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Women and Health

Editorial

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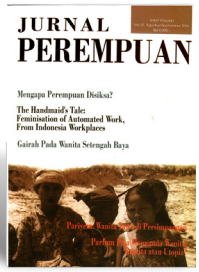

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This JP edition is published by Yayasan Jurnal Perempuan with the support from the Australia-Indonesia Partnership for Gender Equality and Women's Empowerment (MAMPU). MAMPU program is a joint initiative between the government of Australia and the 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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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.

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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, 215-227 DDC: 305

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

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Abstract

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

Introduction

The Maternal Mortality Rate (MMR) is one indicator of a country's development as its management involves comprehensive and integrated efforts (Sajedinejad et al 2015). In Indonesia, the current MMR is still quite high. Based on the Indonesian Demographic and Health Survey (SDKI) report, in 2012 the MMR reached 359 deaths per 100,000 live births (National Research and Development Agency 2013). In addition, the prevalence of stunting — which has reached an alarming level with 37% —indicates maternal health problems in Indonesia (National Research and Development Agency 2013). Some of the factors that increase reproductive health risks are: gaps in access to health services, incomplete antenatal services, poor maternal health and nutrition, lack of awareness about safe pregnancies and childbirth, and inadequate quality of services, especially for women living below the poverty line (UNICEF Indonesia 2012).

Driven by its shortcomings in achieving the Millennium Development Goals (MDGs) in 2015, the Indonesian government is now actively pursuing the 17 Sustainable Development Goals (SDGs). One of the government's goals is ensuring that by 2019, 85% of childbirths occur in healthcare facilities (Ministry of Health 2015, p. 24). The government's failure to achieve its maternal health goals shows that inequality in access to public healthcare exists (Xu, Saksena & Evans 2010). In order to improve maternal health, many aspects of healthcare must be improved. These aspects include the cost of healthcare, epidemiological and demographic dynamics, preventive and promotive health services, and handling of multisectoral maternal health problems (World Bank 2010).

The Government of Indonesia has sought to ensure healthcare access through the National Health Insurance (JKN) program introduced in 2014 which is now better known as the National Health Insurance-Indonesia Health Card (JKN-KIS) scheme. This program aims to ensure that women and children living in poverty receive support to access reproductive health services, including antenatal and childbirth care. However, there are still gaps in basic health services accessible by the poor (Ministry of PPN / Bappenas 2015).

This paper focuses on poor women's access to antenatal care and assisted childbirth in five regencies in Indonesia with high levels of poverty. This article was created based on a midline study report conducted by the SMERU Research Institute and the MAMPU Program

in 2017[1]. This paper aims to explore (1) the availability of prenatal care and assisted deliveries in healthcare facilities, (2) poor women's access to prenatal checkups and assisted childbirth, and (3) the factors and actors that hinder or support poor women's access to these services.

Research methods

This study used a mixed-methods approach. Quantitative methods were used to examine poor women's access to antenatal care and assisted childbirth as well as access to information about these services. Meanwhile, qualitative research methods were used to explore the quality of the health services available, poor women's access to health services, and factors and actors that improve or weaken this access. The mixed methods were used to paint a comprehensive picture of the relevant condition over the past three years and the factors and actors that have contributed to change in this picture.

The study locations were selected by purposive sampling that took a number of factors into consideration (Rahmitha et al 2016). The study areas were located on five of the largest islands and archipelagos in Indonesia, namely Sumatra, Java, Kalimantan, Sulawesi, and Nusa Tenggara. The study locations selected all had relatively high poverty rates compared to the national or provincial average. The study regions represented the five thematic areas of the MAMPU Program and were working areas of MAMPU program partner organisations. The research locations were: Deli Serdang Regency, North Sumatra; Cilacap Regency, Central Java; Kubu Raya Regency, West Kalimantan; Pangkajene dan Kepulauan (Pangkep) Regency, South Sulawesi; South Central Timor (TTS) Regency, East Nusa Tenggara.

Primary data collection at the regency level was conducted in October-December 2017. Families included in the quantitative study were poor families recorded in the 2014 baseline study. The families were selected through focus group discussions (FGD) with local communities that referred to welfare characteristics according to the local context. In every village, 100 poor families were selected from two hamlets from a mixture of female-headed and male-headed families. All of the families selected included women as the study was focused on the experiences of women.

Qualitative data was obtained through in-depth interviews and FGDs. In-depth interviews were conducted using a semi-structured interview guide. In each regency, around 60 interviews were conducted at the family, community, village, sub-district and district levels. Meanwhile, the FGDs encompassed "mini FGDs" and village level FGDs. The mini FGDs were attended by five poor women who fulfilled set criteria while the village FGDs involved representatives of women's groups and community leaders.

Availability for Prenatal and Neonatal Examination in 2017

The availability of village-level health facilities throughout the study locations varied greatly (Table 1). The number and distribution of village-level health facilities in the study locations were either limited (Cilacap and Pangkep) or very limited (Kubu Raya and TTS) with the exception of Deli Serdang. This was due to the fact that the majority of study villages in Deli Serdang had urban characteristics with relatively high population density and various public facilities, including health facilities available (Rahmitha et al 2016).

Of the 15 study villages, only two villages had community health centres (*puskesmas*), and this number had not changed since 2014. In villages that did not have *puskesmas*, the distance to the nearest *puskesmas* varied between 1–21 km. On average people in Kubu Raya had to travel longer distances than people in other regencies. They had to spend 45-60 minutes to access *puskesmas* if they travelled by water and land, or more than two hours if they only travelled by land.

Table 1. Availability of Health Facilities in the Study Villages in 2017

District	Village	*Posyandu*	Village health post/ Village maternity wards	Auxiliary health centre	Puskesmas (if unavailable, distance to the nearest puskesmas)	Doctor's practice	Midwife practice	Nurse's practice
Deli Serdang	A	Available	-	-	Available	Available	Available	-
	B	Available	Available	Available	± 20 km	-	Available	Available
	C	Available	-	Available	± 15 km	Available	Available	Available
Cilacap	D	Available	-	Available	± 7 km	-	Available	-
	E	Available	Available	-	± 13 km	-	Available	Available
	F	Available	Available	-	± 9 km	-	Available	Available
Kubu Raya	G	Available	Available	Available	± 16 km	-	Available	-
	H	Available	Available	Available	± 8 km (by water)	-	Available	-
	I	Available	Available	-	± 21 km (by water + road)	-	Available	-
Pangkep	J	Available	-	-	Available	-	Available	Available
	K	Available	Available	Available	± 2 km	-	-	-
	L	Available	Available	-	± 2 km	-	-	-
Timor Tengah Selatan (TTS)	M	Available	Available	-	± 10 km	-	-	-
	N	Available	Available	-	± 9 km	-	-	-
	O	Available	-	-	± 1 km	-	-	-

Source: Data processed from interviews conducted in 2017 by SMERU.

The table above shows that Deli Serdang had the greatest number of health care facilities provided by government and private sector compared to the other villages in the other four study regencies. This facilitated increased community access and provided more health care options. Private healthcare centres in Deli Serdang were also relatively well spread out and easily accessible. In the other study areas, healthcare facilities were largely limited to government-managed facilities such as village health units (*poskesdes*) and auxiliary health centres (*pustu*), which were limited in number and distribution. Government healthcare facilities were usually located around the village centre and therefore people living in remote areas away from the village centre had difficulties accessing healthcare facilities.

To support the existing health facilities, midwives or nurses in the majority of the study villages provided services outside the operational hours of the villages' health posts or village maternity wards (*polindes*). In general, the presence of midwifes or nurses in the study villages provided easier access for the community to access health services at any time, including times outside the operational hours of the *poskesdes* or *polindes*.

There were no private healthcare practices in three study villages in TTS or in Village K and Village L in Pangkep. Only a limited number of government-provided healthcare services were available in these villages. However, in Village K and Village L in Pangkep, regional government regulations required midwives in the *poskesdes* to live at the locations where they were assigned to work. This provision allowed the community to access midwives' services outside the *poskesdes*' operational hours. These regulations resulted in community access to village health workers being relatively good despite the limited number and type of health facilities at the village level. In contrast, in TTS there was no such local government regulation to increase the community's access to the village healthcare services. TTS had the most inadequate healthcare facilities in comparison to the four other regencies.

Meanwhile, community-operated integrated health service posts (posyandu) played a significant role in facilitating several types of healthcare services, including antenatal check ups. In recognition of the importance of posyandu there have been efforts to increase the number of posyandu at the village level in all study regencies. Healthcare workers in villages are tasked with taking care of *posyandu* in their service areas, including by attending *posyandu* activities that are held routinely. Usually, *posyandu* are available at the hamlet level. In Village L

(Pangkep), there is a mobile *posyandu* that travels to remote areas bimonthly.

Over the last three years in all of the study areas while there has been an increase in the number of *posyandu* but has been no increase in the number of government-run village health facilities (*puskesmas, pustu, poskesdes, and polindes*).

Local governments in Deli Serdang, Kubu Raya, and Pangkep have made many efforts to improve health services such as *posyandu* and village health facilities including *poskesdes*, *pustu*, and *puskesmas*. Improvements and changes in health services are more prevalent at the village level although some improvements have occurred at the district level. An example of a change that occurred at the district level was the providing of a service car to a *puskesmas* in Deli Serdang. The service car, which has been operating since 2015, serves two study villages in the regency and one of the services that it provides is prenatal checkups. The service car facilitates increased access for women to health services. Meanwhile, the *polindes* in Desa M (TTS), which had been inactive since 2014 because the midwife in charge left to continue her education, became active again in 2017 when new healthcare workers were stationed there. This shows that the number of healthcare workers in TTS is still minimal and demonstrates that the construction of further healthcare facilities would be meaningless if there were no healthcare workers assigned to staff these facilities.

The availability of antenatal care and childbirth services was also influenced by regional health policies and programs for women in the community. The study regions variably had regional health insurance programs (some that had been integrated with JKN-KIS and some that had not), regional maternal insurance (Jampersalda), partnerships between midwives and traditional birth attendants, as well as programs to provide incentives to *posyandu* cadre. In the majority of the regencies, there were also classes for pregnant women implemented under the supervision of village midwives and usually carried out at *posyandu* activities. Generally, these classes for pregnant women included prenatal gymnastics, provision of supplementary food, dietary consultations, and health consultations. Meanwhile, in Kubu Raya, Pangkep, and TTS there were also "waiting houses" for pregnant women who were waiting to give birth.

The existence of Law No. 6/2014 on Villages enables village governments to autonomously determine the use of Village Funds. Referring to article 74 paragraph 2 and article 80 paragraph 4 of the law village governments are required to provide basic services, including healthcare services, to the village community. This mandate is then realised, inter alia, through the allocation of Village Funds for healthcare services. In-depth interviews found that in all villages included in the study, Village Funds were allocated for *posyandu* activities, such as funding operational activities and providing cash incentives for cadres. In Village M (TTS), the village government also allocated Village Funds to increase the salaries of healthcare workers on duty at village health facilities and to improve roads to facilitate better access to the healthcare facilities. The allocation of Village Funds for healthcare improvement can contribute to increasing poor people's access to healthcare facilities at the village level.

Poor Women's Access to Prenatal Checkups and Assisted Childbirths in 2017

Pregnancy Tests

This study shows that antenatal checkups were the services most frequently accessed by poor women in health facilities. Based on the results of a household survey, poor women's access to antenatal checkups in healthcare facilities increased from an average of 70% in 2014 to more than 90% in 2017. The most accessible prenatal check-up services were at *puskesmas* (especially in Pangkep) and private midwife practices (in Deli Serdang and Cilacap). This finding is in line with the availability of *puskesmas* in Village J (Pangkep) and the number of private midwife practices in Deli Serdang.

Meanwhile, some poor women attended prenatal checkups at *posyandu* because it was closer to where they live. This was mainly found to be true in Kubu Raya and TTS as two research areas in which the availability of health facilities was still very limited. The types of healthcare facilities accessed by women in the study areas for antenatal care can be seen in Table 2 below.

Table 2. Pregnancy and Childbirth Examination Data by Area

Variable	Deli Serdang (N=173)	Cilacap (N=155)	TTS (N=198)	Kubu Raya (N=219)	Pangkep (N=169)
Location of health examination					
Hospital	5,5%	1,3%	1,1%	1,1%	1,9%
Clinic	10,4%	1,3%	0,6%	1,6%	1,3%
Puskesmas	3,0%	24,2%	53,6%	45,7%	90,3%
Posyandu	1,2%	9,2%	44,1%	24,7%	1,3%
Midwife	79,9%	62,7%	0,0%	22,6%	4,5%
Traditional Birth Attendant's Home	0,0%	1,3%	0,6%	3,8%	0,6%
Others	0,0%	0,0%	0,0%	0,5%	0,0%
Location of delivery					
Home	18,70%	45,00%	34,20%	78,30%	22,60%
Hospital	25,30%	19,90%	8,90%	10,80%	15,50%
Puskesmas/Posyandu	1,80%	9,30%	55,30%	6,90%	47,70%
Doctor's clinic	6,00%	0,70%	0,50%	1,50%	0,00%
Midwife	48,20%	23,80%	0,50%	2,00%	12,90%
Traditional Birth Attendant 's home	0,00%	0,70%	0,00%	0,00%	0,00%
Others	0,00%	0,70%	0,50%	0,50%	1,30%
Main source of assistance during childbirth					
Family/ neighbours	0,6%	0,7%	8,9%	1,5%	3,2%
Midwife	71,1%	55,6%	60,0%	31,5%	66,5%
Doctor	24,7%	19,9%	11,6%	6,4%	15,5%
Traditional Birth Attendant	3,6%	23,8%	19,5%	60,6%	14,2%
Others	0,0%	0,0%	0,0%	0,0%	0,6%
Main source of assistance during childbirth at home					
Family/ neighbours	3,23%	1,47%	23,08%	1,89%	14,29%
Midwife	74,19%	45,59%	21,54%	22,01%	22,86%
Doctor	3,23%	1,47%	0,00%	0,00%	0,56%
Traditional Birth Attendant	19,35%	51,47%	55,38%	76,10%	62,86%

Source: SMERU Research Team survey results, 2017
N: number of samples

Childbirth

The high level of prenatal checkups in health facilities in the research areas was not accompanied by a high level of deliveries assisted by medical professionals. Women's access to professionally assisted childbirth in the study locations was still well below the national average of 93% (BPS 2017). In Cilacap, for example, although more than 97% of women had their pregnancies checked in health facilities, only 73% of women gave birth assisted by medical workers. One of the mini FGD participants in Village E mentioned that her neighbour had wanted to give birth at the *puskesmas*, but the baby was born unexpectedly quickly and so the delivery was not assisted by health workers. Referring to Table 1, the distance from Village E to the nearest *puskesmas* is 13 km. In contrast, prenatal check-up services at the *posyandu* were available at the village level. This finding indicates that the availability of healthcare facilities for antenatal care services is better than for childbirth's services.

Among the five regencies in this study, Kubu Raya had the lowest percentage of childbirths assisted by medical staff. In Kubu Raya, the prevailing tradition was for women to give birth assisted by non-medical professionals such as traditional birth attendants locally referred to as *dukun or dukun bayi*. A proportion of the community in Kubu Raya preferred to be assisted by traditional birth attendants rather than by medical staff.

The quantitative survey results indicated that there were significant gaps in access to childbirth services

between poor women in Deli Serdang and Kubu Raya. Only an estimated 67% of all reproductive-aged poor women within the study areas accessed professional assisted childbirth services. Deli Serdang had the highest level of access to delivery services accompanied by healthcare workers such as midwives, doctors and paramedics with 96% and Kubu Raya had the lowest access with only 38% of women being accompanied by medical professionals during childbirth. In 2017, 41% of women in the study areas gave birth at home (Figure 1). The highest percentage of home births was in Kubu Raya (78%) and the lowest Deli Serdang (19%). Poor road access to the health facilities in Kubu Raya was one of the causes of the high percentage of home births. Although the percentage of poor women who gave birth at the homes of traditional birth attendants was very small (0.1%), the vast majority of women who delivered at home (61%) still chose a traditional birth attendant as their primary source of assistance when giving birth (Figure 1). Among the five regencies in the study, the highest percentage of home deliveries assisted by traditional birth attendants (76%) was found in Kubu Raya. In contrast, in Deli Serdang only 19% of women delivered at home assisted by traditional birth attendants; most were assisted by midwives.

Image 1. Childbirth Locations and Main Parties Assisting Homebirths in 2017

Source: SMERU Research Team survey results, 2017
Note: The number of women surveyed is 865

The quantitative findings above are all in line with the fact that the availability of village health facilities in Deli Serdang was the best out of the five regencies in this study in term of number, distribution, and variation in the types of facilities. This is largely because the villages studied in Deli Serdang had urban characteristics and therefore had better access to a wider range of health services for pregnant women including non-government or private health services. Conversely, the availability of village health facilities in Kubu Raya was still very minimal, especially when the number and distribution of health facilities were compared with the vastness of the area.

The lack of the number, distribution, and types of village health facilities for childbirth services was one of the factors that caused women to give birth at home; this was commonly found in Kubu Raya and TTS. The results of in-depth interviews and observations also identified several other factors, both internal and external, that caused pregnant women in the study areas to deliver at home.

Internal factors that caused women to deliver at home included: (1) a lack of awareness about safe delivery, (2) existing family traditions regarding giving birth at home with the help of a traditional birth attendant, (3) some members of the community thought that national

health insurance for childbirth services had similar time constraints like regular outpatient treatment was prone to, (4) financial constraints limited poor women's access to delivering at health facilities.

The external factors that caused women to deliver at home included: (1) the limited number and distribution of health facilities at the village level that could be used for childbirth, (2) the poor quality of road infrastructure hindered access to reach health facilities, (3) traditional birth attendants existed in great number and within a relatively close distance, and (4) the application of local regulations with repressive disincentive schemes at the village level.

Within the communities in some of the research areas, traditional birth attendants were more trusted than health workers in assisting deliveries. This is because traditional birth attendants were usually much older than village midwives, and thus considered to be more experienced. Traditional birth attendants also often performed certain rituals that provided a sense of comfort for the expectant mothers in labour. These traditions and strong beliefs had a great influence on poor women choosing traditional birth attendants as their main assistants in childbirth.

For the poor, cost constraints were often the biggest factors that hampered women's access to health services and especially to safe delivery services. In some circumstances, health insurance, such as JKN-KIS and Jampersalda was regarded as not being too helpful. Apart from being only accessible at health facilities, there were other costs that are not covered by health insurance schemes. As a result, poor people still had to spend money on transportation, food and other operational costs while accessing health facilities. It is these costs that prevented poor women from giving birth in healthcare facilities even though they were JKN-KIS premium payment assistance (PBI) beneficiaries. In the end, the women chose to give birth at home, either accompanied by traditional birth attendants, family members, or without assistance.

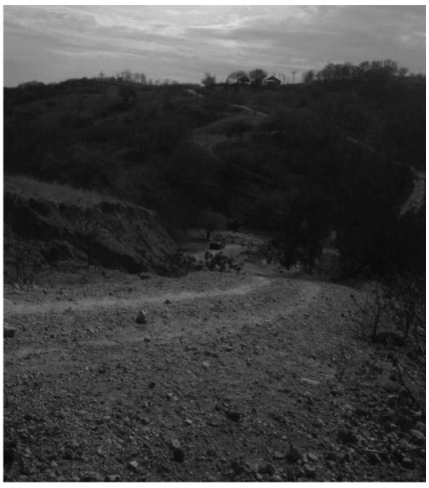
In some of the villages surveyed, particularly in Kubu Raya and TTS, unserviceable and poorly maintained roads negatively impacted on pregnant women's access to childbirth services at the village health facilities, the availability of which was already limited (Figure 2). Women from isolated villages would sometimes choose not to deliver in village health care facilities with support from medical practitioners because of the poor conditions of the roads that needed to be travelled to reach the centres. This is in line with the findings of another study which showed that behaviours did not remain unchanged solely because of individual internal factors, but rather because of the limited access to primary health facilities (Handayani et al. 2014).

> "Road infrastructure in the village is not an obstacle for accessing the *puskesmas* in the dry season because everything is flat so transportation is smooth, but during the rainy season, access is difficult because puddles are inevitable. Another obstacle is that pregnant women are closer to traditional birth attendants, so it is easy to get services from the traditional birth attendants, rather than going to the *puskesmas*. One has to consider that there are only certain hours before the midwife can be of service." - Interview with village midwife in TTS Regency in 2017.

Road conditions to one of the hamlets in Village G (Kubu Raya)

Note: Roads made from peat soil are very difficult to pass through using motorised vehicles during the rainy season.

Road conditions to one of the hamlets in Village O (TTS)



Note: The isolated hamlets are surrounded by rivers and mountains and accessed by a slippery road traversable only by motorbike.

Image 2. Condition of Roads in Study Villages in Kubu Raya and TTS

The number and distribution of traditional birth attendants in several study villages was greater than the number of village midwives. In terms of affordability, it is easier for the community to access traditional birth attendants, especially because childbirth often occurs suddenly. A number of traditional birth attendants were willing to accept non-cash payments which eased the financial burden on low-income families. Childbirth assisted by traditional birth attendants also does not require transportation costs because the delivery is usually conducted at home. Traditional birth attendants live throughout residential areas and the easy physical access and financial access they provide is one of the reasons many women give birth at home assisted by *them*.

Meanwhile, some women in Village O (TTS) chose to give birth at home to avoid fines imposed by the implementation of a village regulation. According to this regulation, traditional birth attendants who assist childbirth and the mothers whose births are assisted by traditional birth attendants must each pay a fine of IDR 500,000. With difficulties in accessing health facilities on the one hand and the application of penalties for being assisted by traditional birth attendants on the other, some pregnant women choose to give birth at home, either with the help of family or relatives or without any assistance. This is in line with the results of the quantitative survey which found that the highest proportion (23%) of family-assisted childbirths in 2017 occurred in TTS.

Increasing Poor Women's Access to Prenatal and Professional Assisted Childbirth Services: Changes 2014-2017

Pregnancy check-ups

The results of in-depth interviews and mini-FGDs showed that the number of women who went for check-ups at *posyandu* during their pregnancies increased over the 2014-2017 period. This was influenced by the increasing availability of services and changes in the behaviour of pregnant women. In terms of service availability, the changes that occurred were: (1) increasing numbers of *posyandu*, (2) increasing participation of midwives at routine *posyandu* activities, (3) more incentives for *posyandu* cadre and traditional birth attendants partnered with midwives, and (4) increasing numbers of participants in the *Keluarga Harapan (PKH)* conditional cash transfer program.

For women living in villages within the study locations, the easiest access to prenatal check-ups by midwives was at the routine *posyandu* activities. This indicates a positive correlation between increasing numbers of *posyandu* and increasing prenatal checkups at *posyandu*. In Village I (Kubu Raya), pregnant women attending the *posyandu* increased in line with the increased attendance of midwives at *posyandu*. Previously, health workers who came to the *posyandu* were often male nurses, so expectant mothers felt uncomfortable to go for checkups. Meanwhile, pregnant women in Village N and Village O (TTS) increasingly attended *posyandu* to ensure they were not fined IDR 5,000 fines (Rahmitha et al 2016, p. 65). The village governments in these two villages have imposed penalties for mothers who do not have prenatal check-ups at *posyandu*. In Village N the implementation of this penalty began in 2016, while in Village O the fines started two years earlier.

The introduction of incentives for *posyandu* cadres throughout the study locations also positively impacted on the increasing number of pregnancy check-ups at *posyandu*. In Kubu Raya, policies also exist to provide incentives to traditional birth attendants who partner with midwives. Offering financial incentives to *posyandu* cadre and traditional birth attendants encouraged them to actively motivate pregnant women to go for prenatal check-ups at *posyandu*.

PKH is a conditional cash transfer program that requires pregnant women who receive PKH undergo regular prenatal check-ups at *posyandu*. The absolute number of women from PKH receiving families who accessed prenatal checkups at health facilities multiplied by 3-4 times compared to 2014 rates. With the increased number of PKH recipients in the research areas, the potential for more pregnant women accessing prenatal checkups at *posyandu* increases.

Meanwhile, in terms of behavioral changes in pregnant women, village midwives and *posyandu* cadre throughout the study locations reported that pregnant women had increasingly participated in prenatal checkups at *posyandu*. The Jampersalda also had the potential to promote behavioral change in pregnant women because in order to access the Jampersalda childbirth cover, pregnant women must routinely go for prenatal checkups at *posyandu*. The survey results also found that the proportion of pregnant women who went for prenatal checkups at health facilities increased in line with increased levels of maternal education.

Childbirth

Although access to childbirth services assisted by healthcare workers in the study areas was still relatively

low, the study found that poor women had increasingly accessed those services over the past three years. Some of the increases occurred in all study areas, while some occurred in only some study areas.

The percentage of women who had last delivered in a health facility, such as *puskesmas*, hospitals, and private midwife practices had increased. Referring to Figure 1, the 2017 study revealed that 58% of women had given birth in a health facility. This percentage is still relatively low but it is markedly better than the 2014 figure. In general, the increase was quite significant and occurred in all research areas. The survey results showed that pregnant women's access to health facilities for childbirth increased along with increased education levels of mothers.

The Jampersalda program and partnerships between midwives and traditional birth attendants in the research locations contributed to increased numbers of women giving birth in health facilities. In Kubu Raya and Pangkep, *Jampersalda* covers the cost of using birthing centres for six days and three days respectively. The costs covered include the operational costs of the birthing centre, such as water and electricity, which are not covered by JKN-KIS. *Jampersalda* in Kubu Raya also covers the cost of transport for expectant mothers to travel to healthcare facilities to give birth and then to return home again, as well as food costs for a maximum of four people. However, no similar policy was found to exist in TTS even though the regency also had *Jampersalda* insurance and birthing centres.

Some regional governments within the research locations, especially Deli Serdang, Cilacap, and TTS, had issued regional policies that required women to give birth in healthcare facilities. In Deli Serdang, a regulation from the regent required women to deliver at health care facilities. In Cilacap, a circular from the regent obliged JKN-KIS participants to deliver at a *puskesmas*. In TTS, there was local regulation on Maternal and Infant Health which prohibited home births. All villages in the research area in TTS had adopted this regulation, though they had yet to formalise it through the issuance of village regulations. Meanwhile, in Kubu Raya there was assistance for pregnant women provided through the Generasi Sehat Cerdas (GSC) program which covered transportation costs involved in giving birth at healthcare facilities. The regency government also promoted partnerships between midwives and traditional birth attendants by offering incentives and disincentives to the traditional birth attendants. The disincentives were in the form of delayed payment for the traditional birth attendants who assisted homebirths. This non-repressive disincentive scheme has the potential to encourage traditional birth attendants to bring expecting mothers to health facilities to deliver.

The survey results found that more than 40% of deliveries in health facilities in all research areas used JKN-KIS insurance for payment. These findings indicate that the health insurance program can support poor families in accessing services at health facilities, including childbirth services.

A decreasing percentage of poor women gave birth at home. Referring to Image 1, the 2017 survey showed that around 41% of women gave birth at home. This percentage is still relatively high, but it represents an improvement when compared to 2014. The results of the survey showed there had been a decrease in the percentage of home births in all study locations. However, it should be noted that the rate of home birth was still very high for the Kubu Raya area. This showed that although a number of healthcare programs operated in the regency, obstacles related to geographical conditions, distance, and poor road access meant that large numbers of midwives would travel to the homes of pregnant women to help them deliver, especially in the wet season when access worsened. Home births assisted by midwives occurred in all research villages in Kubu Raya, especially in hamlets that did not have birthing facilities.

The survey also demonstrated that there had been an increase in the percentage of childbirths assisted by midwives or doctors. This was true in almost all research locations (Image 3). The highest increase in births assisted by doctors occurred in TTS and Pangkep, while the largest increase of births assisted by midwives as the main birth attendants occurred in Kubu Raya. In the context of Kubu Raya, this increase did not correlate with a delivery location meaning that an increased number of births assisted by healthcare workers does not necessarily mean an increased number of births occurring in healthcare facilities. Given the very limited number of healthcare facilities in the research villages in Kubu Raya, it is likely that midwives assisted deliveries at the mothers' houses and not at the village's healthcare facilities.

Generally, there was a decline in the percentage of traditional birth attendant assisted childbirths. Referring to Image 1, the 2017 survey showed that 61% women delivered with assistance from a traditional birth attendant. While still relatively high, the percentage had decreased from 2014 rates. Image 3 shows that the percentage of births assisted by traditional birth attendants decreased by 17%. According to interviews with village midwives, this decrease occurred in all

research areas. This is consistent with the results of the household survey which showed a 10% - 34% decrease in the use of traditional birth attendants in the majority of research areas, except Deli Serdang (Image 3).

The previous section mentioned that traditional birth attendants assisted 19 % of deliveries in Deli Serdang in 2017. When compared with the other four regencies in the same year, this percentage was indeed the lowest. However, when compared with 2014 rates in Deli Serdang, the percentage actually increased, meaning that Deli Serdang was the only district that experienced an increase in the percentage of births assisted by traditional birth attendants. It should be remembered that the quantitative survey does not necessarily reflect the general conditions in Deli Serdang because it was only carried out in the poorest hamlets, generally located away from the centre of the village administration where healthcare services are located. Poor economic conditions and long distances between homes and healthcare facilities were the main factors that influenced poor women's access to safe birthing services in this study.

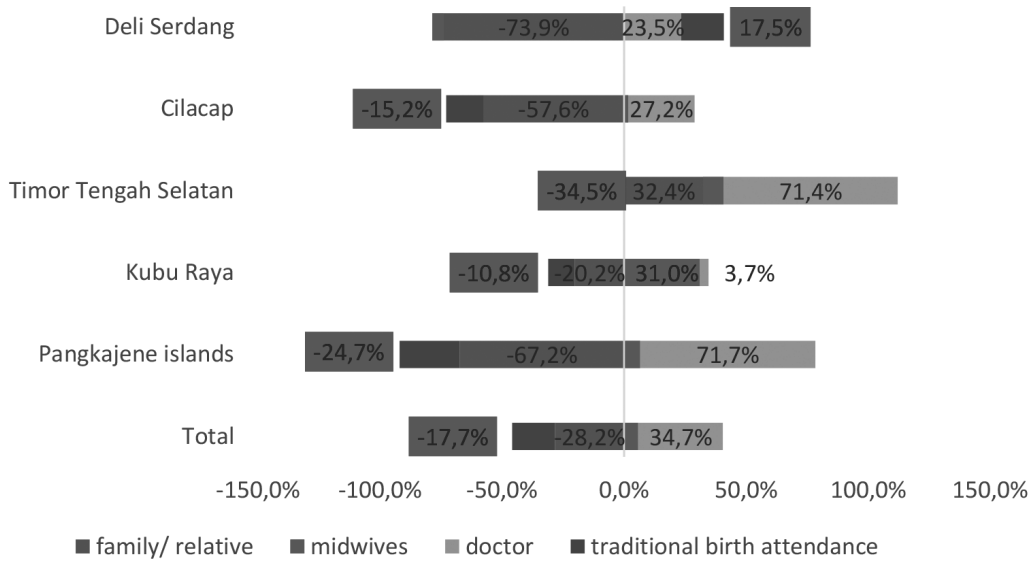


Image 3. Changes in Main Childbirth Assistants 2014-2017

Source: SMERU Research Team survey results, 2017
Note: The number of samples was 685 women in 2014 and 865 in 2017

The most significant decrease in deliveries assisted by traditional birth attendants occurred in TTS. This may have occurred because of similar village regulations in the three research villages which set fines for mothers who gave birth assisted by traditional birth attendants, and fines for the traditional birth attendants who assisted childbirths.

The decrease of traditional birth attendant assisted childbirths in Kubu Raya was likely caused by local government programs, particularly the incentive schemes which promoted partnerships between midwives and traditional birth attendants. Although in 2017, the percentage of births assisted by traditional birth attendants in Kubu Raya was still the highest (76%) of all research locations it was an improvement from 2014 as indicated by a decrease of around 10% (Figure 3). Providing incentives to traditional birth attendants to work in partnerships with midwives is assumed to have the potential to reduce the role of traditional birth attendants as the main sources of assistance for women giving birth in Kubu Raya.

In the majority of research areas, the percentage of childbirths primarily assisted by relatives decreased. TTS was the only district that experienced an increase in the percentage of births assisted by relatives. This increase is predicted to be due to the implementation of the Maternal and Infant Health Regulation at the village level. This type of regulation, which stipulates fines for both the traditional birth attendants who assist women in childbirth and the women who use the traditional birth attendants' services, could result in negative behavioural changes for pregnant women who choose to give birth unattended for fear of being fined.

This type of village regulation aims to lower maternal mortality and infant mortality rates by encouraging

women to deliver at health facilities; however, the application of economic penalties means such regulations are repressive. Many women do not have access to health facilities for childbirth, given the limited number and distribution of these facilities and the geographical barriers that exist (Image 2). Therefore, to avoid the fines that stem from the implementation of these regulations, a number of mothers chose to give birth at home without the help of traditional birth attendants. The role of the traditional birth attendants is then replaced by relatives of the women giving birth.

> "There are still many pregnant women who give birth at home without traditional birth attendants and without health professionals. This is because the cost of transportation to the *puskesmas* is IDR 100,000 (approximately AUD 11) with a pick-up truck and IDR 20,000-50,000 with a motorcycle taxi for a one-way trip, depending on if it is day or night. If you don't have BPJS, you have to pay IDR 500,000-600,000 to the midwife to assist your birth. There is a village regulation, traditional birth attendants will be fined if they help with the delivery process so they don't want to help. Some women are afraid of the costs at the hospital because they do not have money and afraid of the long distances to the *puskesmas*, especially at night. In the end, they give birth at home, alone, or with the [assistance of] family." (FGD in 2017, TTS District)

The results of in-depth interviews and FGDs show that some mothers from poor families in TTS who had difficulty in accessing health facilities decided to give birth at home. A *posyandu* cadre in Village O revealed that with the threat of fines, expecting mothers choose to give birth at home without the help of traditional birth attendants, usually assisted by relatives. In 2015, cases of maternal and infant deaths occurred in Village O when women gave birth at home with the assistance of family members. Infant deaths occurred in the same village in 2016 and 2017 when women gave birth at home without the assistance of traditional birth attendants. These findings clearly need attention because although women avoid fines when they give birth at home, there are inflated risks of maternal and infant mortality attached.

In areas where availability and access to healthcare facilities is still very limited, giving birth at home with the help of a midwife is considered the most appropriate option that can minimise maternal mortality caused by childbirth assisted by untrained personnel. When formulating policies to prevent mortality and support mothers, local governments need to consider local contexts such as culture, infrastructure, geographical conditions, the availability of health facilities and the existing culture of traditional birth attendants assisting deliveries.

In the research Villages in NTT, the existence of village regulations that stipulate penalties for women giving birth in a certain way has the potential to prevent women from obtaining access to safer childbirth support. On the one hand, the penalties contributed to a decrease in childbirths assisted by traditional birth attendants, but on the other hand, the penalties also contributed to an increase in home births assisted by relatives — which is not safer when compared to childbirth assisted by traditional birth attendants.

Regency and village governments need to pay attention to the local context in adopting and implementing policies. In areas with limited healthcare facilities, disincentive schemes will ultimately hamper positive behavioural changes in women choosing safe childbirth options. Incentive schemes, such as the one implemented by the Kubu Raya Government, can increase safer childbirth in healthcare facilities.

Integrated Regional Policies to Increase Prenatal Checkups and Childbirths in Healthcare Facilities

In Kubu Raya, a study area in which the availability and distribution of the health facilities was very limited, the practice of giving birth with help from a traditional birth attendant was still common. Cultural factors and a higher number of traditional birth attendants compared to the numbers of health workers also contributed to low rates of expecting mothers having checkups and giving birth in healthcare facilities. However, if compared to the 2014 baseline study, women in the regency have demonstrated increasingly positive behaviour in regards to accessing healthcare facilities. The number of expecting mothers who accessed healthcare facilities for checkups and to give birth increased from 2014 to 2017.

The Kubu Raya Government has implemented several integrated strategies with the aim to reduce the maternal and infant mortality to zero. The first strategy involves controlling traditional birth attendants. Instead of trying the eliminate the existence of traditional birth attendants and their services, the regency government instead sought to embrace health workers and control traditional birth attendants by promoting partnerships through schemes and incentives. In 2015, the regency government implemented an incentive that provided IDR 300,000 per month to traditional birth attendants who were willing to partner with midwives. In 2017, the government implemented a follow-up policy in the form of a 'traditional birth attendant management book.' This book was developed as a mechanism to guide the provision of cash incentives to the traditional

birth attendants. Each time they brought an expecting mother to a health facility to give birth, their book would be stamped. Their monetary incentive could then be withdrawn at the local *puskesmas*.

The provision of incentives for traditional birth attendants has resulted in increasing numbers of traditional birth attendants seeking partnerships with midwives.

> "In 2015, there was a policy from the health department introduced. Traditional birth attendants who partnered with midwives would receive an incentive of IDR 300,000 / month on the condition that the traditional birth attendant was not allowed to solely assist with childbirth but their duties were rather to bring the expectant mother to health facilities or assist the midwives during delivery. From the moment the incentives were put in place, it motivated many traditional birth attendants to start partnering with midwives." - Interview with a traditional birth attendant in 2017, Kubu Raya District.

The second strategy regarded involving *posyandu* cadres to support village midwives. In 2015, the Kubu Raya Regency Government introduced a monthly incentive of IDR 150,000 per month for *posyandu* cadres. Each cadre is responsible for a maximum of five pregnant women or mothers with infants to monitor and ensure that they have regular checkups at the *posyandu*. The disbursement of the cash incentives for *posyandu* cadres takes place at village health centres (*poskesdes* / *polindes* / *pustu*). The introduction of incentives for *posyandu* cadres had a positive impact on increasing demand for more *posyandu*, especially in hamlets in which *posyandu* were not yet available. With more *posyandu* at the hamlet level, pregnant women will have easier access to these facilities to have monthly prenatal check ups

The third strategy was the reintroduction of *Jampersalda* in 2017. Membership in this health insurance program has several conditions, one of which is that it can only be utilised by pregnant women who give birth at a healthcare facility. *Jampersalda* membership also requires pregnant women to have prenatal check-ups at the *posyandu*. This has resulted in traditional birth attendants actively encouraging pregnant women to go for prenatal check-ups at *posyandu* and give birth at healthcare facilities so that the women are covered by *Jampersalda* and the traditional birth attendants receive their cash incentives.

> "Pregnant women who are registered as *Jampersal* recipients receive free prenatal check-up and childbirth services without having to spend money at the *puskesmas* or hospital. To be covered by *Jampersal* for delivery, the woman must give birth at one of the 10 hospitals or clinics appointed by the government in [Kubu Raya]. The positive impact has been felt by the families of pregnant women, because their economic burdens are alleviated as they do not incur costs for antenatal care and infant care. *Jampersal* clearly helps pregnant women who are not recipients of JKN KIS [insurance] to give birth at *puskesmas* and hospitals". - Interview with the Village Head in Kubu Raya District 2017.

Referring to the Minister of Heath's Regulation No. 71 of 2016, integrating Jampersalda coverage with more health care facilities can be a potential opportunity to increase the number of deliveries in health facilities. In Kubu Raya, the local government has integrated various regional policies (partnerships between midwives and traditional birth attendants, *Jampersalda*, *Posyandu* Cadre empowerment programs etc) to reduce mortal mortality rates. In the implementation of these policies, attention is paid to local culture, geographical conditions, availability of health facilities, and the condition of road infrastructure at the village level.

Conclusion

Poor women's access to prenatal care and professional assistance during childbirth were found to have improved in the study locations from 2014 to 2017. These improvements are evident from the increased numbers of women who accessed prenatal check-up services administered by health workers in midwife practices, *puskesmas* and *posyandu*. Overall, poor women's access to professionally assisted childbirths in health facilities also increased in the study locations. These improvements were accompanied by a decrease in homebirths accompanied by traditional birth attendants and family members. However, when compared to access to prenatal care services, access to childbirth services, especially in Kubu Raya and TTS was still lacking and many women in these regions still performed home births assisted by traditional birth attendants.

The increase in women's access to childbirth in healthcare facilities was still far lower than the increase in access to antenatal checkups. Increasing numbers of childbirth facilities at the village level will not make a significant impact if it is not accompanied by improvements to road infrastructure to increase women's access to these facilities.

Another factor that impacted access to prenatal checkups and childbirth services was the presence of local government policies that aimed to support pregnant women's health. Some of the successful local government programs and policies were purely local initiatives and some were adaptations of central government policies.

Furthermore, implementation of policies at the regency and village level must pay attention to local contexts, such as culture, geographical conditions, road conditions, government readiness regarding the availability of services as well as the community's ability to afford these services. Implementation of policies should be preventive and supportive rather than repressive. Repressive policies, especially towards women from poor families, have the potential to inhibit behavioural changes that could improve health status and reduce infant and maternal mortality in poor areas.

References

Badan Penelitian dan Pengembangan Kesehatan 2013, *Riset Kesehatan Dasar*, Kementerian Kesehatan, Jakarta, viewed 12 May 2018, www.depkes.go.id/resources/download/ general/Hasil%20 Riskesdas%202013.pdf

BPS 2017, *Statistik Kesejahteraan Rakyat 2017*, Badan Pusat Statistik, Jakarta.

Handayani, L, Suharmiati, S, Kurniawan, A, Nuraini, S & Wasito, B 2014, "Utilization of Service Delivery Insurance (Jampersal) for Maternal and Child Health Services in 12 Districts/Cities: Eliminate the Socio-cultural Obstacle on Safe Delivery", *Buletin Penelitian Sistem Kesehatan*, vol. 16 (4 Okt).

Kementerian Kesehatan 2015, *Kesehatan dalam Kerangka Sustainable Development Goals*, Slides dipresentasikan pada Rakorpop Kementerian Kesehatan RI, Sekretariat Pembangunan Kesehatan Pasca-2015 Kementerian Kesehatan RI, Jakarta. 1 Desember 2015. Not published.

Kementerian Kesehatan 2011, *Informasi Jampersal*, Kementerian Kesehatan, Jakarta.

Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional, 2015, *Satu Tahun Pelaksanaan Jaminan Kesehatan Nasional*, Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional, Jakarta.

Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional 2014, *Rancangan Awal Rencana Pembangunan Jangka Menengah Nasional 2015–2019, Buku II Agenda Pembangunan Bidang*, Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional, Jakarta.

Kusumawardhani, Niken, Dyan Widyaningsih, Valentina YD Utari, Joseph Marshan, Dinar Dwi Prasetyo, Hafiz Arfyanto, Veto Tyas Indrio, and Michelle Andrina 2016, "Dinamika Penghidupan Perempuan Miskin: Studi Kasus Ketika Terjadi Perubahan Harga BBM", Draf Laporan Penelitian, The SMERU Research Institute, Jakarta.

Rahmitha, Hastuti, Dyan Widyaningsih, Niken Kusumawardhani, Dinar Dwi Prasetyo, Hafiz Arfyanto, Veto Tyas Indrio, and M. Fajar Rakhmadi 2016, "Penghidupan Perempuan Miskin dan Akses Mereka terhadap Pelayanan Umum", Draft Research Report, The SMERU Research Institute, Jakarta.

Sajedinejad, S, Majdzadeh, R, Vedadhir, A, Tabatabaei, MG & Mohammad, K 2015, "Maternal mortality: a cross-sectional study in global health", *Globalization and Health*, vol. 11, no. 4, Viewed 12 May 2018

UNICEF Indonesia 2012, *Ringkasan Kajian: Kesehatan Ibu dan Anak*, UNICEF Indonesia, Jakarta, Viewed 12 May 2018 <https://www.unicef.org/indonesia/id/A5_-_B_Ringkasan_Kajian_ Kesehatan_ REV.pdf>

World Bank 2010, *"...and then she died": Indonesia Maternal Health Assessment (English)*, World Bank, Washington, DC, Available at: <http://documents.worldbank.org/ curated/en/718951468040488082/and-then-she-died-Indonesia-maternal-health-assessment>

Xu K, Saksena P & Evans DB 2010, "Health financing and access to effective interventions," *World Health Report (2010) Background Paper No 8*, World Health Organization, Geneva. Available at: http://cdrwww.who.int/entity/healthsystems/topics/financing/healthreport/8Accesstocare.pdf

Endnotes

1 The report: *Laporan Tematik Studi Midline MAMPU Tema 4: Meningkatkan Status Kesehatan dan Gizi Perempuan* can be accessed at: http://smeru.or.id/id/content/ laporan-tematik-studi-midline-tema-4-meningkatkan-status-kesehatan-dan-gizi-perempuan.

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