceptives**, with the 2007 IDHS revealing a one point *decrease* in percent of demand for various contraceptives satisfied since 2003.¹⁰⁶

The government's role in meeting contraceptive need has decreased in recent years.¹⁰⁷ Women in Indonesia have increasingly had to turn to the private sector to access contraceptives. The 2007 IDHS shows that only 22% of women use contraceptives supplied by the government, which represents a decrease from 28%, while reliance on the private sector has increased from 63% to 69%.¹⁰⁸ Unsurprisingly, poor women are much less likely to be able to access modern methods of contraceptives—less than 50% of women in the lowest quintile have used modern contraceptive methods, compared to roughly 58% of women in the wealthiest quintile.¹⁰⁹

CEDAW and General Recommendation 21 establish that women's rights to health, life, self-determination, and to determine the number and spacing of one's children require adequate access to information and services for the full range of contraceptive methods.¹¹⁰ Contraception, including emergency contraception, is on the WHO's list of essential medicines.¹¹¹ The Committee stresses the importance of access to information regarding contraceptives, stating that “[i]n order to make an informed decision about safe and reliable contraceptive measures, women

must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.”¹¹² In its previous Concluding Observations to Indonesia, the CEDAW Committee has specifically urged Indonesia to guarantee access to, and information about, contraception.¹¹³

1. Exclusion of Unmarried Women from Contraceptive Laws and Policies

Under Indonesian law, contraceptives are only legally accessible for married women with the consent of their husbands.¹¹⁴ Indonesia’s Population Law establishes the right of married couples to determine the spacing and timing of their children, but does not include any mention of unmarried women and girls.¹¹⁵ Although the government claims that this law is not meant to exclude unmarried females, a recent human rights report on reproductive rights indicates that this exclusion has been interpreted by medical practitioners as **a prohibition on the provision of contraceptives to unmarried women.**¹¹⁶ The focus on married couples is echoed in other national health policies, including the 2009 Law on Health, which protects the reproductive health of married couples.¹¹⁷

2. Contraceptive Usage Impacted by Inaccurate Reproductive and Sexual Health Information

In General Recommendation 21, the CEDAW Committee stresses the importance of access to information concerning contraceptives, stating that “[i]n order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services.”¹¹⁸

Lack of information and misinformation are significant barriers to contraceptive use in Indonesia. Women often have misconceptions about their need for contraceptives as well as the risk of side effects and what to do if side effects are experienced. For example, one study that examined the reasons why poor women in Indonesia do not use contraception found that 40% of women both poor and better off did not use modern contraception because they did not consider themselves at risk of pregnancy or believed they were infertile.¹¹⁹ In addition, compared to women in other developing countries, **women in Indonesia are more likely to cite fear of side effects or concerns about health as the reason why they do not use contraceptives.**¹²⁰

According to the 2007 IDHS, 22% of women do not plan to use contraceptives for these reasons.¹²¹ The 2007 IDHS found that 10% of contraceptive users discontinued use within 12 months due to concerns regarding side effects or health problems¹²² and this percentage is even higher for particular methods, such as the pill (14%) and implants (23%).¹²³ Further, 12.3% of women between the ages of 15-49 state that they do not plan to use contraceptives because of perceived side effects.¹²⁴ Despite this, two out of every three women who used contraceptives report not receiving any counseling on side effects or information on what to do if they did experience side effects.¹²⁵

Further, **misconceptions about side effects persist among health workers as well,** and can lead to denial of contraceptive information and services even to those women who are legally permitted to use them. In an interview conducted with midwives in Indonesia, it was reported that several cited the belief that those who use contraceptives will not be able to have children in

the future and considered this to be a valid justification to **deny contraceptive information and services to married women who do not have children already.**¹²⁶

3. Disproportionate Burden of Contraceptives on Females

Condom use is extremely low in Indonesia; only approximately 1% of women between the ages of 15-49 use condoms.¹²⁷ Low condom use shows that women face almost the exclusive burden of family planning as compared to men. Because condom use is the only modern method of family planning that also offers protection against sexually transmitted infections (STIs), such low condom use also puts women at risk for STIs, jeopardizing their right to health. Male sterilization is only used by 0.2% of those who use contraceptives.¹²⁸

The state party's failure to alleviate the burden of contraceptive use experienced by women violates CEDAW. In fact, the CEDAW Committee has criticized states parties where contraception policies disproportionately burden women rather than ensuring contraceptives are the responsibility of both males and females.¹²⁹

4. Access to and Information about Emergency Contraception is Limited.

Emergency contraception is an essential medicine intended as a back-up contraceptive method in the event of unprotected intercourse or contraceptive failure.¹³⁰ As such, treaty monitoring bodies, including the CEDAW Committee, have recognized that emergency contraception fills a unique role in the range of modern contraceptive methods and is particularly valuable for victims of sexual violence, adolescents, and other marginalized groups who may face greater barriers in accessing other contraceptive methods.¹³¹ Repeatedly, this Committee has urged states parties to make emergency contraception available.¹³²

Emergency contraception is available in Indonesia by prescription.¹³³ However, it is not in the national essential medicine list and there are no standards for its provision at the national or provincial level.¹³⁴ As such, emergency contraception is not available in every province.¹³⁵ Moreover, information on emergency contraception and its role needs to be relayed to medical practitioners and to women in order for it to become an effective tool in lowering the rate of unwanted pregnancies. Currently, only 0.3% of married or ever-married women have used emergency contraceptives.¹³⁶ The 2007 IDHS found that **only 6% of ever-married and currently married women are aware of emergency contraceptives, and stated that limited knowledge of this method is due in part to the government's exclusion of this method from the national contraceptive program.**¹³⁷ One study found that there is a low level of knowledge regarding emergency contraception amongst medical practitioners and it was therefore used infrequently.¹³⁸

II. The Right to Non-Discrimination (Articles 1, 2, 12, 14, and 16)

In addition to protecting women from discriminatory laws and policies which deny women health services that only they need, CEDAW contains equality provisions that the Committee has established to ensure the elimination of discriminatory practices such as early marriage¹³⁹ and FGM¹⁴⁰ and establish a special obligation for states parties to ensure that marginalized women, including rural women¹⁴¹ and adolescent girls,¹⁴² are not discriminated against. This Committee has previously urged Indonesia to ensure women's equality by "[putting] in place an effective strategy with clear priorities and timetables to eliminate discrimination against women in the

areas of marriage and family relations”¹⁴³ and persisting in efforts to ensure that rural women have equal access to appropriate and adequate health care services.¹⁴⁴

Despite these previous Concluding Observations to Indonesia as well as the CEDAW Committee’s clear condemnation of discriminatory practices, early marriage and FGM persist in Indonesia. In fact, despite being a harmful and inherently discriminatory practice, **FGM is being formally promoted by the government through a circular from the Ministry of Health that prescribes guidelines on how to conduct the procedure.** Further, deep disparities in access for reproductive health services exist between urban and rural women as well as for adolescent girls and unmarried women and girls. This section will discuss each of these issues in turn.

A. Marriage-Related Discrimination

The CEDAW Committee has taken a strong stance against women’s inequality within marriage. The Committee has been particularly critical of traditional patriarchal gender stereotypes in the family and attitudes toward women’s roles and responsibilities.¹⁴⁵ It has linked harmful cultural practices to women’s unequal status in marriage and family relations, and has urged systematic and sustained action to eliminate stereotypes and negative cultural practices.¹⁴⁶ The Committee has suggested several specific measures for eradicating sex-role stereotypes in the family, including using local media to promote change;¹⁴⁷ starting awareness-raising campaigns;¹⁴⁸ undertaking a revision of curricula and textbooks;¹⁴⁹ and implementing programs targeted at both men and women.¹⁵⁰ The Committee has also recommended that states parties monitor and assess the measures that are implemented with adjustments to improve the states parties’ progress towards the achievement of stated goals.¹⁵¹

1. Early Marriage

Early marriage is legally permitted in Indonesia under the Indonesia Marriage Law, which establishes that **the legal age for marriage is 16 for girls.**¹⁵² Ten percent of women ages 25-49 were married by 15 years of age while **34% were married by the age of 18.**¹⁵³ Early marriage correlates with a risk of early pregnancy. Giving birth at an early age puts girls and adolescents at high risk of maternal death and morbidity, as this Committee, other treaty monitoring bodies, the WHO, and UNFPA have repeatedly emphasized.¹⁵⁴ Early pregnancy is associated with a higher risk of maternal mortality: girls aged 10-14 are five times more likely to die in pregnancy than women in their twenties while girls aged 15-19 are twice as likely to die.¹⁵⁵ Early pregnancy, when it does not cause death, takes a toll on young women’s bodies and can lead to pregnancy-related morbidities including uterine prolapse and fistula.¹⁵⁶

With such high numbers of children being married in Indonesia, it is critical that girls have access to reproductive health information that includes messages geared towards postponing early marriage and early pregnancy. Ten percent of teenage girls are married with children; yet sexual and reproductive health education is not part of the primary curriculum.¹⁵⁷ The state party has indicated that “reproductive rights of women will be included over the next five years as a subject in the school curriculum at the Junior and Senior High School levels;”¹⁵⁸ however, as the CEDAW Committee has noted, “contraceptive and reproductive health services are aimed at married adults,” meaning that adolescent girls are critically ignored.¹⁵⁹

Article 5 of CEDAW obliges states parties to “take all appropriate measures to modify the social and cultural patterns of conduct of men and women...” that perpetuate discrimination and harm to women,¹⁶⁰ and Article 16(2) states that the marriage of children “shall have no legal effect.”¹⁶¹ The CEDAW Committee has established eighteen as the legal age for marriage under the Convention,¹⁶² and specifically expressed concern about the discriminatory provisions in the Indonesian Law on Marriage in previous Concluding Observations regarding the minimum age for marriage. This Committee has also noted with concern the perpetuation of stereotypes of men as heads of households, while women are relegated to domestic roles under the law.¹⁶³

However, the state party has failed to reform the law accordingly, nor has it meaningfully addressed any of the discriminatory provisions of the Indonesian Law on Marriage in its report to the CEDAW Committee in advance of this session except to state that the “wife and husband in marital relationship have equal rights and obligation regarding all matters related to their marriage life.”¹⁶⁴

Indonesia’s report to the Committee did, however, discuss legislative, administrative, and other measures that the state party has taken to eliminate harmful stereotyping that leads to practices like early marriage.¹⁶⁵ In particular, the state party has indicated that school curricula and teaching materials are reviewed in order to eliminate these detrimental stereotypes that undermine the equality of men and women.¹⁶⁶ The state party has also indicated that it has developed public campaigns and media awareness to address harmful practices related to marriage.¹⁶⁷ While Indonesia deserves to be commended for these steps, the state party continues to violate its obligation to ensure the right to non-discrimination as long as it fails to reform the Indonesian Law on Marriage.¹⁶⁸

The CEDAW Committee has discussed early marriage and applied the relevant language from General Recommendation 21 in numerous concluding observations.¹⁶⁹ While the Committee frequently has recommended that legislation be implemented,¹⁷⁰ reviewed and amended,¹⁷¹ or enforced¹⁷² to eliminate child and forced marriage, it has recognized that legal changes alone will not end the practice. It has recommended implementing public awareness campaigns designed specifically to change attitudes toward women and girls¹⁷³ and point out the negative effects of early marriage on women’s enjoyment of their human rights, especially the rights to health and education.¹⁷⁴

This Committee and the Committee on the Rights of the Child (CRC Committee) have expressly noted that early marriage has many negative long-lasting health effects on women.¹⁷⁵ The CRC Committee has made important links between child and forced marriage and the ability of girl children to exercise the right to health.¹⁷⁶ Notably, the WHO has commented specifically on the connection between child and forced marriage and high maternal and infant mortality rates.¹⁷⁷ The CRC Committee has also expressed concerns about the connection between child and forced marriage and high school dropout rates, especially among girls, and the infringement on the right to education.¹⁷⁸

2. *Marital Rape*

The state party should be commended for passing the Domestic Violence Law (No. 23/2004) to address violence against women. Previously, women had to rely on the Criminal Code (*Kitab Undang-undang Hukum Pidana*, KUHP).¹⁷⁹ However, the definitions of “rape” and “sexual

violence” are narrowly construed and inconsistent between the two pieces of legislation. **Marital rape is not a crime under the Criminal Code.**¹⁸⁰ The Domestic Violence Law refers to sexual violence, but does not define rape or marital rape.¹⁸¹ The state party should be encouraged to include definitions of rape that are consistent between the two laws. Further, it is a concern that the Domestic Violence Law requires women to show two elements of proof that a rape occurred, which could include testimony from the victim, the defendant, or an expert.¹⁸²

In a 2010 report on domestic violence, 45% involved sexual violence and 95% of reports were violence by a husband against his wife.¹⁸³ It is crucial to note that the highest number of recorded cases of violence involves girls between the ages of 13-18 years of age.¹⁸⁴ The CEDAW Committee has recommended that governments enact legislation to criminalize violence such as marital rape,¹⁸⁵ or repeal or amend legislation that discriminates against married women by not penalizing marital rape.¹⁸⁶ Accordingly, the state party needs to provide greater protection to women, especially adolescent girls, against specific forms of sexual violence within marriage including marital rape.

B. Discrimination in Fulfillment of the Right to Maternal Health Services and Abortion for Rural Women and Adolescents

1. Rural Women Suffer Discrimination in Access to Reproductive Health Services.

Rural women face significant barriers to accessing reproductive health services in Indonesia. **Gross disparities exist between deliveries in health facilities among women in rural (28.9%) and urban areas (70.3%).**¹⁸⁷ Rural women are not provided with adequate health care facilities or trained medical practitioners, and instead must rely on traditional birth attendants for pregnancy-related care, including delivery and abortion services.¹⁸⁸ Similarly, the **unmet need for contraceptives is higher in rural areas (9.2%) than urban areas (8.7%).**¹⁸⁹ With limited access to contraceptives, rural women are also disproportionately at risk of unplanned pregnancies. To make matters worse, safe abortion services are inaccessible to many rural women – over **80% of abortions in rural areas are from traditional birth attendants.**¹⁹⁰ This is significantly different than in urban areas, where only 15% are performed by traditional birth attendants.¹⁹¹ When women seek abortions from untrained providers or in poorly equipped facilities, which they are more likely to do when they lack access to safe services, these unsafe, clandestine abortions can result in death or morbidity.¹⁹²

Indonesia has implemented a program for midwives in rural villages, Birth Planning and Complication Prevention Program, which aims to enhance the role of the husband, family, and community in preparing for delivery as well as providing contraception counseling.¹⁹³ The program relies on the application of stickers outside an expectant woman’s home in order to notify people in the community of her pregnancy and potential need for assistance. Even though midwives are being placed in remote areas,¹⁹⁴ midwives are paid low salaries and are sometimes not accepted by the villagers, who then resort to traditional healers.¹⁹⁵ Further, safe abortion services are not included in this program, despite the fact that rural women face such barriers to accessing these services.

2. *Adolescent Women in Indonesia Face Discrimination in Accessing Reproductive Health Services.*

This Committee has noted in particular that the lack of family planning education and difficulty in accessing contraceptives has led to a high rate of teenage pregnancy. As mentioned previously, teenage girls in Indonesia are at great risk of early marriage. However, Indonesian adolescents are unaware of basic reproductive and sexual health issues, such as fertile periods, puberty, and the risk that pregnancy can result from a single act of intercourse.¹⁹⁶ The need for sexual and reproductive health education has not been sufficiently addressed by the Indonesian government because it runs contrary to Indonesian policy to provide this information to adolescents and to those who are unmarried. The CRC Committee voiced concern that “no organized system of reproductive health counseling and services, nor education on HIV/AIDS and STIs for youth exists.”¹⁹⁷ **Even more discouraging to proper information is the criminalization of providing information “to people relating to the prevention and interruption of pregnancy” which can lead from two to nine months of imprisonment.**¹⁹⁸

As noted previously, 10% of teenage women in Indonesia are married and have children.¹⁹⁹ The state party faces a geographic disparity in rates of pregnant adolescents. 13% of rural adolescents had started childbearing in comparison to 4% of urban adolescents.²⁰⁰ The percentage of married adolescents aged 15-19 who have ever delivered a child is significantly higher in rural areas (13.7%) than urban areas (7.3%).²⁰¹

These pregnant adolescents are further discriminated against by their schools. **By the state party’s own admission, pregnant teenage girls are often expelled from school.**²⁰² In one case, a pregnant girl was expelled and her school went so far as to urge other schools to not accept her as a student.²⁰³

3. *Unmarried Women and Girls*

As discussed in Sections I.B(1) and I.C(1) above, married girls and women who become pregnant are discriminated against on the basis of their marital status in the enjoyment of their right to health in Indonesia. **Unmarried adolescents are restricted from accessing reproductive health services and information under government laws on requiring spousal consent for abortion and limiting access to contraceptives to married couples.**²⁰⁴ In General Recommendation 21, the CEDAW Committee establishes that women should be able to enjoy the guarantees under Article 16(1), which include the right to determine the number and spacing of their children without discrimination on the basis of their marital status.²⁰⁵ Unfortunately, as this Committee has recognized in the list of issues for Indonesia, this is due to the large influence religion has in marital and sexual relationships.²⁰⁶ This Committee as well as the Human Rights Committee has acknowledged that laws based in religious ideology can be an impediment to women fulfilling their rights to health and equality.²⁰⁷ Accordingly, provisions for reproductive and sexual health must cover all individuals and should not be restricted due to marital status or age.

C. Female Genital Mutilation (FGM)

In 2007, this Committee recommended that Indonesia prohibit FGM and develop awareness-raising campaigns to change the cultural perceptions connected with FGM and to educate people

that it is a violation of the human rights of women and girls.²⁰⁸ Even after issuing this recommendation, the state party **instead passed a regulation which legitimizes the practice of FGM by authorizing certain medical practitioners, such as doctors, midwives, and nurses, to perform FGM.**²⁰⁹ This is contrary to repeated recommendations made to various states parties by this Committee which have classified FGM as a discriminatory practice to women.²¹⁰ This Committee has also noted that this is a form of violence against women and girls and is in violation of the Convention.²¹¹

The CEDAW Committee is the only treaty monitoring body to adopt a general recommendation solely addressing FGM. In General Recommendation 14, the Committee recognizes the cultural, traditional, and economic factors that perpetuate the practice of FGM and identifies the health-related consequences and makes recommendations to states parties regarding ways to eliminate the practice.²¹² In its General Recommendation 24, the CEDAW Committee further emphasizes states parties' obligation to take steps to eliminate FGM.²¹³ The Committee specifically recommends the "enactment and effective enforcement of laws that prohibit female genital mutilation."²¹⁴ These recommendations are aimed at addressing the health-related aspects of FGM and changing cultural attitudes toward FGM through educational programs.

FGM also violates women and girls' right to health by exposing them to multiple health risks and even death.²¹⁵ FGM can lead to a range of health complications, including fistula from obstructed labor, elevated risk of caesarean sections, and emotional and psychological harm.²¹⁶ Short-term complications include severe pain and risk of hemorrhage that can lead to shock and death.²¹⁷ In addition, there is a very high risk for local and systemic infections, with documented reports of abscesses, ulcers, delayed healing, septicemia, tetanus, and gangrene.²¹⁸ Long-term complications include urine retention resulting in repeated urinary infections; obstruction of menstrual flow leading to frequent reproductive tract infections and infertility; and prolonged and obstructed labor.²¹⁹ In addition to the physical complications, there are also adverse psychological and sexual effects.²²⁰

In Indonesia, circumcision of women and girls is a tradition closely associated with Islam and has been endorsed by the Indonesian Ulema Council (the highest Islamic advisory body in Indonesia) and the Nahdlatul Ulama (NU) (Indonesia's largest Muslim organization).²²¹ In fact, although the Indonesia Ulema Council has issued a statement in 2006 opposing any cutting that is harmful to women, in 2008 it issued a fatwa "prohibiting the prohibition on female circumcision"²²² A 2001 study found that Muslim women had different perceptions of FGM ranging from a practice that was encouraged by the prophet Muhammad, mandatory under Islam, or is meant to purify female babies and promote good hygiene.²²³ Varying viewpoints may be derived from the fact that religious leaders also have differing beliefs as to whether it is encouraged or mandatory.²²⁴

In practice, the procedure of FGM in Indonesia varies, ranging from what the WHO classifies as "Type I" FGM (partial or total removal of the clitoris and/or the prepuce (clitoridectomy) to "Type IV" FGM (harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization).²²⁵ A 2003 study reports that "symbolic only" types of female circumcision, where there is no incision or excision, represented 28% of all cases in the study, while "harmful" forms represented 71% of all cases (49% incision and 22% excision).²²⁶ Regardless of type, FGM impedes the ability of women to enjoy their

rights to life and health. Accordingly, the state party has an obligation to prohibit the practice, regardless of religion's role in society.

III. CONCLUSION: SUGGESTED QUESTIONS AND RECOMMENDATIONS

We respectfully request that this Committee pose the following questions to the delegation representing the Government of Indonesia during its 52nd Session.

1. High rates of maternal death persist, which are most severe for rural, adolescent, and poor women. What steps have been taken by the government to improve maternal health for those populations, including by improving quality, making such services affordable or free where necessary, and ensuring accessibility in rural areas? What is the state party doing to address maternal death and morbidity, including addressing anemia, a leading cause of maternal mortality?
2. In Indonesia, the contraceptive prevalence rate for modern methods had remained “virtually unchanged” since 2003 and the percentage of the demand for contraceptives met by the government has begun to decrease. Misinformation on the safety and effectiveness of contraceptives as well as the lack of clarity on whether unmarried women are permitted to access contraceptives remain significant barriers. What steps have been taken by the government to establish universal access to a full range of contraceptive information and services, including emergency contraceptives, and to reduce the unmet need for contraceptives, especially for unmarried, poor, and rural women and girls?
3. Despite the legalization of abortion on limited grounds in Law No. 36 on Health, the quality of abortion services remains very poor and both women and health care providers continue to falsely believe that abortion is illegal. Further, abortion remains illegal past six weeks in cases of rape and fetal impairment and entirely illegal at any point in the pregnancy in cases of incest or where a woman's health is at risk. The law recognizes an exception where a woman's life is at risk beyond six weeks, but requires spousal consent on this ground as well as in cases of fetal impairment. As a result, unsafe abortion continues to be a cause of maternal mortality. What steps has the state party taken to ensure that women do not die from unsafe abortion and to remove barriers to safe abortion emanating from the law?
4. Adolescent girls continue to experience discrimination stemming from early marriage and early pregnancy. The law permits marriage as early as 16, exposing girls to early pregnancy and increased risks of pregnancy-related death. What steps has the state party taken to address discrimination against adolescents related to the continued persistence of early marriage? What has the state party done to ensure adolescent girls are not at risk of early pregnancy due to lack of access to contraceptive information and services? Further, what steps has the government taken to address incidences of girls being expelled from school because they are pregnant?
5. Women and girls continue to be exposed to gender-based violence, including female genital mutilation and marital rape. What has the government done to eliminate female

genital mutilation and ensure that women and girls are protected from sexual violence within marriage?

The Center further respectfully submits the following recommendations for the Committee to consider incorporating into the Concluding Observations for Indonesia.

1. Prioritize ensuring access to a quality maternal health services, including antenatal, postnatal, and emergency obstetric care, particularly for poor, rural, and unmarried women and adolescent girls. Address anemia as a leading cause of death for pregnant women and ensure maternal health services are affordable.
2. Address unmet need for contraception by prioritizing universal access to the full range of contraceptive methods, information, and services, including emergency contraception, with a particular focus on rural women, poor women, unmarried women, and adolescent girls. Clarify that contraceptives should be provided without discrimination on the basis of marital status.
3. Address the incidence of unsafe abortion, including by implementing the Law on Health to ensure awareness and access to safe, quality abortion on the grounds permitted therein; recognize a health exception to the prohibition on abortion; and remove the 6 week gestational limit for abortion in cases of rape and fetal impairment. Remove restrictions that require spousal or parental consent for access to abortion, and take steps to ensure that providers are aware of this legal change.
4. Eliminate discriminatory practices against women and girls that jeopardize their reproductive health. Amend the Law on Marriage to increase the legal age of marriage for girls to comply with CEDAW and reduce child marriage through proper implementation of the legal ban on child marriage. Investigate allegations that pregnant girls are being forced to drop out of school and take concrete steps to eliminate this practice.
5. Address violence against women through law reform for female genital mutilation and marital rape.

Sincerely,



Melissa Upreti
Regional Director for Asia
Center for Reproductive Rights



Payal Shah
Legal Adviser for Asia
Center for Reproductive Rights

¹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Indonesia*, ¶ 36, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

² *Id.*

³ *Id.* ¶ 37.

⁴ *Id.* ¶¶ 37, 39.

⁵ *Id.* ¶ 37.

⁶ *Id.* ¶ 17.

⁷ Indonesia Health Law No. 36, art. 75 (2009) [hereinafter Health Law No. 36].

⁸ WORLD HEALTH ORGANIZATION (WHO), TRENDS IN MATERNAL MORTALITY: 1990 TO 2008: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, AND THE WORLD BANK 17 (2010), available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/trends_matmortality90-08.pdf [hereinafter WHO, TRENDS IN MATERNAL MORTALITY].

⁹ Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, art. 12(1), G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW].

¹⁰ *Id.* art. 12(2).

¹¹ *Id.* art. 10(h).

¹² *Id.* art. 16(1)(e).

¹³ See, e.g., CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 361, 363, ¶¶ 17, 27, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; see also CEDAW Committee, *Concluding Observations: Belize*, ¶ 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 337, U.N. Doc. A/53/38 (1998); *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

¹⁴ *Id.* ¶ 7.6.

¹⁵ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶¶ 17-19; CEDAW Committee, *Concluding Observations: Belize*, ¶ 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 337, U.N. Doc. A/53/38 (1998).

¹⁶ See, e.g., CEDAW Committee, *Concluding Observations: Belize*, ¶ 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Colombia*, ¶ 393, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 337, U.N. Doc. A/53/38 (1998); CEDAW Committee, *Concluding Observations: Madagascar*, ¶ 244, U.N. Doc. A/49/38 (1994).

¹⁷ Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International, *Indonesia Demographic and Health Survey 2007*, at 217 (2008), available at [http://www.measuredhs.com/pubs/pdf/FR218/FR218\[27August2010\].pdf](http://www.measuredhs.com/pubs/pdf/FR218/FR218[27August2010].pdf) [hereinafter *Indonesia Demographic and Health Survey 2007*].

¹⁸ *Id.*

¹⁹ WHO, TRENDS IN MATERNAL MORTALITY, *supra* note 8, at 24.

²⁰ MINISTRY OF NATIONAL DEVELOPMENT PLANNING/NATIONAL DEVELOPMENT PLANNING AGENCY (BAPPENAS), REPUBLIC OF INDONESIA, REPORT ON THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010 67 (2010) [hereinafter MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010].

²¹ *Id.*

²² See, e.g., CEDAW Committee, *Concluding Observations: Albania*, ¶¶ 34-35, U.N. Doc. CEDAW/C/ALB/CO/3 (2010); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶¶ 37-38, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); CEDAW Committee, *Concluding Observations: Israel*, ¶¶ 38-41, U.N. Doc. CEDAW/C/ISR/CO/5 (2011).

²³ See, e.g., CEDAW Committee, *Concluding Observations: Ethiopia*, ¶¶ 34-35, U.N. Doc. CEDAW/C/ETH/CO/6-7 (2011).

²⁴ See, e.g., CEDAW Committee, *Concluding Observations: Belize*, ¶ 28, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Bolivia*, ¶ 43, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); CEDAW Committee, *Concluding Observations: Pakistan*, ¶ 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007).

²⁵ See, e.g., CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Mexico*, ¶ 445, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations: Mozambique*, ¶ 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 123, U.N. Doc. A/51/38 (1996); CEDAW Committee, *Concluding Observations: Peru*, ¶ 337, U.N. Doc. A/53/38/Rev.1 (1998); CEDAW Committee, *Concluding Observations: Uganda*, ¶ 147, U.N. Doc. A/57/38 (2002).

²⁶ CEDAW Committee, *Concluding Observations: Mozambique*, ¶ 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).

²⁷ *Id.*

²⁸ See, e.g., CEDAW Committee, *Concluding Observations: Republic of Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); CEDAW Committee, *Concluding Observations: United Republic of Tanzania*, ¶ 39, U.N. Doc. CEDAW/C/TZA/CO/6 (2008); CEDAW Committee, *Concluding Observations: India*, ¶ 40, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

²⁹ See, e.g., CEDAW Committee, *Concluding Observations: Turkey*, ¶ 38, U.N. Doc. CEDAW/C/TUR/4-5 (2005); CEDAW Committee, *Concluding Observations: Gambia*, ¶ 34, U.N. Doc. CEDAW/C/GMB/1-3 (2005); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 175, U.N. Doc. A/58/38 (2003); CEDAW Committee, *Concluding Observations: Equatorial Guinea*, ¶ 205, U.N. Doc. A/59/38 (2004).

³⁰ CEDAW, *supra* note 9, art. 12(2).

³¹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶ 13.

³² CEDAW Committee, *List of issues and questions with regard to consideration of periodic reports: Indonesia Addendum, Responses of Indonesia to the list of issues to be taken up in connection with the consideration of combined sixth and seventh periodic reports*, ¶ 84, U.N. Doc. CEDAW/C/IDN/Q/6-7/Add.1 (2012) [hereinafter CEDAW Committee, *Responses to list of issues and questions*].

³³ MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010, *supra* note 20, at 74.

³⁴ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 288.

³⁵ CEDAW Committee, *Consideration of Reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, Combined sixth and seventh reports of State parties: Indonesia*, ¶¶ 137-138, CEDAW/C/IDN/6-7 (2011) [hereinafter CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*].

³⁶ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 181.

³⁷ MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010, *supra* note 20, at 74.

³⁸ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 180.

³⁹ *Id.*

⁴⁰ *Id.* at 181.

⁴¹ Indonesia Health Law No. 23, arts. 15, 17 (1992); Health Law No. 36, *supra* note 7, art. 75.

⁴² Health Law No. 36, *supra* note 7, art. 77.

⁴³ Penal Code of Indonesia, arts. 346-349 (Feb. 27, 1982) [hereinafter Penal Code]; Asia Safe Abortion Partnership, *A Study of Knowledge, Attitudes and Understanding of Legal Professionals about Safe Abortion as a Women's Right*, at 5, available at http://www.asap-asia.org/Indonesia_Abortion_Booklet_Update.pdf [hereinafter ASAP, *A Study about Safe Abortion as a Women's Right*].

⁴⁴ ASAP, *A Study about Safe Abortion as a Women's Right*, *supra* note 43, at 5.

⁴⁵ Penal Code, *supra* note 43, arts. 346-348.

⁴⁶ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Rep. of the Special Rapporteur, Paul Hunt, ¶ 30, U.N. Doc. E.CN.4/2004/49 (Feb. 16, 2004).

⁴⁷ Guttmacher Institute, *Abortion in Indonesia*, IN BRIEF 2, 3 (2008), available at http://www.guttmacher.org/pubs/2008/10/15/IB_Abortion_Indonesia.pdf [hereinafter Guttmacher Institute, *Abortion in Indonesia*].

⁴⁸ *Id.* at 1.

⁴⁹ *Id.* at 2.

⁵⁰ *Id.*

⁵¹ CEDAW Committee, *Concluding Observations: Argentina*, ¶¶ 37-38, U.N. Doc. CEDAW/C/ARG/CO/6 (2010); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶¶ 39-40, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); CEDAW Committee, *Concluding Observations: Côte d'Ivoire*, ¶¶ 40-41, U.N. Doc. CEDAW/C/CIV/CO/1-3 (2011); CEDAW Committee, *Concluding Observations: Republic of Korea*, ¶¶ 34-35, U.N. Doc. CEDAW/C/KOR/CO/7 (2011).

⁵² See, e.g., CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); CEDAW Committee, *Concluding Observations: Honduras*, ¶ 24, U.N. Doc. CEDAW/C/HON/CO/6 (2007).

⁵³ See CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

⁵⁴ See, e.g., CEDAW Committee, *Concluding Observations: Antigua and Barbuda*, ¶ 258, U.N. Doc. A/52/38/Rev.1, Part II (1997); CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

-
- ⁵⁵ See, e.g., CEDAW Committee, *Concluding Observations: Belize*, ¶ 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Chile*, ¶ 228, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Colombia*, ¶ 393, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 337, U.N. Doc. A/53/38 (1998); CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 131, U.N. Doc. A/51/38 (1996).
- ⁵⁶ CEDAW Committee, *Concluding Observations: Rwanda*, ¶¶ 35-36, U.N. Doc. CEDAW/C/RWA/CO/6 (2009); CEDAW Committee, *Concluding Observations: Sri Lanka*, ¶¶ 36-37, U.N. Doc. CEDAW/C/LKA/CO/7 (2011).
- ⁵⁷ See, e.g., CEDAW Committee, *Concluding Observations: Liechtenstein*, ¶¶ 25-26, U.N. Doc. CEDAW/C/LIE/CO/3 (2007); CEDAW Committee, *Concluding Observations: Mauritius*, ¶ 31, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); CEDAW Committee, *Concluding Observations: Nicaragua*, ¶ 18, U.N. Doc. CEDAW/C/NIC/CO/6 (2007); CEDAW Committee, *Concluding Observations: Philippines*, ¶ 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006).
- ⁵⁸ CEDAW Committee, *Concluding Observations: Mauritius*, ¶ 31, U.N. Doc. CEDAW/C/MAR/CO/5 (2006).
- ⁵⁹ See, e.g., CEDAW Committee, *Concluding Observations: Republic of Moldova*, ¶ 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); CEDAW Committee, *Concluding Observations: Mongolia*, ¶ 273, U.N. Doc. A/56/38 (2001).
- ⁶⁰ See, e.g., CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Morocco*, ¶ 30, U.N. Doc. CEDAW/C/MAR/CO/4 (2008); CEDAW Committee, *Concluding Observations: Uganda*, ¶ 147, U.N. Doc. A/57/38 (2002).
- ⁶¹ See, e.g., CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 287, U.N. Doc. A/60/38, Part 1 (2005); CEDAW Committee, *Concluding Observations: Peru*, ¶ 482, U.N. Doc. A/57/38 (2002).
- ⁶² See CEDAW Committee, *Concluding Observations: Mexico*, ¶ 445, U.N. Doc. A/57/38 (2002).
- ⁶³ See, e.g., CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 36, U.N. Doc. CEDAW/C/COD/CO/5 (2006); CEDAW Committee, *Concluding Observations: Guyana*, ¶ 621, U.N. Doc. A/50/38 (1995); CEDAW Committee, *Concluding Observations: Ukraine*, ¶ 287, U.N. Doc. A/51/38 (1996).
- ⁶⁴ CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 36, U.N. Doc. CEDAW/C/COD/CO/5 (2006); CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Oman*, ¶¶ 40-41, U.N. Doc. CEDAW/C/OMN/CO/1 (2011); CEDAW Committee, *Concluding Observations: Burundi*, ¶¶ 35-36, U.N. Doc. CEDAW/C/BDI/CO/4 (2008).
- ⁶⁵ CEDAW Committee, *Concluding Observations: Albania*, ¶¶ 34-35, U.N. Doc. CEDAW/C/ALB/CO/3 (2010); CEDAW Committee, *Concluding Observations: Argentina*, ¶¶ 37-38, U.N. Doc. CEDAW/C/ARG/CO/6 (2010); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶¶ 37-40, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); CEDAW Committee, *Concluding Observations: Ethiopia*, ¶¶ 34-35, U.N. Doc. CEDAW/C/ETH/CO/6-7 (2011).
- ⁶⁶ See, e.g., CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 309, U.N. Doc. A/53/38 (1998); CEDAW Committee, *Concluding Observations: Myanmar*, ¶ 130, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Paraguay*, ¶ 287, U.N. Doc. A/60/38, Part 1 (2005).
- ⁶⁷ See, e.g., CEDAW Committee, *Concluding Observations: Burundi*, ¶ 62, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations: Lebanon*, ¶ 112, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/5 (2006).
- ⁶⁸ See CEDAW Committee, *Concluding Observations: Colombia*, ¶ 23, U.N. Doc. CEDAW/C/COL/CO/6 (2007).
- ⁶⁹ See, e.g., CEDAW Committee, *Concluding Observations: Kenya*, ¶¶ 37-38, U.N. Doc. CEDAW/C/KEN/CO/6 (2007); CEDAW Committee, *Concluding Observations: Mozambique*, ¶ 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007).
- ⁷⁰ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 37, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).
- ⁷¹ *Id.*
- ⁷² Health Law No. 36, *supra* note 7, art. 76.
- ⁷³ *Id.*
- ⁷⁴ Dessy Sagita, *Amnesty Demands Repeal of Indonesia's Anti-Abortion Laws*, JAKARTA GLOBE (Nov. 4, 2010), <http://www.thejakartaglobe.com/home/amnesty-demands-repeal-of-indonesias-anti-abortion-laws/404981>.
- ⁷⁵ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 17, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).
- ⁷⁶ CEDAW Committee, *Responses to list of issues and questions*, *supra* note 32, ¶ 90.

⁷⁷ WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 66-68 (2003), available at <http://whqlibdoc.who.int/publications/2003/9241590343.pdf>; David A. Grimes et al., WHO, *Unsafe Abortion: The Preventable Pandemic*, THE LANCET 1, 6 (Sexual and Reproductive Health Series, Oct. 2006).

⁷⁸ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶ 21.

⁷⁹ CEDAW Committee, *Concluding Observations: Kuwait*, ¶¶ 42-43, U.N. Doc. CEDAW/C/KWT/CO/3-4 (2011).

⁸⁰ *Id.*

⁸¹ Health Law No. 36, *supra* note 7, art. 76.

⁸² *Id.*

⁸³ Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress*, GUTTMACHER INSTITUTE 21-22 (2009), available at <http://www.guttmacher.org/pubs/Abortion-Worldwide.pdf>.

⁸⁴ *Id.* at 23.

⁸⁵ *Id.* at 21-22.

⁸⁶ CEDAW Committee, *Concluding Observations: Lithuania*, ¶ 24, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).

⁸⁷ Health Law No. 36, *supra* note 7, art. 77.

⁸⁸ Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 3.

⁸⁹ *Id.* at 2.

⁹⁰ *Id.*

⁹¹ *Id.* at 3.

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ Budi Utomo et al., University of Indonesia, *Incidence and Social-Psychological Aspects of Abortion in Indonesia: A Community-Based Survey in 10 Major Cities and 6 Districts*, CENTER FOR HEALTH RESEARCH (2001) [hereinafter Budi Utomo et al., *Incidence and Social-Psychological Aspects of Abortion in Indonesia*].

⁹⁶ Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 3.

⁹⁷ CEDAW, *supra* note 9, art. 12(2); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶ 27.

⁹⁸ AMNESTY INTERNATIONAL, LEFT WITHOUT A CHOICE: BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA 35 (2010) [hereinafter AMNESTY INTERNATIONAL, BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA].

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 36.

¹⁰¹ See, e.g., CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention (continued), Combined fourth and fifth periodic reports of Nepal*, ¶ 32, U.N. Doc. CEDAW/C/SR.989 (2011); CEDAW Committee, *Concluding Observations: Benin*, ¶ 158, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Bosnia and Herzegovina*, ¶ 36, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); CEDAW Committee, *Concluding Observations: Cape Verde*, ¶ 30, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 23, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Mali*, ¶ 34, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Mozambique*, ¶ 34, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); CEDAW Committee, *Concluding Observations: Namibia*, ¶ 25, U.N. Doc. CEDAW/C/NAM/CO/3 (2007).

¹⁰² CEDAW Committee, *Concluding Observations: Indonesia*, ¶¶ 36-37, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

¹⁰³ Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 3.

¹⁰⁴ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at xxiv.

¹⁰⁵ MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010, *supra* note 20, at 71.

¹⁰⁶ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at xxiv.

¹⁰⁷ *Id.* at xxiv-xxv.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 75.

¹¹⁰ Under this Convention's Articles 10, 12, and 16, states are obligated to ensure that women and girls have access to a full range of contraceptive choices and to information about those options. In General Recommendation 21, this Committee reiterated that inadequate access to contraceptives contravenes women's right to "decide freely and responsibly on the number and spacing" of children; and that "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services." CEDAW, *supra* note 9, arts. 10, 12, 16; CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by*

Human Rights Treaty Bodies, at 337, 342, ¶¶ 1, 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 21*].

¹¹¹ WHO, MODEL LIST OF ESSENTIAL MEDICINES 23 (16th ed., Mar. 2009), available at http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf. The 750 microgram dose of levonorgestrel (sec. 18.3.1, at 23) is the emergency contraception regimen.

¹¹² CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 22.

¹¹³ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 37, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

¹¹⁴ Indonesia Population Law No. 10 (1992).

¹¹⁵ *Id.*

¹¹⁶ AMNESTY INTERNATIONAL, BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA, *supra* note 98, at 24-25; CEDAW Committee, *Responses to list of issues and questions*, *supra* note 32, ¶ 81.

¹¹⁷ Health Law No. 36, *supra* note 7, art. 76(b).

¹¹⁸ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 22.

¹¹⁹ Juan Shoemaker, *Contraceptive Use Among the Poor in Indonesia*, 31 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 3, 109 (Sept. 2005).

¹²⁰ Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 3.

¹²¹ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 103.

¹²² *Id.* at 100.

¹²³ *Id.*

¹²⁴ *Id.* at 103.

¹²⁵ *Id.* at 81.

¹²⁶ AMNESTY INTERNATIONAL, BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA, *supra* note 98, at 29.

¹²⁷ United Nations Statistics Division, Department of Economic and Social Affairs, United Nations, *Millennium Development Goals Indicators, Indonesia*, <http://mdgs.un.org/unsd/mdg/Data.aspx>.

¹²⁸ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 75.

¹²⁹ CEDAW Committee, *Concluding Observations: Nepal*, ¶¶ 212-213, U.N. Doc. A/59/38 (2004).

¹³⁰ WHO, Media Centre, *Emergency contraception, Fact Sheet No. 244* (Oct. 2005), available at <http://www.who.int/mediacentre/factsheets/fs244/en/index.html>.

¹³¹ United Nations Population Fund (UNFPA), *Where next for Family Planning?* (Dec. 2009), available at <http://www.unfpa.org/public/News/pid/4557>.

¹³² CEDAW Committee, *Concluding Observations: Mexico*, ¶¶ 32-33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).

¹³³ Dyna E. Syahlul and Lisa H. Amir, *Do Indonesian Medical Practitioners approve the availability of emergency contraception over-the-counter? A survey of general practitioners and obstetricians in Jakarta*, 5 BMC WOMEN'S HEALTH 3 (2005) [hereinafter Dyna E. Syahlul and Lisa H. Amir, *Emergency contraception over-the-counter*].

¹³⁴ MINISTRY OF HEALTH, PROVINCIAL GOVERNMENT OF WEST NUSA TENGGARA, AND PROVINCIAL GOVERNMENT OF EAST NUSA TENGGARA, *MEASURING THE FULFILLMENT OF HUMAN RIGHTS IN MATERNAL AND NEONATAL HEALTH* 31 (Nov. 2008).

¹³⁵ *Id.*

¹³⁶ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 70.

¹³⁷ *Id.* at 59-60.

¹³⁸ Dyna E. Syahlul and Lisa H. Amir, *Emergency contraception over-the-counter*, *supra* note 133.

¹³⁹ CEDAW, *supra* note 9, art. 16; CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶¶ 1(b), 2, 36.

¹⁴⁰ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶¶ 12(b), 15(d).

¹⁴¹ *Id.* ¶ 28.

¹⁴² CEDAW, *supra* note 9, art. 14(b); CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶¶ 18, 23.

¹⁴³ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 19, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

¹⁴⁴ *Id.* ¶ 37.

¹⁴⁵ CEDAW Committee, *Concluding Observations: Armenia*, ¶¶ 20-21, U.N. Doc. CEDAW/C/ARM/CO/4/Rev. 1 (2009); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶¶ 19-20, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); CEDAW Committee, *Concluding Observations: Burundi*, ¶¶ 12-14, 17-18, 29-30, U.N. Doc. CEDAW/C/BDI/CO/4 (2008); CEDAW Committee, *Concluding Observations: Chad*, ¶¶ 20-23, 42-43, U.N. Doc. CEDAW/C/TCD/CO/1-4 (2011).

¹⁴⁶ See CEDAW Committee, *Concluding Observations: Vanuatu*, ¶¶ 22-23, U.N. Doc. CEDAW/C/VUT/CO/3 (2007).

¹⁴⁷ CEDAW Committee, *Concluding Observations: Chad*, ¶¶ 20-23, 42-43, U.N. Doc. CEDAW/C/TCD/CO/1-4 (2011); CEDAW Committee, *Concluding Observations: Côte d'Ivoire*, ¶¶ 18-19, 26-27, 30-31, 42-43, U.N. Doc. CEDAW/C/CIV/CO/1-3 (2011); CEDAW Committee, *Concluding Observations: Djibouti*, ¶¶ 12-13, 16-17, 20-21, 36-37, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); CEDAW Committee, *Concluding Observations: El Salvador*, ¶¶ 21-22, U.N. Doc. CEDAW/C/SLV/CO/7 (2008).

¹⁴⁸ CEDAW Committee, *Concluding Observations: El Salvador*, ¶¶ 21-22, U.N. Doc. CEDAW/C/SLV/CO/7 (2008); CEDAW Committee, *Concluding Observations: Ethiopia*, ¶¶ 14-15, 18-21, U.N. Doc. CEDAW/C/ETH/CO/6-7 (2011); CEDAW Committee, *Concluding Observations: Fiji*, ¶¶ 20-21, 38-39, U.N. Doc. CEDAW/C/FJI/CO/4 (2010).

¹⁴⁹ See, e.g., CEDAW Committee, *Concluding Observations: Haiti*, ¶¶ 20-23, 40-41, U.N. Doc. CEDAW/C/HTI/CO/7 (2009); CEDAW Committee, *Concluding Observations: Lebanon*, ¶¶ 24-25, 32-33, 42, U.N. Doc. CEDAW/C/LBN/CO/3 (2008); CEDAW Committee, *Concluding Observations: Lithuania*, ¶¶ 14-15, 22-23, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); CEDAW Committee, *Concluding Observations: Ukraine*, ¶¶ 24-25, U.N. Doc. CEDAW/C/UKR/CO/7 (2010).

¹⁵⁰ See, e.g., CEDAW Committee, *Concluding Observations: Bhutan*, ¶ 116, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Brazil*, ¶ 109, U.N. Doc. A/58/38 (2003); CEDAW Committee, *Concluding Observations: Czech Republic*, ¶ 14, U.N. Doc. CEDAW/C/CZE/CO/3 (2006); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 293, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Estonia*, ¶ 96, U.N. Doc. A/57/38, Part I (2002); CEDAW Committee, *Concluding Observations: El Salvador*, ¶ 266, U.N. Doc. A/58/38, Part I (2003); CEDAW Committee, *Concluding Observations: Guatemala*, ¶ 189, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations: Ireland*, ¶ 383, U.N. Doc. A/60/38 (2005).

¹⁵¹ See, e.g., CEDAW Committee, *Concluding Observations: Bangladesh*, ¶ 246, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Bolivarian Republic of Venezuela*, ¶ 24, U.N. Doc. CEDAW/C/VEN/CO/6 (2006); CEDAW Committee, *Concluding Observations: Cambodia*, ¶ 18, U.N. Doc. CEDAW/C/KHM/CO/3 (2006); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 28, U.N. Doc. CEDAW/C/COD/CO/5 (2006); CEDAW Committee, *Concluding Observations: Equatorial Guinea*, ¶ 196, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Ethiopia*, ¶ 252, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Jamaica*, ¶ 14, U.N. Doc. CEDAW/C/JAM/CO/5 (2006); CEDAW Committee, *Concluding Observations: Kenya*, ¶ 210, U.N. Doc. A/58/38, Part I (2002); CEDAW Committee, *Concluding Observations: Malawi*, ¶ 20, U.N. Doc. CEDAW/C/MWI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Mali*, ¶ 18, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶ 20, U.N. Doc. CEDAW/C/UZB/CO/3 (2006); CEDAW Committee, *Concluding Observations: Vanuatu*, ¶ 23, U.N. Doc. CEDAW/C/VUT/CO/3 (2007).

¹⁵² Indonesia Marriage Law (Oct. 1, 1974).

¹⁵³ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 106.

¹⁵⁴ WHO, THE WORLD HEALTH REPORT 2005: MAKE EVERY MOTHER AND CHILD COUNT 4 (2005), available at http://www.who.int/whr/2005/whr2005_en.pdf; UNFPA, STATE OF WORLD POPULATION 2004, THE CAIRO CONSENSUS AT TEN: POPULATION, REPRODUCTIVE HEALTH AND THE GLOBAL EFFORT TO END POVERTY 76 (2004), available at www.unfpa.org/swp/2004/pdf/en_swp04.pdf [hereinafter UNFPA, STATE OF WORLD POPULATION 2004]; Committee on the Rights of the Child (CRC Committee), *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (33rd Sess., 2003), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 416, ¶ 20, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CRC Committee, *Gen. Comment No. 4*]. (“[e]arly...pregnancy [is a] significant factor in health problems related to sexual and reproductive health”).

¹⁵⁵ *We the Children: End-Decade Review of the Follow-Up to the World Summit for Children: Rep. of the Secretary-General*, ¶ 181, U.N. Doc. A/S-27/4 (2001); UNFPA, STATE OF THE WORLD POPULATION 2004, *supra* note 154, at 26.

¹⁵⁶ Guttmacher Institute, *Women and Societies Benefit When Childbearing Is Planned*, ISSUES IN BRIEF 3, 1-2 (2002), available at http://www.guttmacher.org/pubs/ib_3-02.pdf.

¹⁵⁷ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 148.

¹⁵⁸ *Id.* ¶ 154.

¹⁵⁹ *Id.* ¶ 148.

¹⁶⁰ CEDAW, *supra* note 9, art. 5(a).

¹⁶¹ *Id.* art. 16(2); CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 16.

- ¹⁶² CEDAW, *supra* note 9, art. 16(2); CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 36.
- ¹⁶³ *See, e.g.*, CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 17.
- ¹⁶⁴ CEDAW Committee, *Responses to list of issues and questions*, *supra* note 32, ¶ 91.
- ¹⁶⁵ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶¶ 79-80.
- ¹⁶⁶ *Id.* ¶ 79.
- ¹⁶⁷ CEDAW Committee, *Responses to list of issues and questions*, *supra* note 32, ¶ 33.
- ¹⁶⁸ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 23.
- ¹⁶⁹ CEDAW Committee, *Concluding Observations: Armenia*, ¶¶ 14-15, U.N. Doc. CEDAW/C/ARM/CO/4/Rev. 1 (2009); CEDAW Committee, *Concluding Observations: Bahrain*, ¶¶ 38-39, U.N. Doc. CEDAW/C/BHR/CO/2 (2008); CEDAW Committee, *Concluding Observations: Bolivia*, ¶¶ 44-45, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); CEDAW Committee, *Concluding Observations: Israel*, ¶¶ 48-49, U.N. Doc. CEDAW/C/ISR/CO/5 (2011).
- ¹⁷⁰ *See, e.g.*, CEDAW Committee, *Concluding Observations: Burundi*, ¶ 56, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations: Cameroon*, ¶ 54, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Lao People's Democratic Republic*, ¶ 111, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Maldives*, ¶ 136, U.N. Doc. A/56/38 (2001).
- ¹⁷¹ *See, e.g.*, CEDAW Committee, *Concluding Observations: Albania*, ¶ 61, U.N. Doc. A/58/38, Part I (2003); CEDAW Committee, *Concluding Observations: Belize*, ¶ 32, U.N. Doc. CEDAW/C/BLZ/CO/4 (2007); CEDAW Committee, *Concluding Observations: Morocco*, ¶ 35, U.N. Doc. CEDAW/C/MAR/CO/4 (2008).
- ¹⁷² *See, e.g.*, CEDAW Committee, *Concluding Observations: Burundi*, ¶ 56, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations: Kenya*, ¶ 44, U.N. Doc. CEDAW/C/KEN/CO/6 (2007); CEDAW Committee, *Concluding Observations: Mozambique*, ¶ 23, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); CEDAW Committee, *Concluding Observations: Nepal*, ¶ 209, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Nigeria*, ¶ 299, U.N. Doc. A/59/38 (2004).
- ¹⁷³ *See, e.g.*, CEDAW Committee, *Concluding Observations: Benin*, ¶ 148, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶ 342, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Cambodia*, ¶ 34, U.N. Doc. CEDAW/C/KHM/CO/3 (2006); CEDAW Committee, *Concluding Observations: Cape Verde*, ¶ 34, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); CEDAW Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 216, U.N. Doc. A/55/38 (2000); CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 15, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Israel*, ¶ 262, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Mali*, ¶ 18, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Malawi*, ¶ 20, U.N. Doc. CEDAW/C/MWI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Nepal*, ¶ 154, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Samoa*, ¶ 61, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Togo*, ¶ 15, U.N. Doc. CEDAW/C/TGO/CO/5 (2006); CEDAW Committee, *Concluding Observations: Turkey*, ¶ 368, U.N. Doc. A/60/38 (2005).
- ¹⁷⁴ *See, e.g.*, CEDAW Committee, *Concluding Observations: Gambia*, ¶ 34, U.N. Doc. CEDAW/C/GMB/1-3 (2005); CEDAW Committee, *Concluding Observations: Hungary*, ¶ 334, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations: Peru*, ¶ 489, U.N. Doc. A/57/38 (2002); CEDAW Committee, *Concluding Observations: Serbia*, ¶ 36, U.N. Doc. CEDAW/C/SCG/CO/1 (2007); CEDAW Committee, *Concluding Observations: Yemen*, ¶ 395, U.N. Doc. A/57/38 (2002).
- ¹⁷⁵ CEDAW Committee, *Concluding Observations: Nepal*, ¶¶ 212-213, U.N. Doc. A/59/38 (2004); CRC Committee, *Gen. Comment No. 4*, *supra* note 154, ¶ 16.
- ¹⁷⁶ *See, e.g.*, CRC Committee, *Concluding Observations: Colombia*, ¶¶ 33-34, U.N. Doc. CRC/C/COL/CO/3 (2006); CRC Committee, *Concluding Observations: Ethiopia*, ¶¶ 57-58, U.N. Doc. CRC/C/ETH/CO/3 (2006); CRC Committee, *Concluding Observations: India*, ¶ 50, U.N. Doc. CRC/C/15/Add.115 (2000); CRC Committee, *Concluding Observations: India*, ¶¶ 60-61, U.N. Doc. CRC/C/15/Add.228 (2004); CRC Committee, *Concluding Observations: Lebanon*, ¶ 16, U.N. Doc. CRC/C/15/Add.54 (1996); CRC Committee, *Concluding Observations: Mozambique*, ¶¶ 50-51, U.N. Doc. CRC/C/15/Add.172 (2002); CRC Committee, *Concluding Observations: Niger*, ¶ 48, U.N. Doc. CRC/C/15/Add.179 (2002); CRC Committee, *Concluding Observations: Nigeria*, ¶ 54, U.N. Doc. CRC/C/15/Add.257 (2005); CRC Committee, *Concluding Observations: Suriname*, ¶ 53, U.N. Doc. CRC/C/SUR/CO/2 (2007).
- ¹⁷⁷ *See* WHO, *World Health Day: Safe Motherhood, Delay Childbearing*, at 2 (April 7, 1998), available at <http://www.who.int/docstore/world-health-day/en/documents1998/whd98.pdf>.

¹⁷⁸ See, e.g., CRC Committee, *Concluding Observations: Colombia*, ¶ 76(f), U.N. Doc. CRC/C/COL/CO/3 (2006); CRC Committee, *Concluding Observations: Kyrgyzstan*, ¶ 53, U.N. Doc. CRC/C/15/Add.244 (2004); CRC Committee, *Concluding Observations: Mozambique*, ¶ 56(c), U.N. Doc. CRC/C/15/Add.172 (2002); CRC Committee, *Concluding Observations: United Republic of Tanzania*, ¶¶ 24-25, U.N. Doc. CRC/C/TZA/CO/2 (2006).

¹⁷⁹ Penal Code, *supra* note 43.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*; Indonesia Domestic Violence Law No. 23 (2004) [hereinafter Domestic Violence Law].

¹⁸² Domestic Violence Law, *supra* note 181.

¹⁸³ See National Commission on the Elimination of Violence Against Women (Komnas Perempuan) Annual Report 2010, *available at*

<http://komnasperempuan.or.id/publikasi/Indonesia/Seri%20Dokumen%20Kunci/1%20SERI%20DOKUMEN%20KUNCI%201.PDF>.

¹⁸⁴ See National Commission on the Elimination of Violence Against Women (Komnas Perempuan) Annual Report 2009, *available at*

<http://komnasperempuan.or.id/publikasi/Indonesia/Seri%20Dokumen%20Kunci/1%20SERI%20DOKUMEN%20KUNCI%201.PDF>.

¹⁸⁵ CEDAW Committee, *Concluding Observations: Togo*, ¶¶ 18-19, U.N. Doc. CEDAW/C/TGO/CO/5 (2006); CEDAW Committee, *Concluding Observations: Uzbekistan*, ¶¶ 21-22, U.N. Doc. CEDAW/C/UZB/CO/3 (2006); CEDAW Committee, *Concluding Observations: Mali*, ¶¶ 19-20, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Republic of Moldova*, ¶ 22, U.N. Doc. CEDAW/C/MDA/CO/3 (2006).

¹⁸⁶ See, e.g., CEDAW Committee, *Concluding Observations: Ghana*, ¶ 24, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); CEDAW Committee, *Concluding Observations: Greece*, ¶ 192, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Malaysia*, ¶ 21, U.N. Doc. CEDAW/C/MYS/CO/2 (2006).

¹⁸⁷ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 135.

¹⁸⁸ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 137; Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 2.

¹⁸⁹ MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010, *supra* note 20, at 71.

¹⁹⁰ Guttmacher Institute, *Abortion in Indonesia*, *supra* note 47, at 2.

¹⁹¹ Budi Utomo et al., *Incidence and Social-Psychological Aspects of Abortion in Indonesia*, *supra* note 95.

¹⁹² See, e.g., CEDAW Committee, *Concluding Observations: Argentina*, ¶ 380, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Azerbaijan*, ¶ 73, U.N. Doc. A/53/38 (1998); CEDAW Committee, *Concluding Observations: Bolivarian Republic of Venezuela*, ¶ 31, U.N. Doc. CEDAW/C/VEN/CO/6 (2006); CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶ 35, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Burundi*, ¶ 61, U.N. Doc. A/56/38 (2001); CEDAW Committee, *Concluding Observations: Cape Verde*, ¶ 29, U.N. Doc. CEDAW/C/CPV/CO/6 (2006); CEDAW Committee, *Concluding Observations: Chile*, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); CEDAW Committee, *Concluding Observations: Chile*, ¶ 228, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Colombia*, ¶ 22, U.N. Doc. CEDAW/C/COL/CO/6 (2007); CEDAW Committee, *Concluding Observations: Dominican Republic*, ¶ 337, U.N. Doc. A/53/38 (1998); CEDAW Committee, *Concluding Observations: Eritrea*, ¶ 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); CEDAW Committee, *Concluding Observations: Georgia*, ¶ 111, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations: Ghana*, ¶ 31, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); CEDAW Committee, *Concluding Observations: Lebanon*, ¶ 35, U.N. Doc. A/60/38 (2005); CEDAW Committee, *Concluding Observations: Malawi*, ¶ 31, U.N. Doc. CEDAW/C/MWI/CO/5 (2006); CEDAW Committee, *Concluding Observations: Mali*, ¶ 33, U.N. Doc. CEDAW/C/MLI/CO/5 (2006).

¹⁹³ CEDAW Committee, *Responses to list of issues and questions*, *supra* note 32, ¶ 86.

¹⁹⁴ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 129.

¹⁹⁵ *Id.* ¶ 143.

¹⁹⁶ Augustina Situmorang, Report Prepared for STARH Program, Johns Hopkins University, *Adolescent Reproductive Health in Indonesia*, at 6 (Sept. 2003).

¹⁹⁷ CRC Committee, *Concluding Observations: Indonesia*, ¶ 58, U.N. Doc. CRC/C/15/Add.223 (2004). The CRC Committee's recommendations also included: developing comprehensive policies and plans on adolescent health, taking into account the Committee's General Comment No. 4 (2003) on adolescent health and development; strengthening the implementation of the recommendations of the Commission on Reproductive Health; and

promoting collaboration between state agencies and NGOs in order to establish a system of formal and informal education on HIV/AIDS and STIs and on sex education.

¹⁹⁸ Penal Code, *supra* note 43, arts. 283, 534-535; AMNESTY INTERNATIONAL, BARRIERS TO REPRODUCTIVE HEALTH IN INDONESIA, *supra* note 98, at 30.

¹⁹⁹ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 148.

²⁰⁰ *Indonesia Demographic and Health Survey 2007*, *supra* note 17, at 57.

²⁰¹ MILLENNIUM DEVELOPMENT GOALS: INDONESIA 2010, *supra* note 20, at 73.

²⁰² CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 149.

²⁰³ *Id.*

²⁰⁴ Indonesia Family Welfare Law No. 10 (1992).

²⁰⁵ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 110, ¶ 29.

²⁰⁶ CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 198.

²⁰⁷ CENTER FOR REPRODUCTIVE RIGHTS, FORSAKEN LIVES: THE HARMFUL IMPACT OF THE PHILIPPINE CRIMINAL ABORTION BAN 85 (2010).

²⁰⁸ CEDAW Committee, *Concluding Observations: Indonesia*, ¶¶ 20-21, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

²⁰⁹ Regulation No. 1636/MENKES/PER/XI/2010.

²¹⁰ *See, e.g.*, CEDAW Committee, *Concluding Observations: Burkina Faso*, ¶ 261, U.N. Doc. A/55/38 (2000);

CEDAW Committee, *Concluding Observations: Cameroon*, ¶¶ 53-54, U.N. Doc. A/55/38 (2000); CEDAW

Committee, *Concluding Observations: Democratic Republic of the Congo*, ¶ 215, U.N. Doc. A/55/38 (2000);

CEDAW Committee, *Concluding Observations: Netherlands*, ¶ 207, U.N. Doc. A/56/38 (2001); CEDAW

Committee, *Concluding Observations: Senegal*, ¶ 721, U.N. Doc. A/49/38 (1994).

²¹¹ CEDAW Committee, *Concluding Observations: Indonesia*, ¶ 20, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).

²¹² CEDAW Committee, *General Recommendation No. 14: Female circumcision* (9th Sess., 1990), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 326, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

²¹³ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 13, ¶ 15(d).

²¹⁴ *Id.*

²¹⁵ WHO, GLOBAL STRATEGY TO STOP HEALTH-CARE PROVIDERS FROM PERFORMING FEMALE GENITAL MUTILATION: UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA 6 (2010), available at http://whqlibdoc.who.int/hq/2010/WHO_RHR_10.9_eng.pdf [hereinafter WHO, GLOBAL STRATEGY TO STOP HEALTH-CARE PROVIDERS FROM PERFORMING FGM].

²¹⁶ *Id.* at 3; MINISTRY OF HEALTH, REPUBLIC OF KENYA, MANAGEMENT OF COMPLICATIONS PREGNANCY, CHILDBIRTH AND THE POSTPARTUM PERIOD IN THE PRESENCE OF FGM/C: A REFERENCE MANUAL FOR HEALTH SERVICE PROVIDERS 13-15, 18, available at

http://www.popcouncil.org/pdfs/frontiers/reports/Kenya_FGC_Pregnancy.pdf.

²¹⁷ Royal Tropical Institute (KIT) and Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS), *Female Genital Mutilation – a life-threatening health and human rights issue*, 1 EXCHANGE ON HIV AND AIDS, SEXUALITY AND GENDER 1 (2008), available at

http://www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1416.

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ WHO, GLOBAL STRATEGY TO STOP HEALTH-CARE PROVIDERS FROM PERFORMING FGM, *supra* note 215, at 3, 9.

²²¹ *Indonesia: Female genital mutilation persists despite ban*, IRIN GLOBAL (Sept. 2, 2010), available at

<http://www.irinnews.org/report.aspx?reportid=90366>.

²²² CEDAW Committee, *Article 18: Combined sixth and seventh reports of Indonesia*, *supra* note 35, ¶ 132; Orchid Project, *Submission to the Universal Periodic Review: Indonesia 13th Session 2012*, ¶ 2.6 (2012), available at http://lib.ohchr.org/HRBodies/UPR/Documents/session13/ID/OP_UPR_IDN_S13_2012_OrchidProject_E.pdf.

²²³ UNHCR, *Indonesia: Report on Female Genital Mutilation (FGM) or Female Genital Cutting*, OFFICE OF THE SENIOR COORDINATOR FOR INTERNATIONAL WOMEN'S ISSUES AND OFFICE OF THE UNDER SECRETARY FOR GLOBAL AFFAIRS (June 2001), available at <http://www.unhcr.org/refworld/topic,45a5fb512,46556aac2,46d57879c,0.html>.

²²⁴ *Id.*

²²⁵ *Id.*; WHO, AN UPDATE ON WHO'S WORK ON FEMALE GENITAL MUTILATION (FGM): PROGRESS REPORT 3 (2011). *See also* WHO, GLOBAL STRATEGY TO STOP HEALTH-CARE PROVIDERS FROM PERFORMING FGM, *supra* note 215, at 1-2; USAID, Population Council, *Female circumcision in Indonesia: Extent, Implications, and Possible Interventions to Uphold Women's Health Rights*, at 3 (2003), available at

http://www.popcouncil.org/pdfs/frontiers/reports/Indonesia_FGM.pdf [hereinafter *Female circumcision in Indonesia*]. At 6 there is a description of different words for and descriptions of female circumcision practices used in Indonesia.

²²⁶ *Female circumcision in Indonesia*, *supra* note 225, at viii.