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Women and Health

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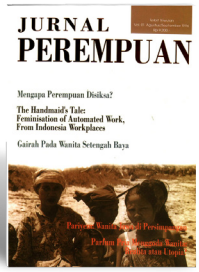

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This JP edition is published by Yayasan Jurnal Perempuan with the support from the Australia-Indonesia Partnership for Gender Equality and Women's Empowerment (MAMPU). MAMPU program is a joint initiative between the government of Australia and the 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, 229-238 DDC: 305

Review of Policy-Oriented Research on Maternal Mortality

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Abstract

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, adolescent reproductive health, unsafe abortion

Introduction

The women's movement and feminist groups, including those in Indonesia, have been concerned about ongoing problems related to maternal mortality and the maternal mortality rate (MMR) for several decades. Maternal mortality continues to be an unresolved critical issue. It is estimated that every day around 830 women worldwide die from preventable causes related to pregnancy and childbirth**.** In 2015 alone, an estimated 303,000 women died during pregnancy, during childbirth or post-delivery. About 99% of those deaths occurred in developing countries, especially amongst women living in rural areas and poor communities. This high maternal mortality rate is unacceptable as it can be prevented (WHO 2018).

Indonesia's efforts to reduce the MMR are reflected in various policies and programs such as Mother and Child Health (KIA) policy and other similar programs that have been implemented by the government since the 1990s. Indonesia is also a party to various international agreements and conferences that aim to reduce MMR and infant mortality rates (IMR) such as the International Conference on Maternal Health 1987, World Summit for Children 1990, International Conference on Population and Development (ICPD) 1994, Fourth World Conference on Women (Beijing) 1995, Safe Motherhood Technical Consultation (Colombo) 1997, Make Pregnancy Safe 1999 and the Millennium Development Goals 2000 (Sadli 2007).

The MAMPU program is a partnership for gender equality and women's empowerment between the Government of Indonesia —represented by the National Development Planning Agency (Bappenas) and the Government of Australia — represented by the Department of Foreign Affairs and Trade (DFAT). One of the thematic areas of the MAMPU program is improving poor women's access to better health and nutrition; a specific objective of this thematic area is reducing the MMR.

In 2014, MAMPU conducted a review of the literature related to maternal mortality that had been published between 2004-2014. The main objective of this review was to identify key gaps in the existing knowledge which would become a priority for future research to address. Looking at the existing research also provided an opportunity to study policies and efforts that could be used as input to improve policies related to maternal and reproductive health in Indonesia.

One of the findings from the of the existing research showed that even though the government of Indonesia

had initiated various programs to address maternal mortality, the MMR remained high. This article, based on the literature review conducted by the MAMPU Program, attempts to answer a number of questions, namely: What is the current situation regarding maternal mortality in Indonesia? What are the causes of ongoing maternal mortality? What are the factors that contribute to maternal mortality still being an issue?

The literature review identified three main study areas: original data compilations that provided analysis of policies and policy development; research into the underlying causes of the high rate maternal mortality, including healthcare systems and policies that create barriers to accessing healthcare, and; research on policy-making processes in Indonesia, particularly related to maternal and reproductive health. This article, in addition to discussing the existing literature, also offers new concepts and presents the latest data regarding maternal mortality retrieved from recent government surveys and databases.

Maternal Mortality, MMR and its Measurement

The 1994 Cairo ICPD Action Plan defines reproductive health as:

> 'A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.'

This definition of reproductive health also infers the right to obtain safe, and affordable reproductive healthcare services (Mohamad 2007). Indonesia, as a signatory to the Cairo agreement, has the responsibility to ensure optimal fulfilment of the principles set out in the agreement, especially with regards to women's reproductive health rights (Sadli 2007).

Twenty-five years after the ICPD agreement, women's reproductive health rights in Indonesia have yet to be fulfilled; this is evident from the continuing instances of maternal mortality. Referring to the definition set by the World Health Organization (WHO), maternal mortality is:

> 'The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric death), but not from accidental or incidental causes.'

The maternal mortality rate (MMR) is defined as the number of maternal deaths for every 100,000 live births during the same time-period (WHO 2015).

At the end of the Millennium Development Goals (MDGs), Indonesia failed to meet its target of reducing the MMR from 390 in 1990 to 110 by 2015. Data collected by WHO, UNICEF, UNFPA, World Bank and the UN Population Division in 2015 placed Indonesia's estimated MMR in the range of 100-299. Meanwhile, data from the 2015 Intercensal Population Survey (SUPAS) showed the MMR to be 305; this is one of the highest MMRs in ASEAN (Achadi 2019). The Indonesian government referred to this SUPAS data in the government's main statement during the Voluntary National Review regarding the implementation of SDGs (UN 2017).

Many countries, including Indonesia, do not have a civil registration system that records the cause of death in detail; however, such records are necessary for accurately measuring maternal mortality. Lack of data presents a significant challenge to measuring maternal mortality in Indonesia. Since 1991, the government has used the Indonesian Demography and Health Survey (SDKI) to measure the MMR (GOI 2014).

The SDKI was designed to provide data on fertility rates, the median marriage age, participation in family planning programs, infant and maternal health, and mortality, including maternal mortality. Another objective of this survey is to measure the prevalence of contraceptive use and to analyse factors that influence changes in marital status and patterns regarding education, breastfeeding habits, and the availability of contraceptives. SDKI is conducted by the National Family Planning Coordinating Board (BKKBN). The last survey conducted in 2017 surveyed 47,963 households (BKKBN 2019).

The National Socio-Economic Survey (Susenas) surveys households about various socio-economic characteristics and matters related to community welfare (Statistics Indonesia 2019). Susenas is conducted by Statistics Indonesia (BPS) every year.

The method used by population-based surveys is usually to ask respondents questions about whether certain conditions or events occurred in the household, for example, whether any family members died during childbirth, and whether or not relatives who passed away were pregnant at the time they died. However, this survey model provides no further information about the cause of death (WHO 2015). By using this questionnaire model, doubts arise regarding the exact cause of death, as the

fatality could have been caused by various reasons that may or may not be related to pregnancy or childbirth.

Another source of data is the Basic Health Research (Riskesdas) study. Riskesdas is carried out by the Health Ministry every few years. It measures public health through several aspects such as health services, biomedicine, risky and hygienic behaviours, and environmental aspects (Ministry of Health 2018). Although the study collects data on the proportion women with anaemia, the number of birth assistants, postpartum contraception provided, and the number of antenatal care (ANC) examinations carried out, it does not collect definitive data about maternal mortality. The Riskesdas does provide information about the proportion of women in certain regions who did or did not receive professional medical care during pregnancy and childbirth, the number of healthcare facilities available to communities within a certain distance, as well as the number of medical specialists available and the number needed.

The survey only shows the national level aggregate data and only a small number of deaths are recorded which contributes to the width of the confidence interval and makes it difficult to come up with reliable interpretations of the data (Pemerintah RI 2014). At the subnational level, the number of deaths at the district level is ascertained from regular reports from local government agencies such as the population agency and health agency. Regional MMR are predicted based on several factors, such as death records, hospitals' birth records and regional maternal and infant health audits. Death records often do not record the cause of death in detail. Reporting and registration of births in hospitals is also limited to deliveries performed in hospitals and does not cover deliveries performed outside hospitals. There are problems with regional data in terms of validity and this data, in turn, influences provincial and national level data. The lack of accurate data means it is impossible to tell the scale of the problem related to maternal mortality which in turn means that monitoring and evaluation of relevant programs' progress is made difficult (Achadi 2019).

The Situation regarding Maternal Mortality and its Causes

Almost 85% of pregnancies and deliveries progress normally while approximately 15% experience complications. Giving birth is a major health event and complications can have serious consequences. Pre-existing complications and conditions may worsen during pregnancy and increase the risk of complication, especially if left untreated. However, a large number of complications cannot be predicted, meaning there are risks in every pregnancy. Maternal deaths can occur due to obstetric complications that are not properly and punctually treated (Achadi 2019).

Almost all complications during pregnancy and childbirth that result in maternal deaths could be prevented. The main complications that cause about 75% of maternal deaths are bleeding (generally postpartum), infection (usually postpartum), high blood pressure during pregnancy (pre-eclampsia and eclampsia), labour complications and unsafe abortions (WHO 2018).

Each of these complications was amongst the biggest causes of maternal deaths in Indonesia over the past decade. Quoting Indonesia's Reproductive Health Profile in 2003, Rachman (2007) said the six causes of the high MMR in Indonesia are: bleeding, eclampsia, abortion, infection, prolonged labour and other. Based on the 2010 census, conditions related to preeclampsia/eclampsia and bleeding were the most common causes of maternal mortality with relatively high variations between different regions and provinces. Deaths caused by preeclampsia/eclampsia were rather high in regions with high populations on the islands of Java and Sumatra, while deaths caused by postpartum haemorrhage occurred more in Eastern Indonesia (Mize et al. 2010).

Assistance by a trained professional before, during and after labor can, in many cases, save the lives of mothers and newborns. The high MMR demonstrates an inadequate fulfillment of women's rights to health and healthcare services. The high maternal mortality rate also reflects the low quality of women's living standards. Increasing women's living standards requires good policies that must be both strategic and practical. Policies designed to reduce MMR have been implemented through several government programs including the Make Pregnancy Safe (MPS) program, the Loving Mothers Movement (Gerakan Sayang Ibu) and also the Expanding Maternal and Neonatal Survival (EMAS) program. The EMAS program, which was launched in 2012, was expected to reduce maternal and neonatal mortality by 25% (Bappenas 2008; Ministry of Health 2018).

In 2017, there were 3,437 Community Health Centers (*Puskesmas*) that collaborated with Blood Transfusion Units and hospitals through local health agencies. 175 districts and cities in 26 provinces provided blood transfusion services to reduce the MMR (Ministry of Health 2018). The minimal number of midwives to staff each outpatient *puskesmas* was set at four while seven

was set as the minimum required for inpatient capable *puskesmas*. This minimum standard applies for urban, rural, remote and very remote areas. In 2017, nationally approximately 81.9% *puskemas* had more midwives than the required minimal, 4.23% of *puskesmas* had exactly the required minimum number of midwives, and 13.9% of *puskesmas* had a lower number of midwives than required (Kemenkes 2018).

Efforts to accelerate MMR reduction should ensure that all women are able to access good quality maternal health services, such as prenatal checkups, childbirth assisted by trained medical staff in healthcare facilities, postpartum care for mothers and babies, specialist care and referrals in times of complications, access to maternity leave, and family planning services (Kemenkes 2018). According to the government's perspective, various potential complications and problems could be prevented and avoided if mothers had routine checkups and received proper care during childbirth.

However, the approaches taken so far which focus on the role of midwives in assisting childbirth and community-based interventions, have not achieved the expected results. Interventions by skilled birth attendants are not always effective in dealing with the complications that arise. Prenatal testing is important, but it is not enough to reduce maternal mortality. The government has increased the number of midwives available but they have not been evenly spread out meaning that many remote areas are still beyond reach. These findings emerged in the Indonesian Maternal Health Assessment conducted by the World Bank, the Ministry of Health and Bappenas in 2010 (Mize et al. 2010).

The assessment also found many remaining barriers to services. Barriers included rejection of patients, medical staff asking for payment before services were provided, and unsuitable treatment. Many hospitals have not applied standardized policies to address the main causes of maternal death such as bleeding, infection and eclampsia.

The assessment also found that the Indonesian government's strategy was in line with best practices and internationally approved evidence-based approaches. However, the implementation and monitoring of this strategy were lacking. Gap analysis suggests that: (1) medical treatment protocols and service standards in hospitals were still below standard and directly contributed to maternal deaths, especially in terms of emergency complications, (2) patterns that emerged in maternal mortality audits at the district and city level were not used to design strategies and address the root causes of maternal mortality, (3) the referral system was not based on needs, for example, according to existing procedures a woman who suffers excessive bleeding is referred to a *puskesmas*; however, the facilities needed to treat such bleeding are only available at hospitals, therefore the patient should be directly referred to a hospital (Mize et al. 2010).

There were other issues found to contribute to the ongoing problem of maternal mortality that have not been comprehensively addressed. These problems include barriers to access to healthcare facilities and problems related to infrastructure in some regions. The MAMPU literature review also explored socio-cultural factors that affect access to healthcare services. In Indonesia, existing barriers that limit access to healthcare services often include factors related to poverty, geography, culture and education.

Many studies have identified poverty as a major contributor to poor maternal health outcomes and poor access to services (Belton, Myers & Ngana 2014; Titaley, Dibley & Roberts 2009; Titaley, et al. 2010; Utomo, Sucahya & Utami 2011). SDKI divides its data into wealth quintiles which show that poverty remains a major barrier to accessing services. Poverty is closely related to education levels, rural-urban divisions and geographically remote locations. The gap between the poor and the rich in regards to health and access to healthcare services remains a problem even though the healthcare system has expanded and overall health outcomes have improved (Utomo, Sucahya & Utami 2011).

Titaley's research found several factors related to the lack of sufficient post-natal care services in Indonesia. Women in rural areas had a higher prevalence of absence from post-natal care services compared to women in urban areas. Factors associated with low participation in postpartum care include low household income, low education level, lack of knowledge regarding post-natal complications and great distances between dwellings and healthcare services.

The complex way that factors related to poverty, culture and social factors combine to affect access to healthcare has been illustrated in a number of qualitative studies. An ethnographic study by Belton, Myers & Ngana (2014) into maternal mortality in Eastern Indonesia revealed that various social and geographical factors interacted to negatively affect the childbirth process. These factors included limited transportation options and the prevalence of deeply rooted traditions that often neglected the best interests of pregnant women. The study found that most women had gone for prenatal

checkups meaning they had some access to healthcare services. However, unfortunately, the women still lacked awareness about the need to act quickly during emergencies to receive assistance from trained medical staff.

Titaley et.al. (2010) revealed that although the government had made efforts to improve pregnant women's access to prenatal health care services and deliveries assisted by skilled birth attendants, many women still chose to deliver at home assisted by traditional birth attendants (*dukun*). Home delivery with the assistance of a *dukun* was preferred by some women despite the availability of midwives in their village. The main reasons for this were economic and pragmatic because women could not afford to pay for deliveries in healthcare facilities or assistance from midwives. This was further exacerbated by their feelings of embarrassment and lack of understanding about the public health insurance scheme (Jamkesmas).

Beliefs and customs influence women's decisions in choosing birth attendants. Women in certain areas consider traditional birth attendants (*dukun, paraji,* etc.) to be an important part of their culture. Due to a number of factors that prevent women from accessing healthcare facilities and personnel, some women prefer to give birth at home, assisted by dukun. This is considered to be a more comfortable option and it allows mothers to stay close with their families and continue to fulfil their other responsibilities at home. Some community members considered that it was only necessary to seek assistance from trained birth assistants (midwives, doctors) when complications occurred. The study concluded that the role of village midwives and traditional birth attendants is vital, especially in rural areas where healthcare services are limited.

Agus, Horiuchi & Porter's (2012) study in West Java focused on social and cultural factors that influenced decisions to use traditional birth attendants. The study found that women's religious and traditional beliefs were deeply rooted in village tradition making it difficult to replace long-practised traditions of using traditional birth attendants with modern healthcare treatment. The role of traditional birth attendants was still very dominant in villages in West Java and women believed that following the customary practices and beliefs would result in a healthy pregnancy. Four main themes related to pregnancy and traditional beliefs emerged in the focus group discussions: (1) pregnancy is a normal cycle in women's lives (pregnancy is a natural phenomenon and not an illness; maternal and infant mortality is God's will. (2) women follow traditional beliefs (both out of positive motivation and out of fear about the consequences of not following the tradition), (3) women rely on traditional birth attendants commonly referred to as *paraji*, rather than midwives. P*araji* were considered kind, tolerant and patient, and more experienced than midwives; they were also easier to reach and they encouraged natural births), (4) midwives were considered safer than *paraji* as midwives adhere to healthcare standards.

D'Ambruoso, Byass & Qomariyah (2010) discussed access to emergency childbirth care from the perspective of service users in two districts/cities in rural areas. This study revealed that social and economic factors affected access to healthcare and health insurance for poor people was very problematic. For service providers, incomplete reimbursement and low public funds were barriers to providing services to the poor. There was a lack of understanding about health insurance schemes amongst healthcare users; the schemes were often considered too complicated to understand and use. Services, staff, transportation, supplies and equipment were also generally not available or affordable. The accumulation of the various barriers that limited access ultimately resulted in exclusion from healthcare services. These factors led to communities' having a sense of fatalism and powerlessness regarding maternal mortality.

These findings reiterate the need to better develop knowledge and understanding about the social and cultural factors that affect women's access to and willingness to use maternal healthcare services. Without such an understanding, policies will not be able to encourage women to seek professional healthcare. Furthermore, qualitative studies can complement and provide relevant analyses regarding maternal mortality and its causes, rather than relying only on quantitative epidemiological and biomedical studies.

The Indonesian government often talks about the *'three toos'* as being causes of maternal mortality. This refers to women giving birth too young, giving birth too old or giving birth too soon after a previous pregnancy. Most of these mortalities would be preventable if women had access to effective contraception. Increasing the reach and effectiveness of family planning programs could help to address maternal mortality arising from such situations.

Hull's (2007; 2005) studies explain that family planning has been a frequently researched subject in Indonesia given the successes of government programs in 1970-1980 in reducing fertility rates and expanding the delivery of family planning services at the village level

through BKKBN initiatives. However, decentralisation and decreased investment in family planning at the district and city level resulted in stagnation in the prevalence of contraceptive use. There have recently been efforts to revitalize the family planning program to overcome this stagnation. In the early 2000s decentralization brought a significant change in the implementation of the family planning program. BKKBN retained its role as the relevant family planning policymaker but the authority for the implementation of family planning shifted to local governments. This meant that the quantity and quality of contraception services offered at the local level depended on the commitment, policies, and budgets of local government (Hull & Mosely, 2007). Hull also paid attention to the unknown unmet need for contraception, particularly among single people; information about contraception methods being used, the level of unintended pregnancies amongst single and married women, and the need to increase access to good quality and affordable family planning services.

When the MAMPU (2014) study was undertaken, the national fertility rate indicated that families with two children had become the accepted norm and there was no demographic justification to continue such a campaign. It was apparent that married women largely wanted to control their fertility. Half of married women did not wish to have more children, and half of those who did desire more children would delay doing so for at least two years. This meant that three-quarters of women had a need for safe and effective contraception (Hull & Mosely 2007).

The following 2012 SDKI data (BKKBN 2019) shows the percentage of women aged 15-49 who had used contraception: 6.3% of women aged 15-19; 36.2% of women aged 20-24; 55% of women aged 25-29; 60.2% of women aged 30-34; 62.9% of women aged 35-39; 58.6% of women aged 40-44 and 39.8% of women aged 45-49. Most women preferred to use modern contraceptive methods. The most commonly used methods were injections and pills. The unmet level of contraceptive needs in 2017 was 10.6% having decreased from 11% in 2012 (BKKBN 2019).

In the 2014 ICPD progress report, UNFPA and BKKBN raised concerns about universal access and a rights-based approach to family planning policies and services. The current existing laws in Indonesia do not allow singles to access family planning services and measurements of unmet need for contraceptives often overlook single women. The report also mentioned that lack of political will —particularly at the district level— and growing conservatism affected the lack of family planning services available for single individuals, both teenagers and adults. This limited the fulfilment of the sexual and reproductive health rights of those groups who did not have sufficient access to contraceptives and family planning services.

It can be assumed that unmet needs for contraceptives for unmarried individuals is much higher than reported, considering their lack of access to contraception. The high level of unplanned pregnancies amongst both married and unmarried women can be deduced from the high number of abortions reported and the fact that one in six mothers reported their latest pregnancy was unplanned (Hull & Mosely 2007).

Research concerning the prevalence of unmet contraceptive needs generally relies on SDKI data. However, several studies, such as the Withers, Tavrow & Abe (2012) study, sought to better understand the demand for contraceptives. The longitudinal study conducted in a village in Bali looked at 665 married and fertile aged women who did not wish to get pregnant again. The researchers found that nearly 30% of these women gave birth in the fourth year of the study. Young women who do not use long-term contraceptive methods face a higher risk of unintended pregnancies.

The study indicated that women's ability to not get pregnant again depended on their motivation and existing family size, their fertility (influenced by their age) and their long-term contraceptive usage. The study results showed that in order to reduce unintended pregnancies among rural women, family planning service providers need to recommend long-term contraceptive methods to young women who have clearly stated their desire to not have any more children.

Maternal mortality is closely related to adolescents' sexual and reproductive health. UNFPA defines adolescents as people in the age bracket of 10-19. When entering adolescence, a person experiences various physical, biological and psychological changes due to hormonal changes. Reproductive hormonal changes cause changes to reproductive organs which begin to function actively marked by the presence of sexual desire which, if not managed, can lead to various consequences such as unintended pregnancies and abortion (Wahyuni & Sustiwi 2007).

According to WHO, adolescents face a higher risk of potentially fatal complications during pregnancy compared to women from other age groups. One of the leading causes of high maternal mortality is women's poor nutrition commonly referred to as chronic energy

deficiency. 2018 Riskesdas data shows that 33.5% of girls aged 15-19 years who suffered chronic energy deficiency were pregnant, while 36.3% were not pregnant. Approximately 84.6% of pregnant women with chronic energy deficiency were aged between 15-24 (Ministry of Health 2018). Nutritional status during pregnancy is important as it impacts on pregnancy and childbirth (Rachman 2007).

Quantitative surveys about pregnancies amongst adolescents in Indonesia shows that although marriage age is increasing and child marriages are declining, young single people are involved in sexual relations that put them at a higher risk of unintended pregnancy. Although the extension of compulsory basic education to 12 years contributed to reducing the rate of child marriage amongst Indonesian girls in the 1990s more young, single people have become sexually active (Utomo & Mc. Donald 2009).

In Padang, West Sumatra, 16.6% of senior students had engaged in unsafe sex behaviours (Nursal 2008). In West Papua, approximately 38% of senior high school students had engaged in premarital sex. Among the sexually active female students, 32% had become pregnant and many had resorted to abortions to terminate the pregnancies (Diarsvitri et al. 2011). A 2010 survey of 4,500 teenagers in twelve cities conducted by the Indonesian Child Protection Commission (KPAI) reported that 63% of adolescents had engaged in sexual intercourse and 21% had undergone an abortion (Kusumaningsih 2010). The Indonesian Family Planning Association (PKBI) in Central Java mentioned that in a month, an average of 8 to 10 teenagers would come to the PKBI clinic for a consultation about unintended pregnancies (Kusumaningsih 2010).

In 2003, the Indonesia Youth Reproductive Health Survey was conducted with respondents between 15-24 years. The survey indicated about 1% of females and 5% of males had engaged in premarital sex. In the 2007 survey, the percentage of females remained 1% but the percentage of males increased to 6%. In 2012, 14.6% in the 20-24 age group reported having engaged in premarital sex (Central Bureau of Statistics et al. 2004; 2008; Statistics Indonesia 2013a and 2013b).

The 2010 Greater Jakarta Transition to Adulthood Survey (GTAS) conducted in Jakarta, Bekasi and Tangerang revealed that 11% of unmarried respondents had engaged in sex with significant differences between men (16%) and women (1%). The survey results showed that among the sexually active unmarried respondents 34% used contraception with the majority (32%) choosing condoms when they first had sexual intercourse.

A 2012 preliminary SDKI report revealed that only 47% of married women aged between 15-19 used modern contraception, this was lower than women in the 20-24 age group (59%). 2013 statistics showed that the pill (8.8%) and injections (37.3%) were the modern contraceptive methods most frequently chosen by married women from the 15-19 age group, this was also true of the 20-24 age group 10.9% of whom used the pill and 42.7% used injections. These figures do not include sexually active singles who did not use contraceptives.

Low awareness about reproductive health and unsafe sexual behaviour influences adolescent pregnancies, abortion, and sexually transmitted diseases (STDs), including HIV/AIDS. The 2010 GTAS revealed that respondents with higher education levels felt that they had possessed adequate knowledge about contraception and safe sex when they had first had sex. Various studies have looked at young peoples (aged 15-24) knowledge about family planning. The Adolescent Reproductive Health Survey in 2003 found that 91.1% of people aged 15-24 had some awareness about safe sex practices and family planning. Similarly, SDKI (2012) found that 93.3% of people in this age group had such awareness.

The awareness of family planning and safe sex was higher amongst females when compared to males. About 50% of single respondents (aged 15-24) stated that family planning programs should be available for them. Furthermore, approximately 80.2 - 87.9% of single young people (aged 15-24) desired access to family planning services in the form of information, while 72.3 - 80% desired family planning counselling services (Biro Pusat Statistik et al. 2004; 2008).

Law No. 52 of 2009 regarding Population and Family Development states that access to family planning services is exclusively for married couples. This negatively affects efforts to prevent pregnancies in unmarried teenagers. Studies on teenage pregnancy in Indonesia have demonstrated that various negative consequences result from teenage pregnancy. Social and religious stigmas regarding premarital pregnancy in Indonesia result in psychological and health burdens for young women. The negative impacts of unmarried adolescents becoming pregnant also includes stigmatisation of children born from such pregnancies and ongoing cycles of poverty.

Widyoningsih's (2011) study found that families with pregnant teenagers often tried to save face by marrying the girls involved. Unintended pregnancies in teenagers in addition to causing physical and psychological harms

to the children involved can also cause stresses in families' social relations and financial situations.

Utomo & Utomo (2013) explained that some of the most serious complexities and social impacts of adolescent pregnancies are the death of pregnant teenagers caused by murder or unsafe abortions. Utomo's study found many media reports of such occurrences which demonstrated the extreme risks that arise from community-driven stigmatisation of adolescent pregnancy. The study showed that the existing statistical and academic research on the scale of the problem and the primary cause of teenage pregnancy could be used as a strong evidence base to formulate policies and programs to increase the fulfilment of adolescent's reproductive health rights. The study also highlighted the limited policy response to teenage pregnancy, both in terms of measures to prevent unintended pregnancies and services to support young women and girls who face unintended pregnancies.

Given the limited availability of data, more qualitative studies related to adolescent sexual and reproductive health need to be conducted. Utomo and Utomo (2013) suggest that future research about the impact of adolescent pregnancy on young mothers and their children in Indonesia would benefit from longitudinal data analysis.

In order to avoid relying solely on figures from large surveys, quantitative and qualitative micro studies on young people would produce more reliable predictions and in-depth knowledge required for understanding matters related to the prevalence of premarital sex, abortion and adolescent pregnancy as well as the need for educational and reproductive health services for this group (Utomo, Habsjah & Hakim 2001).

The Indonesian Maternal Health Assessment (Mize et al. 2010) stated that complications with abortions accounted for 6% of maternal mortality. These complications that resulted from unsafe abortions should be largely preventable. Many studies have suggested that unmet family planning needs contribute to the occurrence of unintended pregnancies, which in turn leads to women seeking abortions. Due to the strict legal requirements needed to fulfil to access legal abortions, many women opt for unsafe abortions which in turn lead to maternal deaths.

In a 2014 government health sector review it was mentioned that the prevalence of abortion in Indonesia was unclear due to a lack of reliable data and estimations were made based on unreliable assumptions. Many reports and studies refer back to a survey conducted by Utomo, Habsjah & Hakim (2001): *"Incidents and Social-Psychological Aspects of Abortion in Indonesia: Community Survey in 10 Cities and 6 Regencies, 2000"*. The study estimated about two million abortion cases took place every year in Indonesia. The study contended that women who had abortions were mainly 20 years or older (92%) and the number of abortions was higher at district level (60%) compared to in cities (30%). One-third of the respondents in cities, and half of the respondent in villages who had an abortion had it performed during their first pregnancy. The majority of the respondents were single at the time of their abortion. Of all inpatients at hospitals in Yogyakarta due to abortion-related problems, 4.6% were single or married by religious marriages unrecognised by the state (*nikah siri*).

The same survey found that 24% of abortions were performed by traditional birth attendants, and approximately 15% occurred in cities, while 84% occurred in rural areas. The study discovered that 66% of women who had abortions were reported to have had a labour induction, so it is estimated that 1.3 million labour induction abortions occurred every year. It was also found that one-third of the women who had abortions were single and 50% had never used contraception. These findings further confirm the need to improve the family planning program.

A study conducted by Hull & Hartanto (2009) estimated that young women under the age of 19 accounted for 10% of abortions at abortion clinics while single women accounted for 33% of abortions. The percentage of women under the age of 19 who had an unsafe abortion was estimated to be higher and these abortions usually occurred in rural areas (Sedgh & Ball 2008).

Often young women who experienced unintended pregnancies would initially try to abort pregnancy by over-consuming peptic ulcer medication (such as Cycotec), menstrual pain drugs, herbal medicine or pineapple juice; which were considered to be able to trigger a miscarriage. If these efforts were unsuccessful, the women would approach a traditional healer or traditional birth attendant who often would massage their abdomen to abort the pregnancy (Utomo & Mc. Donald 2009).

The Guttmacher Institute's policy brief about abortion in Indonesia stated that a large number of women in Indonesia experienced unintended pregnancies and many of them wanted to avoid childbirth and therefore opted for abortion. The brief found that the details

regarding the extent of and the impacts of unsafe abortion were still unknown (Sedgh & Ball 2008).

In the 2010 World Bank assessment on maternal health, it was mentioned that the legal status of abortion remained ambiguous despite the existence of Law No. 36 of 2009 on Health. The legislation permits safe abortion for rape cases, if pregnancy poses a risk to the woman's life or if serious genetic conditions exist. However, the definition of an emergency situation in which abortions are permissible is not made clear in the legislation. The law also requires women to undergo professional counselling and obtain approval from their husband for the abortion. According to the assessment, these legal provisions were not conducive for supporting mothers' health outcomes and they failed to consider the needs of single women.

The existing knowledge and the gap in knowledge about abortion in Indonesia means that updating national data about the prevalence of abortion and maternal mortality caused by unsafe abortions in Indonesia should be a priority of future research. Predictions of case numbers at the provincial and district level are also important, especially in relation to the decentralisation of the role of government in family planning. In addition, in-depth research that focuses on women's experiences in relation to barriers to accessing and using effective contraceptives is needed. Further studies on pregnant women's decision making processes, community attitudes towards abortion and efforts to terminate pregnancies is also needed. Such research would help policymakers to better understand women's struggles to manage their fertility and enable these policymakers to better respond to the existing issues (Sedgh & Ball 2008).

It is also important to attempt to assess the cost — both financial and social — of unsafe abortions for women, their families, the health care system and the government. Furthermore, policymakers in Indonesia would benefit from comparisons between Indonesia and other Muslim countries in terms of abortion, complication rates, maternal mortality resulting from abortion, and policies and programs directed at reducing unsafe abortion.

Conclusion

In various surveys and reports produced by government agencies, it is often mentioned that maternal mortality is caused by biomedical and clinical factors, such as complications during labour, bleeding, high blood pressure and infection. Therefore, government efforts have been largely directed at preventing and avoiding complications by employing clinical approaches such as increasing the numbers of midwives in rural areas, improving basic and comprehensive emergency obstetric and newborn care, increasing the number of obstetricians, prenatal examinations, and providing additional nutrition for pregnant women. The government also implements a maternity insurance program that is integrated with the National Social Security System and the application of Minimum Standard Services in the health sector.

However, like the tip of an iceberg, the aforementioned factors are only the visible factors, while the fundamental issues and the pretext to the problems faced by pregnant women remain not much disclosed or addressed. Meanwhile, various socio-cultural aspects that encompass poverty, geographical factors, lack of infrastructure, religion and customs that contribute to maternal mortality are often overlooked.

Many cases of maternal mortality are caused by unsafe abortion. Women choose to undergo unsafe abortions because the existing laws do not allow them to access safe abortions if they do not fulfil strict criteria set by the law. Women and adolescent girls often elect to have abortions when unintended pregnancies occur. Unintended pregnancies can be avoided, one of the solutions is to provide universal access to family planning programs. Until now, the government family planning program can only be accessed by married people. Unmarried individuals, especially adolescents, are excluded from family planning services. Information about and access to safe and affordable contraception options for all women needs to be improved.

Therefore, efforts to reduce MMR through the existing government programs need to be supported by efforts aimed at eliminating factors that prevent or limit women's access to healthcare services. In addition, it is also necessary to encourage changes in society by providing comprehensive education about sexual health and reproductive rights for a range of age groups including adolescents, adults and the elderly. However, the first and foremost priority is to build collective awareness that every woman's life is important and therefore, all parties need to work together to end maternal mortality.

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Jurnal Perempuan (JP) is a quarterly interdisciplinary publication in the English language that aims to circulate **original ideas in gender studies.** JP invites critical reflection on the theory and practice of feminism in the social, political, and economic context of Indonesian society. We are committed to exploring gender in its multiple forms and interrelationships.

The journal encourages practical, theoretically sound, and (when relevant) empirically rigorous manuscripts that address real-world implications of the gender gap in Indonesian contexts. Topics related to feminism can include (but are not limited to): sexuality, queer, trafficking, ecology, public policy, sustainability and environment, human and labor rights/ issues, governance, accountability and transparency, globalization, as well as ethics, and specific issues related to gender study, such as diversity, poverty, and education.

JP welcomes contributions from researchers, academia, activists, and practitioners involved in gender advocacy in any of the areas mentioned above. Manuscripts should be written so that they are comprehensible to an intelligent reader, avoiding jargon, formulas and extensive methodological treatises wherever possible. They should use examples and illustrations to highlight the ideas, concepts and practical implications of the ideas being presented. Feminist theory is important and necessary; but theory — with the empirical research and conceptual work that supports theory — needs to be balanced by integration into practices to stand the tests of time and usefulness. We want the journal to be read as much by stakeholders as by academics seeking sound research and scholarship in women's study.

JP appears annually and the contents of each issue include: editorials, peer-reviewed papers by leading writers; reviews, short stories, and poetry. A key feature of the journal is appreciation of the value of literature, fiction, and the visual narrative (works of art, such as paintings and drawings) in the study of women´s issues

Submissions

To discuss ideas for contributions, please contact the Chief Editor: Anita Dhewy via anitadhewy@jurnalperempuan.com. Research papers should be between 5000-10000 words. Please make sure to include in your submission pack an **abstract outlining the title, purpose, methodology and main findings.** It is worth considering that, as your paper will be located and read online, the quality of your abstract will determine whether readers go on to access your full paper. We recommend you place particular focus on the impact of your research on further research, practice or society. What does your paper contribute? In addition, please provide up to **six descriptive keywords.**

Formatting your paper

Headings should be short and in bold text, with a clear and consistent hierarchy. Please identify **Notes or Endnotes** with consecutive numbers, enclosed in square brackets and listed at the end of the article. **Figures** and other images should be submitted as .jpeg (.jpg) or .tif files of a high quality. Please number them consecutively with Arabic numerals and mark their intended location within the body of the text clearly. If images are not the original work of the author, it is the author's responsibility to obtain written consent from the copyright holder before using them. Authors will be asked to confirm the status of images, tables and figures in the journal submission pack. Images which are neither the authors' own work, nor are accompanied by the necessary permission, will not be published.

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