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102

Women and Health

Editorial

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Articles

Cultural Value Factors That Affect Mother and Child Health
Inang Winarso & Ressa Ria Lestari

The Vulnerability of Occupational Health of Women Home Workers: A Study Labor-Intensive Industries in Penjaringan, North Jakarta
Evania Putri Rifyana

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Theresia Pratiwi Elingsetyo Sanubari & Catherina Frisca Yaniariyani

Data Collection to Fulfill the Targets for the SDGs: The APIK Gender Justice Index (AGJI)
Saskia Wieringa

Personal Experiences of Women Surviving Breast Cancer as a Confrontation of the Meaning of the Women's Body
Abby Gina & Atnike Sigiro

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Dyan Widyaningsih, Elza Samantha Elmira & Andi Misbahul Pratiwi

Review of Policy-Oriented Research on Maternal Mortality
Dewi Komalasari & Jane Daniels

Women's and Health Officer's Knowledge on Access to Reproductive and Sexual Health Services Covered by the National Health Insurance: Surveys in 15 District-Cities in Indonesia
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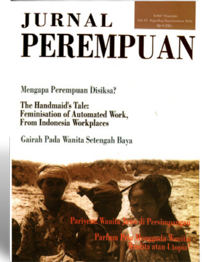

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102 | Women and Health

Contents

Editorial
Women and Health iii

Articles

- Cultural Value Factors That Affect Mother and Child Health 149-159
  Inang Winarso & Ressa Ria Lestari

- The Vulnerability of Occupational Health of Women Home Workers: A Study in Labor-Intensive Industries in Penjaringan, North Jakarta 161-175
  Evania Putri Rifyana

- Preliminary Study on Access to Health Service for Elderly Women: The Age and Socio-Economic Issues of Elderly Women in Pancuran Village, Salatiga 177-187
  Theresia Pratiwi Elingsetyo Sanubari & Catherina Frisca Yaniariyani

- Data Collection to Fulfill the Targets for the SDGs: The APIK Gender Justice Index (AGJI) 189-202
  Saskia Wieringa

- Personal Experiences of Women Surviving Breast Cancer as a Confrontation of the Meaning of the Women's Body 203-213
  Abby Gina & Atnike Sigiro

- Poor Women's Access to Antenatal Care and Childbirth Services in Indonesia: A Case Study in Five Districts 215-227
  Dyan Widyaningsih, Elza Samantha Elmira & Andi Misbahul Pratiwi

- Review of Policy-Oriented Research on Maternal Mortality 229-238
  Dewi Komalasari & Jane Daniels

- Women's and Health Officer's Knowledge on Access to Reproductive and Sexual Health Services Covered by the National Health Insurance: Surveys in 15 District-Cities in Indonesia 239-251
  Herna Lestari & Atnike Nova Sigiro

- Community Knowledge and Behavior Towards Unintended Pregnancy in Eight Provinces of Sumatera: Between Religious, Customary, and State Norms 253-265
  Dina Lumbantobing, Sita Van Bemmelen, Andi Misbahul Pratiwi, & Anita Dhewy

This JP edition is published by Yayasan Jurnal Perempuan with the support from the Australia-Indonesia Partnership for Gender Equality and Women's Empowerment (MAMPU). MAMPU program is a joint initiative between the government of Australia and the government of Indonesia that aim to improve access of poor women in Indonesia to public services and other government programs in order to achieve gender equality and women's empowerment. Opinion in the articles solely belong to each of the authors and do not represent the views of the government of Indonesia and the government of Australia.

Women and Health

Health is a human right that has always been an important issue for both the public and the individuals, including women. In Indonesia, health is one of the important issues that is regulated in the constitution with an allocation in the State Budget (APBN). However, various data and researches show the complexity of public health issues and also health issues with regard to gender and age group.

Basic Health Research Data (Riskesdas) in 2018 mentioned that nutrition and non-communicable diseases remain Indonesia's biggest homework. The same data noted that the Ministry of Health was only able to reduce the stunting rate from 37.2 percent to 30.8 percent over five years. Malnutrition was only slightly reduced, from 19.6 percent to 17.6 percent. Meanwhile, the obesity rate actually increased from 14.8 percent to 21.8 percent. At the same time, non-communicable diseases, such as cancer, strokes, chronic kidney disorders, diabetes, and hypertension, have almost all increased.

The condition of the health sector in Indonesia can also be seen from the condition of family's health and women's health. Currently, there are obstacles in the application of vaccines for infectious diseases such as Measles & Rubella (MR) and polio vaccines due to the incompatibility between the product's standards with religious values, as well as myths surrounding the impact of vaccines on children.

Meanwhile, data from the Ministry of Health in 2015 shows that the maternal mortality rate (MMR) in Indonesia is still high: of 100,000 live births, around 305 ended in the death of the mothers. Data from the Ministry of Health 2017 also shows that the highest number of persons with AIDS by status/ occupation are housewives, of 14,721 persons.

The health sector is an important issue for the women's movement and feminist studies. Feminists find gaps in the relations between women, health and the medical world. In the second wave of the global women's movement, feminist groups struggled to bring the issue of women's health to the surface. The positive impact of the second wave women's movement can be seen today with more and more women taking part in the field of medicine and the increasing attention and resources dedicated to women's health issues. Nevertheless, feminists remain critical of the medical field that is still biased or gender neutral. This can be seen in existing practices such as diagnosis, prescription or different medical actions between men and women due to gender stereotypes, or medical research that does not include sex-based analysis.

Furthermore, feminist thinking offers a comprehensive approach to health issues. This approach is based on the concept that places humans as a unit (body and mind) that interacts with their social and physical environment. As such, this approach defines health holistically, as a result of social relations. This is different from the biomedical approach, which views the body mechanically, defining individuals as a collection of components.

Feminist approach also encourages recognition of physiological and social differences between the sexes and recognizes the diversity of individuals, whether male or female, rich or poor, heterosexual or other sexual preferences, with special needs or not, and so on, using the intersectionality approach. Feminist approach views health as a matter of social justice.

In Indonesia, the issue of health policy is also a concern of the women's movement. The issue of maternal mortality, for example, has been the focus of attention of the women's movement since several decades ago. But to this day, it remains to be a critical issue that has never been resolved.

Women's health is also related to the position of women as subjects. Particularly in term of reproductive health, knowledge on sexual and reproductive rights and health (SRHR) determine not only women's physical health condition but also women's well-being.

Several research papers in this edition of Jurnal Perempuan show that values and cultural elements that are prevalent in society have strong influence on people's beliefs, decisions, attitudes and behavior towards women's health. The local context's aspect needs to be seriously considered in all efforts to improve and to advance women's health. In addition, the experience of women dealing with health issues should not be viewed in uniformity and universally. These whole aspects need to be well understood by policy makers and health officers so that health policies and health services would truly consider the voices and the needs of women. Furthermore, health policies and services should position women as subjects who are entitled to make their own decisions regarding their health. (**Anita Dhewy**)

Jurnal Perempuan, Vol. 24 No. 3, August 2019

Abstracts Sheet

Inang Winarso & Ressa Ria Lestari (Asosiasi Antropologi Indonesia [AAI] Pengurus Daerah Jawa Barat, Bandung, Jawa Barat, Indonesia)

Cultural Value Factors That Affect Mother and Child Health

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, Agustus 2019, pp. 149-159, 1 image, 1 table, 6 ref

Mother and child health as a key indicator of community welfare is measured by the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). But why have efforts to reduce MMR and IMR not yet reached the target? This research answers this question by using an approach of cultural values in mother and child health. The focus of this research is on the human life cycle starting from marriage, pregnancy, birth and death in Situbondo Regency, East Java and Ngada Regency, NTT. Research has found four cultural elements that predominantly influence health beliefs, family and community decisions in dealing with maternal and infant health problems. These cultural elements are the religious system, the kinship system, the knowledge system and the livelihood system. These four systems can increase or decrease the risk of maternal and infant mortality. The government must consider the cultural values of the community in making health policies. First, strengthen factors that reduce the risk of maternal and child mortality. Second, reduce the factors that increase the risk of maternal and child mortality.

Keywords: cultural values, ethnography, mother and child health, maternal mortality, infant mortality.

Evania Putri Rifyana (Trade Union Rights Centre [TURC] Lembaga Pusat Studi dan Advokasi Perburuhan, Jakarta Pusat, Indonesia)

The Vulnerability of Occupational Health of Women Home Workers: A Study in Labor-Intensive Industries in Penjaringan, North Jakarta

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp.161-175, 11 images, 2 graph, 26 ref

Labor-intensive industries oriented to low prices, has a strategy of reducing labor costs to compete in a competitive market. To streamline the production burden, the company issues a portion of its production commodities to workers outside the factory, in this case homeworkers. The majority of homeworkers are poor women who live around industrial areas. Through a qualitative approach, this study wants to find out the working conditions of women homeworkers working in labor-intensive industries, especially in the shoe sector, in the slums of the Capital City of Jakarta, namely the Penjaringan area, North Jakarta. The study found that women homeworkers do not have access to proper occupational health, making their conditions vulnerable. This vulnerability is influenced by poor working environment conditions, inadequate Health and Safety (K3), and the absence of social protection and security for women homeworkers. In addition, the house, which is used as a production space on a massive scale, also has implications for the daily survival of women homeworkers and their families.

Keywords: women, homeworkers, laborers, Occupational Health and Safety (OHS).

Theresia Pratiwi Elingsetyo Sanubari & Catherina Frisca Yaniariyani (Universitas Kristen Satya Wacana, Salatiga, Indonesia)

Preliminary Study on Access to Health Service for Elderly Women: The Age and Socio-Economic Issues of Elderly Women in Pancuran Village, Salatiga

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 177-187, 1 image, 3 tables, 38 ref

The increasing number of elderly people from year to year shows the high life expectancy in elderly women. This situation coupled with cultural and social aspects can trigger vulnerability for elderly women, including the health aspect. This study aims to describe the factors of access to health services for elderly women in the village of Pancuran, Salatiga. The method used is descriptive-quantitative with data collection carried out in Pancuran Village using a questionnaire. Elderly women in Pancuran Village have different economic, educational, employment and social status backgrounds but have the same vulnerability to access health services due to the unavailability of posyandu for the elderly in Pancuran Village. Nevertheless, efforts to access health services are still underway. This research shows that cultural involvement in health care is needed to realize integrated, patient-centered, and gender-friendly health services.

Keywords: elderly women, health services, social culture.

Saskia Wieringa (Universitas Amsterdam, Amsterdam, Belanda)

Data Collection to Fulfill the Targets for the SDGs: The APIK Gender Justice Index (AGJI)

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 189-202, 10 tables, 23 ref

Indonesia has committed itself to the 2030 Agenda with 17 Sustainable Development Goals (SDGs) which were approved by the United Nations on September 25, 2015. Seventeen objectives and 169 related targets must be achieved by 2030. Gender equality is an independent goal (SDG number 5), but gender related issues are also contained in the goal of poverty alleviation (SDG 1), health care including maternal and child health (SDG 3) and education (SDG 4). SDG number 16 concerns a commitment to peace, access to justice and strong institutions. Reliable and inclusive gender statistics are needed to monitor progress towards achieving gender equality and justice and to identify key gender inequalities that require policy interventions. Both quantitative and qualitative data are needed. In addition, certain problems are specific for women, such as maternal death. Given the wide diversity in gender relations and socio-economic conditions of the Indonesian archipelago subnational data are required. This article outlines the methodology of designing the APIK Gender Justice Index. The main findings are that the availability of sex-disaggregated data at the subnational level leaves much to be desired. The AGJI proves to be a reliable, comprehensive and flexible tool that can easily be used by policy makers and activists to design policies and programs to address gender-based discrimination in Indonesia, for instance in the field of health. The AGJI is based on locally available data. The advantages of the AGJI are that it can be computed with a minimum of cost and effort to achieve a maximum of reliability and ease in use. The GSI was found to be comparable with the Global Gender Gap Index (GGGI) for Indonesia but it is more sensitive to

political empowerment. The AGJI assesses in how far women have been able to take up leadership positions at subnational levels, including at the village level and are represented in the major decision-making bodies such as the judiciary.

Keywords: gender index, gender justice, gender statistics, SDGs.

Abby Gina & Atnike Sigiro
(Jurnal Perempuan, Jakarta, Indonesia)

Personal Experiences of Women Surviving Breast Cancer as a Confrontation of the Meaning of the Women's Body

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 203-213, 14 ref

This study highlights the experiences faced by women breast cancer survivor in Jakarta in defining their bodies. Despite of medical assessment, breast cancer needs to be analyzed through feminist's lense because breast cancer has close link with discourse of sexual body and engendered body. This study used a qualitative methodology that emphasizes critical analysis. Data collection was gathered through interviews with 8 women who are breast cancer survivors. The research reveals that under the normality of femininity of the patriarchal society, the women breast cancer survivors could confront the dominant interpretation upon women's body.

Keywords: breast cancer, body experience, gender structure, feminine, body normalization.

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Poor Women's Access to Antenatal Care and Childbirth Services in Indonesia: A Case Study in Five Districts

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 215-227, 3 images, 2 tables, 13 ref

The health of pregnant women often becomes an indicator of human development. On the other hand, the fact of the high maternal mortality rate, raises questions related to the government's attention to the health of pregnant women, especially women in poor areas. This article focuses on poor women's access to health services for antenatal care and childbirth in five regencies in Indonesia. The aspects studied include the availability of health services for antenatal care and childbirth, poor women's access to these services, and supporting factors/actors and barriers to poor women's access to health services. This article showed that the availability of health facilities is not always in line with the increased awareness of pregnant women to access these services. Road infrastructure condition, distance, and cost to access health service still remain a challenge. Meanwhile, the policy of incentives and disincentives to traditional birth attendants has an influence on the increasing number of pregnant women who check their pregnancies and childbirth at health facilities. Thus, health issues of pregnant women and safe childbirth require a different effort. Aspects of the local context and supporting infrastructure also require serious attention.

Keywords: access to health for poor women, antenatal care, childbirth.

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1 Dewi Komalasari & 2 Jane Daniels (1 Jurnal Perempuan, Jakarta, Indonesia & 2 MAMPU, Setia Budi, Jakarta, Indonesia)

Review of Policy-Oriented Research on Maternal Mortality

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 229-238, 34 ref

Maternal mortality remains an unresolved critical issue. This condition indicates that women's reproductive health rights has not yet been fulfilled. Maternal mortality occurs due to medical and non-medical factors. Even though a small amount of those deaths still happens due to unpreventable causes, however most of those deaths could have been prevented and avoided. Government efforts to address the problem of maternal mortality are carried out through various policies that focus on medical factors and through programs aimed at increasing the coverage and quality of maternal health services. On the other hand, other factors such as social economic and cultural are being neglected. A review of researches on the theme of maternal mortality found various factors that contributed to the causes of maternal mortality such as socio-cultural barriers that limit women's access to health, ranging from poverty, geography and local culture.Unmet need for contraception in family planning program, adolescence reproductive health issue that still hasn't been addressed in a serious and comprehensive manner, as well as unsafe abortion are the key underlying causes of maternal mortality.

Keywords: maternal mortality, reproductive health, family planning, adolescence reproductive health, unsafe abortion.

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[1] Herna Lestari & [2] Atnike Nova Sigiro (1 Yayasan Kesehatan Perempuan, Jakarta, Indonesia & 2 Jurnal Perempuan/ Universitas Paramadina, Jakarta, Indonesia)

Women's and Health Officer's Knowledge on Access to Reproductive and Sexual Health Services Covered by the National Health Insurance: Surveys in 15 District-Cities in Indonesia

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 239-251, 15 tables, 22 ref

The availability of reproductive and sexual health services provided by the National Health Insurance (Jaminan Kesehatan National/ JKN) in Indonesia could expand women's access to reproductive and sexual health services. However, the knowledge of community and service provider will determine to what extent women will access the reproductive and sexual health services provided by JKN. This article assesses and analyzes the knowledge of women and health officers about the availability of reproductive and sexual health services provided in JKN. The article elaborates for main findings from the research that was conducted by women organizations that are members of the Women's Health Care Network (Jaringan Perempuan Peduli Kesehatan or JP2K). JP2K conducted longitudinal research with a series of surveys in 2015, 2016, and 2017 in 15 regions of districts/ cities in Indonesia on knowledge and access to reproductive and sexual health services provided by JKN. The surveys show limited knowledge of the respondents, both women and health officers, about forms and scope of reproductive and sexual health services that are covered by JKN. The research concludes that one of the important agendas for encouraging women's access to health services covered by JKN is through intensifying the socialization of the scope of sexual and reproductive health to women and health facility officers.

Keywords: national health insurance, reproductive and sexual health, women's health.

[1] Dina Lumbantobing, [1] Sita Van Bemmelen, [2] Andi Misbahul Pratiwi & [2] Anita Dhewy ([1] PERMAMPU, Medan, Indonesia & [2] Jurnal Perempuan, Jakarta, Indonesia)

Community Knowledge and Behavior Towards Unintended Pregnancy in Eight Provinces of Sumatera: Between Religious, Customary, and State Norms

DDC: 305
Jurnal Perempuan, Vol. 24 No. 3, August 2019, pp. 253-265, 2 tables, 8 ref

Based on field observations and experiences in assisting women by the PERMAMPU Consortium, there are still many women who face unintended pregnancy (KTD). Therefore it is needed research to find out the needs of women related to KTD. This article focuses on three things, namely (1) understanding and knowledge of informants about KTD; (2) perception of the best and the worst solutions for KTD cases; (3) women's behavior related to KTD. The study uses three categories of KTD: KTD experienced by married women, KTD experienced by unmarried women, and KTD experienced by victims of acts of violence. This article is written from the 2014 PERMAMPU Consortium research report entitled The Compilation of Unintended Pregnancy Research Reports/KTD in Eight Provinces, Sumatra Island. The study used a qualitative approach with data collection conducted through interviews and FGDs. This paper shows that there are similarities and differences in the understanding, perceptions, behavior of women and society in relation to KTD. Various forms of rules and norms generally view pregnancy as natural, so that it is always desirable, have controlled women and society in behaving and handling KTD. There are various forms of KTD and various forms of coping methods that are not always in line with existing rules and are generally done secretly. Thus, women who experience unintended pregnancy need recognition of their problems, including their voices and needs and supported to make decisions for themselves.

Keywords: unintended pregnancy, religious norms, customary norms, abortion.

Jurnal Perempuan untuk pencerahan dan kesetaraan Vol. 24 No. 3, August 2019, 189-202 **DDC: 305**

Data Collection to Fulfil the Targets for the SDGs: The APIK Gender Justice Index (AGJI)

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Abstract

Indonesia has committed itself to the 2030 Agenda with 17 Sustainable Development Goals (SDGs) which were approved by the United Nations on September 25, 2015. Seventeen objectives and 169 related targets must be achieved by 2030. Gender equality is an independent goal (SDG number 5), but gender related issues are also contained in the goal of poverty alleviation (SDG 1), health care including maternal and child health (SDG 3) and education (SDG 4). SDG number 16 concerns a commitment to peace, access to justice and strong institutions. Reliable and inclusive gender statistics are needed to monitor progress towards achieving gender equality and justice and to identify key gender inequalities that require policy interventions. Both quantitative and qualitative data are needed. In addition, certain problems are specific for women, such as maternal death. Given the wide diversity in gender relations and socio-economic conditions of the Indonesian archipelago subnational data are required. This article outlines the methodology of designing the APIK Gender Justice Index. The main findings are that the availability of sex-disaggregated data at the subnational level leaves much to be desired. The AGJI proves to be a reliable, comprehensive and flexible tool that can easily be used by policy makers and activists to design policies and programs to address gender-based discrimination in Indonesia, for instance in the field of health. The AGJI is based on locally available data. The advantages of the AGJI are that it can be computed with a minimum of cost and effort to achieve a maximum of reliability and ease in use. The GSI was found to be comparable with the Global Gender Gap Index (GGGI) for Indonesia but it is more sensitive to political empowerment. The AGJI assesses in how far women have been able to take up leadership positions at subnational levels, including at the village level and are represented in the major decision-making bodies such as the judiciary

Key words: gender index, gender justice, gender statistics SDGs, Indonesia

Introduction

The APIK Gender Justice Index (AGJI) is a result of the program "Making Rule of Law Meaningful for Poor Women, Marginalized and Vulnerable Groups" (hereafter referred to as the Rule of Law Program). The program was carried out by the National Secretariat of APIK in collaboration with seven LBH APIK offices in Jakarta, Medan, Makassar, Palu, Semarang, Mataram and Jayapura, from 2014-2019. [1] This article assesses the performance of this pilot phase.

The AGJI consists of three parts, the quantitative Gender Status Index (GSI), the qualitative Women's Progress Measure (WPM) and the project-specific Project Impact Analysis. The GSI, which consists of four blocks, gives an overview of the status of gender relations in a particular region, and can be used for various policy purposes of both regional administrations and NGOs. The WPM provides information that is women-specific, such as maternal mortality, FGM (Female Genital Mutilation) and child marriages and measures socio-legal progress of women. The third part is specifically adapted to the needs of the present project of APIK and measures women's access to economic and civil rights.

The AGJI was specifically designed for this program on Rule of Law, on the basis of an analysis of existing gender indices. LBH APIK staff and paralegals suggested many of the indicators, particularly on women's empowerment and civil rights. The AGJI is based on a barefoot methodology, in which the most relevant data were collected by NGO activists from provincial- level institutions and relevant duty bearers. The philosophy of the AGJI is that the users of the index must also be able to collect the data and compute the results. It is a flexible and comprehensive tool that can help gender activists and policy makers alike to design and monitor their policies and programs.

In 1995 the UNDP presented its first two gender indices, the GDI (Gender-related Development Index) and the GEM (Gender Empowerment Measure), in preparation for the 1995 Fourth Women's World Conference, held in Beijing. These indices measured the

gendered differences in capabilities and opportunities of human beings (following the work of Amartya Sen)[2] rather than national income. Yet national income was still dominant, meaning that rich countries (barring some outlier countries) still ended up higher, as a block, than poor countries and thus that progress on domestic welfare measures that poor countries had made were not considered sufficiently.[3] Secondly variables considered relevant for higher income countries still dominated. Third several indicators had flaws (longevity for instance is a stock indicator and slow to change). Fourth as the GDI and the GEM depended on international data sets (such as those of ILO, UNESCO) the data were outdated by the time they were presented, as these international organizations first had to collect the national data and harmonize them for international comparative use. Fifth, women-specific indicators could not be collected, such as the Maternal Mortality Rate. Further, much national specificity got lost due to the complicated harmonization processes required to compare various national data sets. Last, these indices could only be computed, and thus checked, by statistical experts, due to their complex formulas.

In later years various other gender indices were developed. For instance, the World Economic Forum constructed the GGGI (Global Gender Gap Index). The UN Economic Commission for Africa (UNECA) developed its own index, the AGDI (African Gender and Development Index), based on national data. This index combines a quantitative part and a women-specific qualitative part. This last part is called AWPS (African Women's Progress Scorecard). This measure focuses on policy performance in four areas, women's rights, economic and social aspects and political power. The methodology of the AGDI has informed the methodology of the AGJI, though the design of the second part of the AGJI is significantly different.[4] In 2010 the UNDP presented another gender index, the GII (Gender Inequality Index).[5]

The quantitative part, the Gender Status Index (GSI), measures the gender gaps in health, education, income and political power. As it is assumed that the data are based on sets that are collected according to the same (nationally stipulated) standards, harmonization of data is not necessary. No weighing procedures were introduced. The four blocks of the GSI (health, education, income and power) all receive the same weight, and the same goes for the indicators within each block. The Women's Progress Measure (WPM) contains women specific indicators, such as the MMR. Other indicators are the domestic violence law, the marriage law, reproductive rights and FGM. The specifications for the AGJI were that it had to be user-friendly. The users being defined as activists and officials at the subnational level. This involved a simple and transparent way of computation. The third part of the AGJI collects information on access to women's rights.

Given the sheer size and the wide diversity of the nation, country-level averages do not reliably represent the situation at the subnational level. This thwarts efforts in the various regions to monitor the SDGs defined at the national level. The UNDP has argued for the importance of providing subnational data sets and has published a Subnational Human Development Index (SHDI) in 2018.[6]

Indonesia has produced both a provincial level Human Development Index and a subnational GII for 2015. For the seven regions for which the AGJI was calculated the following data are available:

Table 1 provincial level HDI and GII in 2015 [7]

Province	HDI	GII
DKI Jakarta	78.99	0,110
Central Java	69.49	0,331
Central Sulawesi	68.75	0,536
South Sulawesi	69.15	0,477
North Sumatera	69.51	0,481
NTB	62.67	0,463
Papua	57.25	0,516

Judging from Table 1, gender inequality is lowest in Jakarta and highest in Papua.[8] In 2016 the BPS (Badan Pusat Statistik, Central Statistical Bureau) adapted the GII for the Indonesian context and calculated it for the subnational level.[9] The GII has only one quantitative part. It consists of three blocks with a total of five indicators. The first block is the reproductive health index, which consists of a proxy indicator for the MMR which will be

discussed below and the adolescent (15-19) birth rate. The second block is empowerment, consisting of two indicators. The first one is the education rate up till the end of lower secondary level. The second one is the sex-based composition of parliament. The third block relates to the economy and calculates the labour participation rate.

The GII has several advantages. The outcome is a single figure which can be used for the ranking of gender inequality at the subnational level. Secondly it combines women-specific indicators (MMR, fertility rate) with quantitative gender statistics. Thirdly its use of the adolescent fertility rate gives a strong indication of the prevalence of child marriages.[10] Fourthly it uses only a limited set of indicators. These characteristics make it suitable for comparisons at the macro level, but limit its use for policy purposes.

The GII has other limitations. In the first place it is not transparent. Computing it must be done by statisticians. The process entails seven steps each with different formulae. Secondly its very simplicity, in number of indicators, is also a major setback. The paucity of indicators means that a lot of information is not taken into account. This includes family laws and other regulations and important dimensions of political, economic and civil rights. Third its use of a proxy indicator for the MMR is highly troubling. Reducing the high MMR of Indonesia is a major component of its SDG programme. The proxy indicator, the proportion of women who don't give birth in medical facilities is insufficient.[11] Fourthly the GII is limited in relation to the measurement of political power. Only the share of women lawmakers is measured, while power at the lower levels, up to that of the village as well as in the judiciary is ignored. Lastly the gender gaps in wages and income, and in education level from the junior high school upwards are ignored.

The Gender Status Index

The Gender Status Index of the AGJI measures the gender gap in health, education, income and political power at the provincial level. It consists of four blocks, which each have the same weight. Each block consists of a number of indicators which again have the same weight within their blocks. Health is measured by the gender gaps in child mortality and HIV and sexually transmitted disease (STD) rates. Education is measured by the gender gaps up to the first level after the completion of secondary school. Income is measured by the gender gap in the formal sector. The last block, political power, counts the largest number of indicators, nine, from the gender gap in members of provincial councils, to the village level, and includes judges in both religious and national courts, prosecutors and the police.

Table 2. Gender Status Index

Indicator	Scores	Average	Gender Status Index
Child mortality			
HIV/ STD			
Primary school			
Junior high school			
Senior high school			
Diploma/university			
Formal sector income			
Provincial council			
Regency			
Judge religious court			
Judge national court			
Public prosecutor			
Police			
District head			
Village head			
Village council			

The AGJI is a one-sided scale which only measures the difference in achievement of women in relation to men. The score is set at 100 when gender parity is reached or when women overachieve. Only one reverse indicator is used, HIV/STD when higher rates for women do not mean women are more empowered, quite the contrary.

Table 3 gives the overall score of the index and the ranking of each province/region. The data demonstrate that within Indonesia the gender gap differs widely and significantly.

Table 3. Overall score of GSI for 7 provinces

Province/region	score
Central Sulawesi (Palu)	72.2
Central Jawa (Semarang)	70.9
South Sulawesi (Makassar)	70.6
DKI Jakarta	69.8
North Sumatera (Medan)	66.6
Papua (Jayapura)	63
NTB (Lombok, Mataram)	61.9

The low score of NTB (Nusa Tenggara Barat, West Nusa Tenggara,) is partly caused by the fact that the level of STD/HIV infection of women in comparison with men is high. Its score on political power is low.

Gender parity has almost been reached in education; here the exception is Jakarta, with a score of 58. This is primarily caused by a big gender gap at the university level. In provinces which could not provide figures for the diploma/university level a proxy of 80 is used.[12] A proxy was also used for the income variable, which was uniformly set on 69.2, discussed below. The major differences between women and men are related to the very low level of power women have in relation to men. Here Jakarta scored considerably higher than the other regions. It has a score of 52, as compared to NTB which only scored almost 10.

Due to several technical problems in data collection, the figures are not always comparable. The data are derived directly from the sources, such as the provincial Departments of Education, Health and Manpower; these are the primary data sources for the national and thus for the international level. Other sources are census and survey data. If data are needed which are only collected by nationwide surveys, such as the DHS (Demographic and Health Survey) they must be shared with the provincial level statistical bureaus, but these were often not made available to the APIK teams.[13]

A comparison with the GII is interesting. In 2015 the GII for Indonesia as a whole was 0.466. As the GII measures inequality, a lower score means higher levels of equality. Table 4 provides the GII score in relation to the GSI score per province:

Table 4. GII and GSI per ROL province in 2015

Province/region	GSI score	GII score
Central Sulawesi (Palu)	72.2	0.536
Central Jawa (Semarang)	70.9	0.331
South Sulawesi (Makassar)	70.6	0.477
DKI Jakarta	69.8	0.110
North Sumatera (Medan)	66.6	0.481
Papua	63	0.516
NTB (Lombok, Mataram)	61.9	0.463

Source GII score BPS 2017, p. 63

From the above table it is clear that the GSI and the GII measure different issues and rely on different data sets and indicators. Some anomalies are apparent. The GII score of DKI Jakarta for instance, pointing to a high level of gender equality, needs further exploration. Remarkably, for 2017, two years later, the GII score has jumped up to

230, more than double (BPS 2017: p 63). As in the GII the values of the individual indicators are invisible, it is not immediately clear what factors cause the discrepancies in scoring between the GSI and the GII.

Health

The health variable of the GSI consists of two indicators. Longevity, which is used in some other indices (such as the GDI) was not used, as it is a stock indicator; it also needs adjusting for biological differences between women and men. Preference was given to two flow indicators which are more sensitive to changes in the short to mid term. The gender gap in child mortality (under 5) was selected as it may indicate a preference for children of a particular sex. In five of the seven regions under review a score of 100 was reached, which means that there are few indications of son preference in these regions in Indonesia. In North Sumatera the score was 94.6, which is close to parity. It is recommended to replace this indicator with stunting.

The other indicator selected was infection with STDs and/or HIV. HIV and STDs usually affect people who engage in high risk sexual behaviour. People engaging in such risky sexual behaviour are most often sex workers (male and female, in Indonesia condom use is notoriously low),[14] people with multiple partners, MSM and women who would like to get pregnant. Usually the infection rate of men with STDs/HIV is higher in the stage of a beginning HIV/AIDS epidemic. The group at the lowest risk consists of those women and men who engage in a monogamous sexual relationship with a non-infected partner. In Indonesia (as in other countries) men more often have multiple sexual partners than women have. Yet women are more at risk due to biological factors. When the epidemic is reaching the stage of a full-blown epidemic also monogamous heterosexual women are becoming at risk. This indicator is a reverse indicator, in the sense that a higher rate of women with STDs/HIV indicates that the epidemic has reached a high level. It is also a reference to sexual empowerment. High infection rates of women usually correlate with low bargaining power to engage in safe sex practices.[15]

In two regions (Palu and Makassar) the infection rate of men is higher than that of women. In Central Java, North Sumatera and Papua the infection rates of women are higher than those of men, indicating that the AIDS epidemic there is at a more advanced stage. In NTB more than twice as many women are infected than men indicating a full-blown epidemic and a low level of sexual bargaining power of women. Surprisingly the data for Jakarta were not available.

Education

Apart from Jakarta, the other regions all report near parity in educational achievements between women and men. Both Papua and DKI Jakarta score lower in all indicators of this variable. In Jakarta there is near parity for those who only have finished primary education, but at higher levels the gender gap widens. In SLTP (Sekolah Lanjutan Tingkat Pertama, junior high school) the gender gap is reported to be at 64.2, at the level of SLTA (Sekolah Lanjutan Tingkat Atas, SMA, senior high school) the gender gap has widened to 44.9. While at the lower university levels (S1, Sarjana 1, BA) the gender gap had risen to 32.5. For NTB the data for university level education were not available.

Income variable

The indicator selected for this variable was the gender gap in income in the formal sector. This is generally the most accessible and reliable figure, as income derived from informal sources is not always computed in a uniform way. It turned out that it was hardest to collect data on this indicator. No team was able to collect reliable data, though they visited the provincial level statistics bureau. Although the income variable has been criticised in relation to the HDI, GDI and GEM (Charmes and Wieringa 2003) the team decided that it was an important variable. To overcome the problem in data collection it was decided to use a proxy. Taniguchi and Tuwo, in a 2014 report on the gender wage gap in Indonesia for the Asian Development Bank, computed the overall gender gap in formal wage labour as 69.2. Interestingly they conclude that urbanization tends to benefit male workers more than female workers. In our case that might mean that in Jakarta the wage gap might be higher than in other more rural regions. Unfortunately, we don't have those data. Taniguchi and Tuwo posit that the gender wage gap in Indonesia is due to non-market reasons, and must be attributed to gender discrimination. In our study we note that almost everywhere (Jakarta is the exception) women have reached parity with men in education up to the tertiary level. This however does not lead to women's equal chances on the labour market, underscoring the conclusions of Taniguchi and Tuwo.

The GII uses labour participation rates. For Indonesia as a whole the labour force participation rate for the period in which the GSI was calculated, is provided in Table 5.

Table 5. Labour Participation rate of women and men in Indonesia (2010 and 2015)

Year	Men	Women	Rate
2010	83.76	51.76	0.617
2015	82.71	48.87	0.590

Calculated after table 5.4, BPS 2016, p. 74.[16]

For both men and women, the labour force participation decreases in the period for which it is calculated, but the decrease in the rate of women's participation in the labour force is steeper. Hence the total rate declines.

As this is a sensitive and available indicator it is recommended to add this indicator to the AGJI. But it is important to keep the indicator of income in the formal sector, to press the relevant provincial departments to collect those data. The information would be even more complete if reliable data on the informal sector and on time use were available.

Political power

With near-parity in education at least up to senior high school level (for four regions) and generally high scores in the health variable, the major component accounting for the gender gap in Indonesia is the variable of political power, besides the income component. This variable of the GSI consists of nine indicators, which together constitute the score in the political power block. The only exception to the generally very low scores is Jakarta. This may be a rather optimistic picture however as the researchers could not easily find the performance of women in relation to men in a number of indicators in which women in other regions score relatively lower than in other regions, such as the percentage of police officers and neighbourhood heads. The scores of judges (in state courts) and prosecutors are available in Jakarta, indicators in which the score of women in relation to men is often higher in relation to other indicators. The lowest score was reached by NTB, indicating that men dominate in all areas of public life.

In relation to members of regional councils, with the exception in DKI Jakarta (with 37%), women occupy between 7.9% (Papua), 10% (NTB) and 29% (Central Java) of the seats. At the regency (kabupaten) level women's score is generally lower, only in Papua it is higher (11%). Two kinds of judges are included in the index, judges in the religious (Islamic) courts and judges in state courts. The percentages of women who are judges in religious courts vary widely. In Central Sulawesi women occupy 40% of the seats, with a slightly higher score in Northern Sumatera. In NTB however there are no women judges in the religious court, while the score in Central Java is around 8%. For the remaining two regions there were no data available. In both DKI Jakarta, Central Java and in Central Sulawesi women occupy half of the seats of judges in the state courts. In NTB the score for the same indicator is 22%. In DKI Jakarta and in Central Java women outnumber men as prosecutors. The number of women police officers in contrast is remarkably low. In three regions women occupy less than 10% of the total police force (Central Java, North Sumatera and NTB). There are no figures for DKI Jakarta. In Papua 16.2 of the police officers are women. In Palu, Central Sulawesi, women make up one third of the police force, in Makassar 13%. Two indicators are included to capture the lowest levels of governance, subdistrict (kecamatan) head and village head. In both indicators the gender gap is very wide. For the two provinces where data are available for subdistrict heads the score is below 15%. The percentage of women village heads is even lower. Three provinces reported a score of around 5%, while in NTB and Papua no woman regional or village head was reported. In Makassar the score is slightly higher, with 15% of the village heads being women. These nine indicators together give a comprehensive picture of women's political power, including in the judiciary.

Methodology

The data for this index should be widely and easily available in the various relevant governmental offices. They are simple primary data that are critically important for any provincial government to plan its policies. NGOs too need access to these data to help assess their priorities and implement their projects. However, the researchers engaged in this pilot project faced numerous difficulties in accessing the data they sought. In some cases, they were not available at all. In several cases it was reported that complicated and time-consuming procedures were needed to access the data. In other cases, the officers responsible for those data seemed to consider them their personal property and they were loath to share them. These problems indicate that either

provincial departments or bureaus only report to the higher, national levels and do not consider colleagues in other provincial departments or staff at NGOs in need of reliable data. Or they indicate even deeper problems of data availability which throws doubt on the reliability of national data collection. This works both ways. Many data have to come up from the provinces. In other cases data are centrally produced, for instance on the basis of nationwide surveys. Regional data are then produced at the central level and they should go to the subnational level for further analysis. From this pilot project it appears there are serious shortcomings in the flow of data between the national and the subnational levels

At the start of the data collection process it was also assumed that the data would be easily comparable so that it would not be necessary to implement complicated harmonization exercises. After all the project relates to regions within one country. This assumption did not always hold. Maternal mortality (see below) and HIV/STD may be areas in which the process of data collection is probably not the same nationwide; this needs further research.

Overall conclusion

The gender gap in the various regions in Indonesia is relatively wide. A second conclusion is that the differences between the regions are wide. The gender gap in Papua and NTB, the regions that score lowest in this exercise is around 10 points lower than the highest scoring region, Central Sulawesi. The widely used global report on gender relations, Global Gender Gap Index (GGGI) Report of the World Economic Forum (WEF) ranks Indonesia on the 92nd place (out of 146 countries), with a total score of 0.681.[17] If we calculate the overall score of the GSI for the seven regions in this project, the outcome is 67.8. As in the GSI, the variables of health and education of the GGGI indicate there is almost gender parity for women and men. The economic variable of the GGGI consists of two indicators, economic participation (0.60) and income (0.48). The Asian Development Bank proxy used in the GSI (income of formal sector) is thus higher than the gender gap in income in the WEF reports (which means a smaller gap is reported by the Asian Development Bank).

The major difference between the GSI and the Global Gender Gap report is that the GSI is much more precise in relation to political empowerment. The indicators the WEF uses however are much simpler, consisting only of share of women in parliament and ministerial positions, and the number of years with female heads of state (over a period of 50 years).

The advantages of the GSI of the AGJI are thus that the GSI can be collected at the subnational level, providing more detailed data to indicate gender gaps within Indonesia. Secondly it is much more detailed at the most worrisome variable, political empowerment. It can be computed easily and cheaply. As discussed above it is recommended to add the indicator labour force participation. Another recommendation is to upgrade the process of data collection at the provincial level.

Women's Progress Measure (WPM)

Part 2 of the AGJI is called the Women's Progress Measure. It focuses on issues that are directly relevant for women's empowerment but cannot be inserted in a gender analysis, such as the Maternal Mortality Rate (MMR) and Female Genital Mutilation (FGM). The WPM consists of five variables: it measures MMR and FGM, the domestic violence law, the marriage law and reproductive rights. As progress is measured, a time span of five years has been taken. The most recent data available are those of 2015 (or sometimes 2014), and the data 5 years prior to that, 2010 (or 2009),

Table 6. Maternal Mortality Rate

Province/Region	GSI score	MMR 2010	MMR 2015
Central Sulawesi (Palu)	72.2	611	619
Central Jawa (Semarang)	70.9	na	na
South Sulawesi (Makassar)	70.6	1123	967
Dki Jakarta	69.8	na	74 (year 2014)
North Sumatera (Medan)	66.6	577	352
Papua (Jayapura)	63	130 (year 2009)	106 (year 2014)
NTB (Lombok, Mataram)	61.9	37	239

Maternal mortality is a huge problem in Indonesia. It was as high as 359 in 2012, much higher than in neighbouring countries. Indonesia failed to reach the MDG goal of reducing its MMR.[18] The SDG global target on maternal mortality reduction to 70 per100 000 live births seems impossible for Indonesia to achieve, as the WHO estimates (in Asia, Indonesia is in the company only of North Korea, Myanmar and India).[19]

Although Indonesia has made progress in training birth attendants and in providing medical facilities, the MMR has not decreased. Traditional gender ideology and practices, in particular the highly skewed gender division of labour seem to affect the efficacy of the measures taken. The high MMR is also related to women's gender subordination in general and measures to reduce it can not only rely on medical progress.[20] This is a major reason why the proxy used by the GII for the MMR (namely proportion of births attended by skilled health personnel), is not sufficient to indicate the seriousness of the problem.

Collecting the date for the MMR did not prove easy to the APIK researchers, a major reason why BPS chose the proxy. In general data collection on maternal mortality is uneven and prone to various biases at the local level.[21] Only Central and South Sulawesi and North Sumatera have provided data indicating a change in the MMR which can be considered moderately reliable. In North Sumatera the rate went down in the period studied from a high 577 to 352, which is close to the national maternal mortality rate. In Central Sulawesi the rate went slightly up in this period, from 611 to 619. In NTB it was low in 2009 and increased for unspecified reasons in 2014. The figures for the two provinces in Sulawesi are almost double the national rate. The APIK researchers in Central Java (for both years) and DKI Jakarta (for 2009) were not able to collect these data.

Female Genital Mutilation (FGM)

Female genital cutting is widespread in Indonesia It is often done right after birth: more than 80% of female circumcision is performed on babies under 1 year old. It is estimated that some 60 million women have undergone FGM.[22] Data on FGM is hard to come by at the provincial level. The most reliable data are those collected by the Ministry of Health in 2013. These data were collected in a nationwide cross sectional survey in which the answers of 115.000 respondents were collected in relation to FGM: more than half of all girl children below 11 years old were circumcised in 2013 (Ministry of Health 2013: 207). Yet the topic is hardly discussed in national level policy documents.

Indonesian official policy on FGM is inconsistent. Indonesia attempted to ban the practice in 2006. But Muslim clerics issued an edict declaring that it was part of Islamic religious practice, even though it is not explicitly mentioned in the Quran. In 2010, the Indonesian Health Ministry released a regulation that allowed medical personnel to perform female genital cutting on young girls. In this way the state condoned the practice it earlier intended to abolish. The argument in favor of the medicalization of FGM is that it is better to have trained medical personnel perform the procedure than risking severe infections if it is performed by traditional circumcisers. However, medicalization may actually be more dangerous. Trained midwives tend to use scissors. Hence, they actually may cut the skin, which may include removing the inner labia, and harm or remove the clitoris. Traditional circumcisers, meanwhile, use penknives for more symbolic acts of scraping or rubbing. Practices vary, though. While in some regions a relatively mild form of incision is used, in other areas routinely the inner lips including the clitoris are excised. In 2014 the Ministry lifted the regulation. But medical establishments and small private health clinics continue to carry out the procedure.

Table 7. Percentage of girls below 11 years who had undergone FGM in 2013

Region	Percentage
Central Sulawesi	53
Central Java	28
South Sulawesi	38
Jakarta	70
North Sumatera	55
NTB	71
Papua	3

Source: Ministry of Health 2015: p 207. The percentages given in the table above are estimates based on table 3.13.15.[23]

The high percentage in Jakarta may be caused by the fact that in general the level of FGM is higher in urban than in rural areas.[24]

Domestic Violence Law

As elsewhere, domestic violence is a huge problem in Indonesia.[25] To measure the progress on the implementation of the 2004 Domestic Violence Law, five indicators were used, reports to the police and to APIK, reports to the state bureau P2TP2A,[26] requests for divorce from women at the religious and state courts. It is assumed that a higher number of women reporting the domestic violence they experience to the police is an indicator both of women's empowerment and of the knowledge of officials of this law, as well as of its level of sensitivity. Variations in reporting to APIK may be related to relative strength and quality of APIK staff, but also to external factors, such as a higher number of people reporting to the authorities. Likewise, it is assumed that a higher number of women asking for divorce is an indicator of women's empowerment, as in situations in which women have a low level of empowerment, they are too scared or too intimidated to divorce their husbands.

Table 8. Implementation Domestic Violence Law

Province/region	GSI score	Domestic violence law	2010 (b2009)	2015 (b 2014)
Central Sulawesi	72.2	Report to police	543	1345
		Report to APIK	163	349
		P2TP2A	370	564
		Divorce state court	50	123
		Divorce religious court	129	296
Central Java	70.9	Report to police	632	1971
		Report to APIK	75	51
		P2TP2A	373	1971
		Divorce state court	21	228
		Divorce religious court	9914	41150
South Sulawesi (Makassar)	70.6	Report to police	455	352
		Report to APIK	19	461
		P2TP2A	-	48
		Divorce state court	951	1499
		Divorce religious court	-	-
DKI Jakarta	69.8	Report to police	4 (b)	35 (b)
		Report to APIK	793	579
		P2TP2A	950	1612
		Divorce state court	4	61
		Divorce religious court	4655	7904
North Sumatera	66.6	Report to police	276	881
		Report to APIK	65	60
		P2TP2A	-	-
		Divorce state court	1424	4631
		Divorce religious court	6275	9607
NTB	61.9	Report to police	-	126 (b)
		Report to APIK	-	19
		P2TP2A	-	336
		Divorce state court	-	56
		Divorce religious court	4002	-
Papua	63	-	-	-

In general, the level of reporting to the police goes up. This may be related to a greater trust in the police due to more gender sensitivity. It may also be related to the hard work and growing expertise of APIK's paralegals, who as peer councillors help abused women to report. The numbers reporting to P2TP2A indicates the effectiveness of this new state institution.

Marriage law

The 1974 marriage law allows for polygyny, but only under certain conditions. The first wife has to give her consent. Recent debates on *nikah sirri* indicate that men still engage in polygynous relations in which women have very few rights. A *sirri* marriage is only registered by an Islamic religious official. In many cases of polygyny first wives have not given their consent. The 'secondary' wives themselves may not know that their new husband is already married.[27]

Another big problem is the consistently high level of child marriage, around 23% of all marriages contracted. Each year 340.000 girls marry below the age of 19, and 50.000 of them even before the age of 15. Indonesia ranks seventh in the world and second in ASEAN, after Cambodja. Child brides face health risks, and usually drop out of school.[28] UNICEF and the Central Statistics Agency (BPS) published a report in 2016, which showed that the prevalence of early marriage stood at 22.82 percent in 2015, slightly down from 24.17 percent in 2013.[29]

One in five women aged between 20 and 24 said they had been married at least once before they reached the age of 18 years; many of them had married when they were 16 or 17. In 2015, the prevalence of women marrying before 16 was 3.54 percent, and the prevalence decreased to 1.12 percent when it comes to marrying before 15.The prevalence of child marriage is higher in rural areas, with 27.11 percent, compared to 17.09 percent in urban areas, according to data in 2015.[30]

Article 7 of the 1974 Marriage Law sets the marriageable age for women at 16 and for men at 19, even though the 2002 Child Protection Law defines children as anyone 'under the age of 18'. Religious courts, however, have been granting minors as young as 15 years dispensation to be married, especially in regions where child marriage is considered the norm. The court's discretion to give dispensation is stipulated in Article 7 of the Marriage Law.

The Constitutional Court ruled early December 2018 that the 16 years' old minimum age requirement for women to marry, as stipulated in the 1974 Marriage Law, was unconstitutional.[31]The United Nation's Sustainable Development Goals (SDGs) state that child marriage is a violation of children's rights. Goal five, point three of SDGs requires nations to eliminate all harmful practices of early and forced marriage.

This variable has three indicators, two of which deal with child marriage - marriage below the age of 15 and marriage between the ages of 15-19. The third indicator is the number of polygynous marriages contracted officially. In an official polygynous marriage, the junior woman/women have more rights than in a *sirri* marriage. In an official secondary marriage, the first wife has to consent to her husband's marrying another wife. So, the assumption is that this indicates a lower level of marriage deceit by the husband and a higher level of empowerment of both (or more) wives.

Table 9. Implementation Marriage Law

Province/region	GSI score	Marriage law	2010 (b2009)	2015 (b 2014)
Central Sulawesi, Palu	72.2	Marriage below 15	-	-
		Marriage 14-19	-	-
		Registered polygyny	-	-
Central Java, Semarang	70.9	Marriage below 15	-	
		Marriage 14-19	190	3876
		Registered polygyny	-	-
South Sulawesi, Makassar	70.6	Marriage below 15	-	-
		Marriage 14-19	-	-
		Registered polygyny	-	4
DKI Jakarta	69.8	Marriage below 15	-	-
		Marriage 14-19	-	-
		Registered polygyny	-	-
North Sumatera, Medan	66.6	Marriage below 15	-	-
		Marriage 14-19	2897	1195
		Registered polygyny	26	79
NTB, Lombok, Mataram	61.9	Marriage below 15	-	-
		Marriage 14-19	-	-
		Registered polygyny	-	-
Papua, Jayapura	63	Marriage below 15		
		Marriage 14-19		
		Registered polygyny		

No data were collected of girls marrying below the age of 15. Lower figures for 2015 as compared to 2010 such as in North Sumatera are good news. It is difficult to interpret the data for Central Java.

Because of the unreliability of the data the BPS uses a proxy for its GII, children born before the mother reached the age of 19. On the one hand this seems justified, as child marriages are often contracted because the bride-to-be is already pregnant, and women are supposed to bear children straight after being married. On the other hand, not all marriages result in pregnancies.

Reproductive rights

For this variable two indicators were selected after extensive discussions; increase in the number of men who are acceptors of contraceptives and decrease in the percentage of unmet contraceptive needs. The first indicator assesses whether men too are taking their responsibility for contraceptives, and the second indicator points to the overall performance of the (regional) governments' reproductive programmes.

Table 10. Reproductive Health

Province/region	GSI score	Reproductive rights	2010 (b2009)	2015 (b 2014)
Central Sulawesi, Palu	72.2	Increase male acceptors	70283	80264
		Decrease unmet needs	-	-
Central Java, Semarang	70.9	Increase male acceptors	45430	36322
		Decrease unmet needs	-	-
South Sulawesi, Makassar	70.6	Increase male acceptors	5004	5849
		Decrease unmet needs	8,10%	20,37%
Dki Jakarta	69.8	Increase male acceptors	1593(b)	1436 (b)
		Decrease unmet needs	13,69%	13,20%

Province/region	GSI score	Reproductive rights	2010 (b2009)	2015 (b 2014)
North Sumatera, Medan	66.6	Increase male acceptors	1429414	1604457
		Decrease unmet needs	18,57	16,22
NTB, Lombok, Mataram	61.9	Increase male acceptors	20.614(b)	23.675 (b)
		Decrease unmet needs	-	15,34%
Papua, Jayapura	63	Increase male acceptors	-	11701
		Decrease unmet needs	-	29,70%

In Central and South Sulawesi, as well as in North Sumatera and in NTB the number of men who have joined the family planning programme has increased, although the number in South Sulawesi is very low. In Jakarta the number of male acceptors is likewise low, and has even decreased. In Central Java the number of male acceptors has declined and remains low for such a heavily populated province.

The percentage of couples with an unmet need for contraceptives varies. In two regions no data were available. In NTB and Papua only data for 2015 were available. The interpretation of these data is not always clear. In general, the ideal situation would be that there are no unmet needs. From that perspective a decrease in unmet needs such as reported in North Sumatera and to a lesser extent in Jakarta is good news. On the other hand, an increase may also show that more couples have become aware that they would like to join a family planning programme while before they had not considered this possibility and had thus not reported they had an unmet need.

Third part

The third part of the AGJI is composed of two variables, economic and civil rights. It is the most flexible component of the tool, and can be adapted to assess different gender-related policies and projects. For the needs of the Rule of Law programme it was important to collect data on access to economic and social rights and entitlements. As was the case with collecting data for the other components of the AGJI, data were not always available, and LBH APIK researchers faced serious problems in accessing them.

The variable of economic rights has three indicators, the number of women who have land titles (as compared with men,) the number of women who have certificates of their houses and the number of women who have access to credit. Unfortunately, no team was able to collect these data. Yet they are essential data to assess the progress of women's empowerment, both in relation to the SDGs and to CEDAW, which Indonesia ratified.

The block on civil rights forms the core of APIK's project on the Rule of Law for poor women and vulnerable groups. On the basis of close observations of their target group the APIK teams identified 12 indicators, documents that everybody should have such as an identity card (KTP), a birth certificate, a family card, a marriage or divorce certificate as well as documents that are made available to members of groups who have a specific right to them, such as a health card, a card that entitles poor people to a ratio of rice, a card that provides education to children of poor families, a card on family welfare, and cards for fishermen and –women, for old and/or disabled people. Ideally this variable should show the progress made for the time period indicated earlier, but very few teams have been able to collect data for 2010 (or 2009). This is also related to the fact that some of these entitlement cards have been introduced relatively recently.

Overall Conclusion

Designing the AGJI was done in a participatory manner. Participants, mainly lawyers and paralegals, learnt how to break down elements of socio-economic gender relations. The discussions on the block on political power were particularly rewarding. Here a list was made of positions that directly impact on women's power, in the specific context of Indonesia. If the AGJI will be adapted to other contexts here the cultural specificity can be best expressed. The second, qualitative component, WPM, provides women-specific data and the third part includes information relevant to this project. The two latter parts can easily be adapted to other topics and to other contexts, by selecting the relevant variables.

The barefoot statisticians of this project could not always collect the needed data. This is largely due to the reluctance or perhaps incompetence of various government offices which should make these data easily available. Here too, great regional differences can be noted. Particularly worrisome is the fact that no data for income were available, nor on land titles and other economic variables.

Although this was a modest pilot project, the data this exercise yield are interesting. The fact that the GSI compares well with the Global Gender Gap Index report, while the methodology is so much simpler and cheaper, and the indicators deployed are much broader in scope, suggests that it can be used more widely.

The sophisticated GII that the BPS computes is able to rank regions at the subnational level. It is a complex tool which also suffers from the low availability of relevant data. The absence of the indicator for the MMR is significant in this respect. However the methodology of the GII is not very transparent. The AGJI is a much simpler and more transparent tool. Although ranking is an interesting exercise in itself, a lower or higher place does not immediately tell activists and policy makers what particular problems in a specific region need to be addressed.

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Endnotes

1 LBH APIK is Lembaga Bantuan Hukum, Asosiasi Perempuan Indonesia untuk Keadilan, Legal Aid Institution, Indonesian Women's Association for Justice.

2 See Sen, *1985 and 2001.*

3 Charmes and Wieringa 2003, Dijkstra 2002.

4 The AGDI and the AWPS have been designed by S.E. Wieringa and J. Charmes at the request of the UN Economic Commission for Africa. At present 42 of the 54 African countries have implemented the Index. Instrumental in its creation and implementation were Josephine Ouédraogo, Thokozile Ruzvidzo, Tacko Ndiaye. Beatrice Duncan and Gonzague Rosalie and their teams, as well as the many members of the country teams.

5 See for a full discussion of the various gender indices APIK report, Wieringa 2019.

6 http://hdi.globaldata.org

7 The subnational HDI data are taken from Ministry of Health 2016; Health profile of the Republic of Indonesia 2015, based on table 1.19. The GII data are from BPS 2018, p 63.

8 The Indonesian part of the huge island is divided in two parts, Papua and West Papua. In English the whole part is usually called West Papua. In this table the province Papua is meant, the eastern part of what is called West Papua in English. The low gender gap reported in the GII for 2015 for Jakarta is remarkable and needs further explanation. The score of the GSI in the AGJI, discussed in the last part of this report, provides a different picture.

9 The design of the Indonesian GII is discussed in BPS 2016. (KPPPA and BPS 2016) The subnational calculations are presented in BPS 2017.

10 But this relation is not as direct as is suggested in BPS 2016 (KPPPA and BPS 2016: 69). After all, not all married women give birth immediately after the marriage is consummated. The high adolescent fertility rate is a matter of concern. In 2016, 26% of babies were born to young women under the age of 20 years (KPPPA and BPS 2016: 69).

11 Zaluchu 2018.

12 Approximating the figure found for the provinces where this information was available.

13 Several tables in the DHS are disaggregated by region, but this information was not always made available to our researchers at the provincial level.

14 On the low level of condom use and the relation with HIV infections see for example http://www.asiaone.com/health/low-condom-use-blamed-new-hiv-cases-indonesia. Yet contradictorily influential conservative clerics denounce what they call the 'condomization' of society, for fear it might lead to 'free sex'. They promote abstinence and aim to restrict condom use only among married couples. https://qz.com/433657/indonesian-lawmakers-want-to-fight-aids-by-restricting-access-to-condoms/

15 On the relationship between women's sexual empowerment and HIV rates see for example https://www.theglobalfight.org/empowering-women-girls-shrink-global-hiv-epidemic/

16 The BPS has more recent data, but these were not used for this article, as we preferred to take the same years as for which the GSI is computed. The national level BPS has more data on the gender wage gap as well, but this pilot project aimed to collect data at the provincial level – theye were not available there

17 The 2015 report, the same year as the GSI

18 See Mundayat, Arif, Noerdin, Agustioni, Aripurnami and Sri Wahyuni, 2010.

The MDG 5 target was to reduce MMR in 2015 to three quarters of its level in 1990. For Indonesia that would mean reducing it from 390 per 100.000 live births to 102. (Zaluchu 2018: 44-46). Zaluchu cites Bappenas 2014.

19 WHO 2018, Regional progress in survival of new borns, children and mothers: Moving towards Global Strategy targets apps.who.int

20 This is why Zaluchu 2018 proposes to hold a gender audit, beside the regular maternal audit.

21 See Zaluchu 2018 for a more detailed discussion of the possible biases in data collection of the MMR.

22 UNICEF 2016, Female genital mutilation/cutting, country profiles.

23 Based on the 2013 National Basic Health Survey (Riskesdas)

24 See for a further discussion on FGM for instance http://theconversation.com/female-genital-cutting-common-in-indonesia-offered-as-part-of-child-delivery-by-birth-clinics-54379

25 See Katjasungkana 2013. See also Lianawati 2009 and Yentriyani, Ratih and a Chandrakirana, 2009. See also Mohamad and Wieringa 2013.

26 P2TP2A, Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak, Integrated Service Center for the Empowerment of Women and Children.

27 On such forms of marriage deceit see for example Wieringa 2015.

28 See Marcoes and Hidayat eds 2018. See also Woodward, and Rohmaniyah 2014. See also https://www.asiasentinel.com/society/indonesia-child-marriage-problem/

29 Other figures are provided by KPPPA and BPS (2013) This report found that the percentage of age of first marriage below 15 was 11.13, below 19 stood at 32.10, and above 19 at 56.76 2013: 65). These are for the whole country. In the countryside, more girls of minor age get married than in the cities. In both cities and the countryside an early marriage age is related to a low level of education (2013: 66). Remarkably in this profile of Indonesian women of 2013, data for MMR are not included.

30 ttps://www.unicef.org/indonesia/UNICEF_Indonesia_Child_Marriage_Reserach_Brief_.pdf

31 APIK is part of this coalition.

Expression of Gratitude to Reviewers

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