Women's Rights and Health in Indonesia's Prisons: A Review of Current Practices

"Where there is a will there is a way"

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Foreword

Prison health constitutes an integral part of public health, as a vast majority of prisoners, both women and men, have been and will be part of society outside of the prisons. Therefore, addressing health and health care in prisons will have a positive impact on overall public health. However, more often than not, prisons fail to meet women's basic needs and are far from fulfilling accepted international recommendations guided by human rights principles and social justice.

International efforts to improve and protect the rights and health of women in prison have led to the formulation and subsequent ratification of several important declarations and rules, with the most important ones being the **"Declaration on Women's Health in Prison"**, jointly launched by the WHO and UNODC in 2009, and the **"United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders" (Bangkok Rules)**, adopted by the UN General Assembly (Resolution A/RES/65/229) in late 2010. Based on the above mentioned declarations and rules, the Directorate General of Corrections (DGC), supported by UNODC, conducted a mapping exercise on women's rights and health in prison. It is hoped that the results from this mapping exercise can be used as reference by the DGC, Ministry of Justice and Human Rights of Indonesia, to formulate and ratify a national regulation, which specifically addresses the special needs of women in prison.

We would like to express our sincere thanks and appreciation to the authors, contributors, and the consultant for completing the Mapping Report on Women's Rights and Health in Indonesian Prisons and to the United Nations Office on Drugs and Crime (UNODC) for their funding support and assistance throughout the whole process. Hopefully, this Mapping Report on Women's Rights and Health in Indonesian Prisons will bring about positive change and benefits for the rights and health of women in prison in Indonesia.

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01. Executive Summary

Criminal justice systems routinely overlook the specific needs of women and girls in prisons. Although there are major differences in the policies and practices adopted by countries around the world, many still fail to meet women's basic needs and are far from complying with accepted international recommendations, human rights principles and social justice (WHO and UNODC 2009). The purpose of the mapping exercise is to learn more about the situation of women's health in Indonesian prisons. Its aim is to review current policies and practices, and to generate strategic information on the needs and gaps relating to women's health in prisons.

A desk review of international and national laws, policies and recommendations was conducted, as well as a review of literature on women's health in prison in Indonesia. Data was collected using the WHO/UNODC Women's health in prison – action guidance and checklists, specifically designed for stakeholders with responsibility in prisons to (self-) assess the current situation and identify areas for improvement. Checklists were filled in by Directorate of Corrections representatives (13), heads of prisons (15), and prison health staffs (15).

While the Indonesian law provides prisoners with basic rights, including access to education, health services, decent nutrition, and the right to maintain contact with family members, current legislation does not specifically address the human rights and health of women and their children in prisons. Prison management policies and practices related to the treatment of women and their health vary considerably across Indonesian prisons. The same is true for awareness and attitudes among prison managers and health staff. A lack of gender sensitive legislation regarding women in prisons on a national level, limited resources and awareness, as well as overcrowding makes it difficult for correctional facilities and prison health staff to take into account the specific needs of women in prisons and put into practice related UN standards and rules for the treatment of women prisoners.

Indonesia is one of 193 countries, which has voted for the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules) in December 2010, therefore acknowledging that women in the criminal justice system do have gender-specific characteristics and needs, and agreed both to respect and meet them. In 2016 two representatives of the Directorate General of Corrections (DGC) took part in the "Bangkok Rules Training" conducted by the Thailand Institute of Justice (TIJ) in Thailand. As a follow-up to the training, in 2017, the DGC reached out to UNODC to get support with the implementation of the Bangkok Rules in Indonesia, which was promptly responded with this mapping exercise. By attending the Bangkok Rules Training in Thailand and conducting this mapping exercise, Indonesia has taken two important steps towards improving the rights of women in prison.

This mapping exercise constitutes the first review of current policies and practices regarding women's health and health care in Indonesian prisons using the WHO/UNODC checklists. While limited in terms of methodology and scope, much needed information on needs and gaps,

but also good practices and initiatives, can be generated and used to inform future planning and actions by those who can make a difference.

There is a clear need for more gender sensitive penal policies and prison rules to ensure women's health needs are properly addressed. Moreover, joint commitment by all key actors who are involved in the treatment of women prisoners is needed to push for a change in awareness, attitude and practices to put international standards into practice and improve health outcomes for women prisoners, their children and the wider community.

Definitions

The following definitions apply in this report (English version) and are based on the Kyiv Declaration on Women's Health in Prison:[1]

Girl: a female person younger than 18 years of age.

Prison: a place of compulsory detention in which people are confined while on remand awaiting trial, on trial or for punishment following conviction for a criminal offence because they have been convicted of a crime (not including police cells).

Prisoner: a person held in prison, awaiting trial or serving a prison sentence.

Woman in prison: a female person of at least 18 years old, held in prison, awaiting trial or serving a prison sentence.

Women's health: a state of "complete mental, physical, spiritual and social well-being" for all female infants, girls and women regardless of age, socioeconomic class, race, ethnicity and geographical location.

[1] WHO Regional Office for Europe and United Nations Office on Drugs and Crime (2009) *Women's health in prison: Correcting gender inequality in prison health*. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf?ua=1, accessed 22 October 2017).

02.
Background

2.1 Global Situation of Women in Prison

Globally, in 2015, more than 700'000 women and girls were held in penitentiary institutions, either awaiting trial or following conviction. While women prisoners only constitute a small minority of the total prison population, usually representing an estimated 2% - 9% of national prison populations, the Global Prison Trends Report 2017 highlights that there has been a sharp increase in women being incarcerated in recent years, a 50% increase since 2000, as compared to an estimated 20% increase among the total world prison population (TIJ and Penal Reform International 2017). As further outlined in the report, this increase in women's imprisonment constitutes a global trend towards increasing popularity and use of imprisonment, rather than rehabilitation services and non-custodial sanctions. This trend is particularly pronounced in countries with high rates of illicit drug use and applies mostly to minor drug offences and non-violent theft and fraud.

The majority of offences for which women are imprisoned are non-violent petty crimes closely linked to poverty, such as minor drug-related offences, theft, and fraud. Therefore, many women only serve a short sentence, which means that the turnover rate is high. A considerable proportion of women offenders come from deprived backgrounds, and many have experienced some form of physical and sexual abuse, and are addicted to alcohol and drugs. The UNODC (2008) report notes, women entering prison and those already imprisoned, are more likely than men to have poor mental health, often as a direct result of domestic violence and physical and sexual abuse.

Prisons and their policies and practices, from the architecture and security procedures to healthcare, family contact, psychosocial support, and training opportunities, are usually designed for the male prison population. Gender-sensitive alternatives for both pre-trial detention and post-conviction sentencing, which address the root causes of offending (mostly non-violent offences) are still a rarity in most countries. The specific characteristics and needs of women in prisons are thus still largely unacknowledged and unmet (WHO and UNODC 2009).

Women in prison often have more health problems than male prisoners. Many women suffer from chronic and complex health conditions resulting from lives of poverty, alcohol and drug use, domestic and sexual violence, adolescent pregnancy and malnutrition. Once in prison, many of these problems are accentuated due to the sub-optimal conditions they are imprisoned in. Poor physical and mental health, environmental stressors, overcrowding, poor access to gender-specific health services, sexual abuse and poor nutrition are among the most common problems (WHO and UNODC 2009; Rahmah *et al.*, 2014). Moreover, women with a history of drug use, sex work, or victims of sexual violence have a higher prevalence of HIV and other sexually transmitted infections (STIs) than male prisoners or women in the community (Convington 2007).

Prison health is an integral part of public health because there is an intensive interaction between prisons and society. This is especially the case for women, who often serve relatively short sentences. Therefore, addressing health in prisons is essential in any public health initiative

that aims to improve overall public health (Van der Bergh, B.J. *et al.* 2011). Of equal importance is ensuring continuity and linkage to health care and community services after release from prison.

Within the last ten years international efforts to improve and protect the rights and health of women in prison have been intensified around the globe. This has led to the formulation and subsequent ratification of several groundbreaking declarations and resolutions, some of which have explicitly addressed the different and specific needs that imprisoned women have. The following section will provide a short overview of the most important ones.

2.2 Human Rights Standards and International Conventions

Firstly, women who are imprisoned are still covered by human rights legislation, as guaranteed by the Universal Declaration of Human Rights (United Nations 1948). More specifically relating to the human rights of women, providing the basis for guaranteeing equality between women and men, is the Convention on the Elimination of All Forms of Discrimination against Women (United Nations 1979). The UN Nelson Mandela Rules (revised Standard Minimum Rules for the Treatment of Prisoners), ratified in 2015, constitute the main international standards relating to the protection of the human rights of prisoners, with the aim to facilitate the social reintegration of prisoners after release. These standards constitute the fundamental principles, which are valid in all criminal justice systems worldwide and apply to all prisoners, without discrimination (United Nations 2015).

Despite above described international conventions, until recently there has been a gap in international standards specifically addressing the needs of women in the criminal justice system. In April 2009 this gap was filled when the World Health Organization (WHO) Regional Office for Europe and the United Nations Office for Drugs and Crime (UNODC) jointly launched a Declaration on Women's Health in Prison. The Declaration and its concomitant background paper present detailed evidence about the current situation of women's health in prison and include clear and detailed recommendations on key aspects of health care for women prisoners.

One year later, in 2010, the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders", known as the Bangkok Rules, were drafted and subsequently adopted and endorsed by resolution 2010/16 of the Economic and Social Council on July 22, 2010, and approved unanimously by all 193 countries who are members of the United Nations (United Nations General Assembly) in September 2010. The Bangkok Rules include 70 rules on the gender-specific health care needs of women prisoners, mirroring concerns and recommendations previously included in the Declaration on Women's Health in Prison.

The recommendations included in the Declaration and Bangkok Rules are clear and unambiguous and the evidence for what should be done is clear and consistent. However, there is an urgent need to review the current situation of

women's health in prisons across the globe and identify gaps and challenges in policies and practice and come up with recommendations to improve what is not in compliance with the international recommendations. As a follow-up to the declaration and to review the current situation related to women's health in prison in countries worldwide the WHO and UNODC developed jointly three checklists that address issues that have a direct or indirect impact on health care of women in prisons.

The checklists provide an important tool for Member States to review current policies and practices relating to women's health in prisons as well as identify areas of improvement. This will help to ensure greater safety and better quality medical care for women in prison. UNODC regional offices across the globe are now undertaking in-country assessment exercises using the three checklists.

2.3 Situation of Women prisoners in Indonesia

As of November 2017, Indonesian prisons housed a total of 231'621 men and women in 510 prisons and detention centers. Of these, 12'643 were women (3723 in detention centers and 8920 in prisons), thus making up roughly 5.5% of the total prison population in Indonesia (Ministry of Justice and Human Rights 2017). According to the same data source, between 2015 and 2017, there has been a 32% increase in women prisoners. Overcrowding remains a huge challenge for the Indonesian prison system, with 188% overcapacity as of November 2017.

In Indonesia, only 34 prisons and 4 detention centers have been specifically designed to accommodate women and children.[2] Of these, 23 female prisons have been established within the last two years, but mostly adjacent to or within men's facilities. About half of all women prisoners are held in the 38 facilities designed to housing women (including here Rutan Jakarta Timur and Lapas Anak Wanita Tangerang), with the other half of women detained within men's prisons, albeit in separate blocks or cells.

There are only few studies on the health of women in Indonesian prisons. Just one research study specifically deals with women's health in prison, exploring the health needs and health-coping strategies of female prisoners in six prisons and one detention center in Indonesia (Rahmah *et al.* 2014). Another recent study, a bio-behavioral survey, looks at HIV and Syphilis prevalence and risk behaviors among both male and female inmates in Indonesia (Blogg et al. 2014). The study confirmed what has been documented in numerous studies from other parts of the world (Butler and Papanastasiou 2008; Strazza, Azevedo and Massad 2004; UNODC 2008), namely that HIV prevalence among women prisoners is higher than among male inmates. According to this bio-behavioral survey conducted in 2010, HIV prevalence in the surveyed prisons was found to be more than five times higher among female prisoners (6%) than among male prisoners (1.1%). For those prisoners with a history of injecting drug use, the HIV prevalence was 8% in males and 12% in females. Among prisoners with no history of injecting drug use, the difference was even more pronounced, with prevalence among women being more than 10 times higher (5.6%) than among male prisoners

[2] This includes two facilities (Rutan Kelas IIA Jakarta Timur and Lapas Anak Wanita Kelas IIB Tangerang), which were not originally designed for women prisoners, but which in praxis only house women (with the latter one housing girl prisoners).

(0.5%). Prevalence of syphilis was also higher among female inmates, with 8.5% infected as compared to 5.1% among male inmates. Location also played a role, with both HIV and syphilis prevalence being highest among female prisoners in Jakarta (Blogg *et al.* 2014).

The Indonesian law provides prisoners with basic rights, including access to education, health services, decent nutrition and the right to maintain contact with family members (Government Regulation Republic of Indonesia 1999). Yet, structural and institutional limitations, notably overcrowding and under-resourcing, makes it a challenge for penal institutions to fulfill these commitments for both female and male prisoners, even where there is willingness to do so. The situation is especially challenging for women prisoners due to their specific health needs and the fact that almost all Indonesian prisons have been designed by men for men.

Now the UNODC aims to support the Directorate General of Corrections (DGC) of the Ministry of Justice and Human Rights to address the special health needs of women in prisons, including their sexual and reproductive health. In order to do so, the UNODC has conducted a mapping exercise on current policies and practices, and to generate strategic information on the needs and gaps relating to women's health in prisons using the WHO/UNODC Women's health in prison – action guidance and checklists. It is hoped that the findings from the mapping exercise highlighted in this report, as well as the recommendations put forward based on these findings and in compliance with international Human Rights standards and conventions (in particular the Bangkok Rules), can assist the DGC to take further action and move step by step closer towards implementing the Bangkok Rules and ensuring that women prisoners' needs are met.

03.
Methodology

The main data collection tool for this mapping exercise on women's health in prison consists of three checklists jointly developed by the WHO and UNODC to review policies and practices in prison settings. The checklists are based on the WHO/UNODC Declaration on women's health in prison as well as the Bangkok Rules. The three checklists address issues that have a direct impact on the health care of women in prisons while also addressing other areas regarding the detention and sentencing of women and the circumstances in which they are imprisoned, which can influence their overall health, including their mental health. While some issues covered in the checklists are applicable to men in prisons, it is important to note that they are of particular relevance for women in their specific circumstances, especially due to their close links with other concerns that apply to women.

The three checklists have been designed for stakeholders with responsibility in prisons and target the following three categories:

- Decision and policy-makers, to review current policies and legislation
- Senior prison managers, to review current practices and quality
- Prison health staff, to review current health care services

The first step consisted of a desk review of international and national laws, policies, and conventions related to women's health in the prison setting. This also included a literature review of research studies on the health of women in prison, both on a global scale and in Indonesia.

Parallel to this, the checklists were translated from English into Bahasa Indonesia. The translation was then reviewed and discussed with UNODC and representatives of the DGC to minimize potential ambiguities and differences in meaning due to the translation. The checklist were then sent electronically by the DGC together with a circular letter containing information on the purpose of the exercise and instructions on how to fill in the checklist. Checklists were sent to the Secretary of the DGC (1), the Director of Healthcare and Rehabilitation of the DGC (1), all provincial/regional offices of the DGC (33), and all prisons and detention centers primarily housing women prisoners (38) to be completed by prison managers and prison health staff (for a detailed overview of checklist recipients and participants see appendix).

Completed checklists were returned by the Secretary of the DGC (1), the Director of Healthcare and Rehabilitation of the DGC (1), provincial/regional representatives of the DGC (11), heads of prisons (15), and prison health staff (15), all of which have been evaluated for this report. This equals a response rate of 38.7%.

In addition to the checklists, data were collected through two semi-structured interviews with representatives of the DGC, as well as through a number of informal discussions with representatives of the DGC.

04.
Findings and Discussion

[3] TIJ's primary objectives are to promote the implementation of United Nation Rules for the treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) as well as other relevant UN standards and norm, especially those related to women and children.

Indonesia is one of 193 countries which are members of the United Nations and which has voted for the Bangkok Rules in December 2010, therefore acknowledging that women in the criminal justice system do have gender-specific characteristics and needs, and agreed both to respect and meet them. This represents a vital step forward for women in Indonesian prisons. This vote brings with it the commitment for Indonesia to improve outcomes for women prisoners, their children, and ultimately the wider community. However, now the standards put forward in the Declaration on Women's Health in Prison and the Bangkok Rules need to be put into practice.

In August 2016 a number of representatives from Indonesia (from the DGC and heads of prison) were invited by the Thailand Institute of Justice (TIJ)[3] to partake in a 10 days training in Thailand called "The Bangkok Rules Training". The training course on the management of women prisoners for senior correctional staff in the ASEAN region aims to provide guidance and practical knowledge on translating the Bangkok Rules into practice. Using an action plan template, the training is intended to assist the participants in designing a framework for implementing the Bangkok Rules and other international standards in the respective countries. By attending this training Indonesia has taken an important first step towards improving the rights of women in prison.

As stated earlier, the recommendations put forward in the Declaration and Bangkok Rules are clear and consistent. However, there is a well-recognized need for a way to assess the current situation in Indonesia and detect those areas of service which could be improved, as well as documenting examples of good practice already in place. The checklists used in this mapping exercise can thus be seen as a starting point to check current policies and practices regarding women's health and health care in Indonesian prisons, to draw attention to deficiencies and to come up with recommendations on how to overcome shortcomings. The following section provides an overview of the results of the mapping exercise using the WHO/UNODC checklists on women's health in prison and is structured based on the different actors, who have completed the checklists.

4.1 Decision and Policy-Makers

Decision and policy-makers have the power to plan criminal justice policies that have an impact on the health of women in prison. Only through leadership and commitment of politicians, particularly those who are in charge of policies relating to prisons and criminal justice, can the effects of gender inequalities in services for women in prison and the criminal justice system as a whole be reduced and ultimately eliminated.

The checklist for decision and policy-makers was sent to the Secretary of the DGC (1), the Director of Healthcare and Rehabilitation of the DGC (1), and all provincial/regional offices of the DGC (33). A total of 13 checklists were returned, which accounts for a return rate of 37.1%. The 13 returned checklists, as well as two interviews with representatives from the DGC, provide the basis for this section.

The overwhelming majority of respondents confirmed that Indonesia has a national policy concerning gender equality (question 1.1.: 10 stated "yes", 2 stated "no", and 1 did not answer the question). According to representatives from the DGC this also extends to legislation concerning prisoners, as the Indonesian law provides all prisoners, regardless of sex, with basic rights, including access to education, health care, decent nutrition, and the right to maintain contact with family members (to mention just a few). Furthermore, almost all participants were of the opinion that current legislation specifically addresses the human rights of women and their children in the criminal justice system (question 1.2.: 11 checked "yes" and 2 checked "no").

However, according to information obtained during two interviews with key representatives from the DGC, current legislation does not specifically address women's rights, including their health care needs, in prison. They stated that currently only juvenile prisoners are covered under a specific regulation (Juvenile Criminal System law, 2014) and that they hoped that a similar regulation could be introduced for women prisoners in the future.

An important principle of the Declaration and Bangkok Rules is that pre-trial detention and imprisonment should be used as a last resort for women who have committed non-violent offenses and pose no risk to society. This clause, for instance, is included in the new regulation for juvenile offenders, but for women offenders no such alternatives are available yet (sub-question of 1.2. asking about "Alternatives to pre-trial detention and imprisonment for women": 8 checked "no" and 5 checked "yes").

The Bangkok Rules respond to the different needs of women and girls in prisons, providing guidance on a wide range of aspects of the prison system, from health care to rehabilitation programmes to the training of prison staff and visiting rights.

Most participants stated that in Indonesia there is a separate set of policies governing the provision of facilities and the management of women's prisons or sections of prisons where women are held (question 1.3.: 9 checked "yes" and 4 checked "no"). However, when asked in more detail which aspects such policies cover, answers varied considerably between respondents. For instance, participants were divided almost equally when responding to the question whether the architectural design of facilities housing women promote mental well-being (sub-question of 1.3.: 6 checked "yes" and 7 checked "no"). When asked whether current policies and practices cover the prevention of sexual violence and abuse (sub-question of 1.3.), 8 participants checked "yes" and 5 stated "no". There was more consensus on the regulation of women prisoners' access to health care services which take into account their special health care needs, with 10 checking "yes" and 3 checking "no".

Most respondents were of the opinion that a general policy has been agreed between the Ministry responsible for prisons and the Ministry of Health regarding women's health during imprisonment (question 1.4.: 10 checked

"yes", 2 checked "no", and 1 did not answer).

The Bangkok Rules emphasize that in addition to reproductive health care, gender-specific responses are needed for mental health, substance abuse and the treatment and care of other diseases.

Most participants thought that women prisoners have the same access to health care as women in the community (sub-question of 1.4.: 9 checked "yes", 3 checked "no", and 1 did not answer). For instance access to voluntary HIV testing and counselling is widely available (sub-question of 1.4.: 11 checked "yes", 1 checked "no", 1 did not answer), as well as antiretroviral treatment (8 checked "yes", 4 checked "no", 1 did not answer). However, all participants stated that there is no access to condoms and lubricants or dental dams, and access to sterile injecting equipment is also rare (3 checked "yes", 9 checked "no", and 1 did not answer).

Mental health promotion, care and treatment programmes specific to women also seem to be almost nonexistent (only 4 checked "yes", while 8 checked "no" and 1 did not answer) and the same goes for access to breast cancer screening (11 checked "no", 1 checked "yes", and 1 did not answer).

The Bangkok Rules stipulate that prison services must provide for the full range of needs of children in prison with their mothers, whether medical, physical or psychological. As these children are not prisoners, they should not be treated as such. The Rules also require special provisions to be made for mothers prior to imprisonment, in order for them to organize alternative childcare for children left outside.

In Indonesia all women prisoners, regardless of their conviction, are allowed to keep their babies or infants with them in prison. However, once the child reaches two years of age it must be given to a family member for care outside of prison. Generally, there are no special facilities provided to support the upbringing of children in prison, but supplementary food for infants is provided (Regulation of the Ministry of Justice and Human Rights No. 40/2017).

Questions 1.5. ("Is it clear in all policies relating to women and prisons that where children are involved, the interests of these children need to be the main factor in decisions regarding their placement?"), and 1.6. ("Is there a written policy about what must be provided for children who are with their mothers in prison?") in the checklist focus on the situation and rights of children in prison.

Most participants indicated that current policies do cover what must be provided for children in prisons (question 1.6.: 10 checked "yes", 2 checked "no" and 1 did not answer), and most were of the opinion that such policies prioritize the interests of children (sub-question of 1.5.: 8 checked "yes", 4 checked "no", and 1 did not answer). However, when taking a closer look at specific aspects of such policies, responses were more varied.

For instance, only a minority of participants thought

that the participation of children in decision making is sufficiently promoted and facilitated (sub-question to 1.5.: 8 checked “no”, 4 checked “yes”, and 1 did not answer), more than 2/3 (8 out of 13) stated that there is no suitable and regular monitoring and re-assessment of children’s welfare, and more than half (7 out of 13) indicated that there is no access to health care services for children provided by qualified children’s health care specialists (sub-question of 1.6.).

Overall, it can be said that while some of the standards put forward in the Bangkok Rules are already being implemented in Indonesian women prisons, the implementation of these Rules is still partial and not binding. The Indonesian prison system still lacks an overarching policy specifically addressing the rights and particular needs of women in the prison setting, similar to the situation of juvenile offenders before the introduction of a new law in 2014, which is aimed at protecting their rights.

4.2 Senior Prison Managers

Senior prison managers or heads of prisons play a crucial role when it comes to the treatment of women offenders and prisoners. While their actions are largely determined and guided by national policies and legislation, each head of prison creates their own working ethos, deemed best for carrying out the duties in their prisons and for leading and managing their staff. Thus, prison management styles and practices may vary considerably within the possibilities and limitations of the overarching legislative framework. Evidence from around the globe shows that prison policies and practices do not always take into account the specific needs of women prisoners. Lack of protective legislation on a national level, limited resources available on the ground, and limitations due to poor infrastructure and a lack of space have a considerable impact on what can be done or not done in a prison.

The checklist for senior prison managers was sent to all 38 women prisons and detention centers across Indonesia (including Lapas Anak Wanita Tangerang and Rutan Kelas IIA Jakarta Timur). Filled in checklists were returned by 15 heads of prisons. This adds up to a return rate of 39.5%, slightly higher but similar to the return rate among policy makers.

Many prisons in Indonesia are old buildings with limited space and poor infrastructure. To make things worse, most prisons are overcrowded, with some facilities having 200%-300% overcapacity. Due to the limited number of women prisons in the country, many women are housed far away from their homes, or they are detained within separate blocks of male prisons. Such sub-optimal conditions have been confirmed by many of the prison managers who have filled in the checklist (question 2.1.: “Have there been recent reviews of (i) the physical state and location of the prisons or of those parts of the prison where women prisoners are held, and (ii) the security levels in which the women are detained?”).

A majority of participants confirmed that no gender-specific security risk assessment is being carried out


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upon admission to prison (sub-question of 2.1.: 8 checked “no”, 7 checked “yes”), and 2/3 of participants (10 out of 15) stated that prisons where women are housed are far from their homes, thus making regular family visits difficult (sub-question of 2.1.). Moreover, 2/3 of participants (10 out of 15) indicated that there are no child-friendly visiting rooms available at their prison (sub-question of 2.1.).

The provision of appropriate health care, including reproductive health, mental health, substance abuse and the treatment and care of other diseases remains a huge challenge for many prisons.

Only a fifth of participants (3 out of 15) confirmed that their prison service has a policy document requiring the provision of comprehensive services for the special health needs of women and their children (question 2.2. and sub-questions, only 3 checked all questions with “yes”). In most prisons only certain aspects of comprehensive health care provision for women were in place, most commonly HIV prevention, care and treatment services (11 checked “yes” and 4 checked “no”), preventive health care services (10 checked “yes” and 5 checked “no”), and health care for babies and dependent children (11 checked “yes” and 4 checked “no”).

Changes in awareness, attitudes and practices can be achieved if there is a committed investment in the training of the people who can make a difference, including policy-makers, heads of prisons, and the prison staff.

According to a majority of the participants training programmes on human rights are already available for staff working with women in prisons (question 2.3.: 12 checked “yes” and 3 checked “no”). However, only a fifth (3 out of 15) thought that a majority of prison staff has actually participated in such trainings.

Furthermore, only slightly more than half (8 out of 15) indicated that trainings on gender sensitivity were available, and again only a fifth (3 out of 15) stated that a majority of staff has participated in such trainings. And while such trainings seem to be available at least in theory, a majority of staff has not attended a training on human rights or gender. This has also been confirmed during an interview with a representative from the DGC, who stated that there has not yet been any formal socialization of the Bangkok Rules after the TIJ Bangkok Rules Training in Thailand.

At most of the surveyed prisons there seems to be a separate registration process upon admission, which includes women specific questions (question 2.4.: 13 checked “yes and 2 checked “no”).

However, when taking a closer look at the sub-questions, it can be concluded that women specific questions are rather superficial and not detailed enough. For instance, the registration process does neither cover any questions on the circumstances in which women’s children live outside prison (sub-question of 2.4.: 10 checked “no” and 5 checked “yes”), nor inquire about women’s history of domestic violence or sexual abuse (sub-question of

2.4.: 9 checked “no” and 6 checked “yes”).

The provision of essential commodities available for women and women with children in prison does not seem to be regulated by any biding policy, as related practices vary considerably between different prisons.

A slight majority of the heads of prisons who filled in the checklist stated that women in their prison have access to sanitary towels/pads (sub-question of 2.5.: 9 checked “yes” and 6 checked “no”), and roughly half confirmed that nursing women have access to diapers for their babies and small children (sub-question of 2.5.: 8 checked “yes” and 7 checked “no”). In 2/3 of the surveyed prisons pregnant or nursing women receive supplementary feeding (sub-question of 2.5.: 10 said “yes” and 5 said “no”). However, access to condoms (both male and female) or dental dams seems to be practically nonexistent at most prisons (sub-question of 2.5.: 13 checked “no” and 2 checked “yes”).

While women’s specific health care needs are not being met comprehensively in most prisons, access to female doctors and nurses already seems to be the norm in the surveyed prisons (question 2.6.: 13 checked “yes” and 2 checked “no”). However, this mainly includes services on a primary health care level (sub-question of 2.7.: 13 checked “yes” and 2 checked “no”), with specialist health care services not being available at more than 1/3 of prisons (sub-question of 2.7.: 9 checked “yes” and 6 checked “no”). Confidentiality of medical records is guaranteed at 80% of surveyed prisons (sub-question of 2.7.: 12 checked “yes” and 3 checked “no”).

The availability of an independent and confidential complaints system (clinical and otherwise) for women prisoners is only available at 1/3 of the surveyed prisons (sub-question of 2.8.: 10 checked “no” and 5 checked “yes”). At about half of the prisons it is standard procedure to inform women about the possibility of making use of the complaints system, however, complaints may not be handled independently and or confidentially.

Pre-release preparations and continuity of care after release are crucial to make the transition to life outside prison.

It is common practice at the surveyed prisons to establish and maintain contact with the inmates’ families throughout her imprisonment (sub-question of 2.8.: 10 checked “yes” and 5 checked “no”), and at about half of the prisons continuity of care is facilitated through ongoing contact with support services in the communities of the women (sub-question of 2.8.: 8 checked “yes” and 7 checked “no”).

In summary, prison management policies and practices related to the treatment of women and their health vary considerably between prisons. The same seems to be true for awareness and attitudes related to gender-sensitive approaches. However, a lack of gender sensitive legislation regarding women in prisons on a national level, limited resources and awareness, as well as overcrowding makes it difficult for correctional facilities to take into account the


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specific needs of women in prisons and put into practice related UN standards and rules for the treatment of women prisoners. But despite all the above mentioned limitations and challenges, examples of good practice can be found, proofing that awareness, goodwill and innovative thinking can lead to positive changes in the lives of women in prison, often extending far beyond the women themselves.

To give an example, a couple of years ago, the former head of prison of the female prison in Palembang (Lapas Perempuan Kelas IIA), South Sumatra, created a program called "good mothers' day", which was aimed at strengthening the bonds between women prisoners and their husbands and children outside of prison. She observed that many families were breaking apart due to women's imprisonment and the negative stigma that goes along with women's imprisonment, as these women are widely seen as "bad women" and "bad mothers". The "good mothers' day" allowed families to get together and bond during a full day, and children were encouraged to give their mothers a gift.

Or take the female prison in Malang (Lapas Perempuan Kelas IIA), East Java, which has previously been awarded by the Ministry of Justice and Human Rights for its just treatment of inmates and innovative efforts to improve conditions for prisoners, for instance by establishing a model clinic in a separate block, allowing for adequate and professional primary health care services, by creating nice and friendly visiting rooms, establishing a reading corner with books, and providing a wide range of vocational trainings.

4.3 Prison Health Staff

Prison health staff are the ones who are in direct contact with women prisoners and thus play the crucial role of actually providing direct services to the inmates. Prison health staff should consist of medical professionals who are professionally recognized as adequately qualified according to the standards of the Ministry of Health. This should entail links with their peer professional colleagues in the community, and they should have regular and easy access to continued professional education and training. In practice clinical protocols and nursing standards at prisons are curtailed by restrictive prison policies, surveillance and strict security procedures. Poor infrastructure and limited prison budgets pose another huge challenge to the provision of human and quality health care services in prisons. Thus, prison health staff face the difficult task to provide services under these limiting circumstances, constantly having to balance respect for and the dignity of the women in prison with the few resources available to them.

The checklist for prison health staff was sent to all 38 women prisons and detention centers in Indonesia (including Lapas Anak Wanita Tangerang and Rutan Kelas IIA Jakarta Timur). Checklists were returned by 15 prisons, which adds up to a return rate of 39.5%. Most checklists filled in by prison staff are from prisons where the senior prison manager has also filled in the checklist.

Roughly half the prison staff who returned the checklist said that they were able to provide an adequate and professionally satisfying primary health care service

to women in prison (question 3.1., 7 checked all sub-questions with "yes", 5 checked more than half of the sub-questions with "yes", 1 checked less than half with "yes", and 2 checked all with "no"). It would be interesting here to also look at the side of the recipients of the services, that is the women prisoners, but the checklist does not include the voices of the women in prison. However, according to findings of a recent research study on the health of female prisoners in Indonesia (Rahmah et al. 2014), which explored the health concerns of women in prison, most of the interviewed women reported that services were of low quality and that services were usually unable to respond adequately to their basic health needs.

One of the recommendations put forward in the Declaration is that all women should undergo a comprehensive and detailed health screening when first admitted to prison, and regularly repeated throughout their stay.

According to the respondents this seemed to be standard procedure at most prisons (question 3.2.: 12 stated "yes" and 3 stated "no"). However, the nature of such health screenings and which aspects were included differed considerably between prisons. Mental health screening was done in only slightly more than half of the prisons (9 checked "yes" and 6 checked "no").

Screening related to substance abuse, reproductive health and pregnancy was done at most but not all prisons (11 checked "yes" and 4 checked "no"), but in a majority of prisons history of violence or abuse or post-traumatic stress disorder (6 checked "yes" and 9 checked "no") are not part of the assessment.

The Declaration on women's health in prison and the Bangkok Rules both stress the importance of health services and programming that recognize and reflect women's gender specific health care needs and the need to individualize such services. Apart from reproductive and specialist health care, gender-specific responses are needed for mental health, substance abuse and the treatment and care of other diseases. Moreover, pre-release preparations that are adequately planned and provided in order to ensure continuity of care and access to health and other services after release are of equal importance (WHO and UNODC 2009).

Questions 3.3. and 3.4. focus on the range of services available at the prison or through links with external services:

The responses show that reproductive health services, including pre-and postnatal care are available at 2/3 of surveyed prisons (sub-question of 3.3.: 10 checked "yes" and 5 checked "no").

HIV and STI related services are widely available, with the exception of two prisons where no HIV related services are available and 4 prisons where no STI related services are available.

Mental health, including post-traumatic stress disorder

services are provided at roughly half of the services (8 checked “yes” and 7 checked “no”).

Drug dependence treatment is only available at 1/3 of the prisons, and the same is true for breast cancer and cervical cancer screening.

Two thirds (2/3) of prisons have a female doctor.

Information and education material related to HIV, hepatitis, and TB transmission, prevention, testing and treatment is widely available (13 checked “yes” and 2 checked “no”). But tools to prevent the spread of HIV, hepatitis and other STIs are hardly available (each prevention tool only at 3 prisons).

Antiretroviral treatment is only available at slightly more than half of the surveyed health services (8 said “yes” and 7 said “no”), with ART for pregnant women to prevent mother-to-child transmission only being available at 6 prisons, which is less than half.

TB treatment is more easily available and can be accessed at 3/4 of the clinics (12 said “yes” and 3 said “no”). Treatment for hepatitis B and C seems to be practically inexistent, with only two prisons offering related services.

When asked whether their service is able to meet personal requests of women prisoners, such as to be seen by a female doctor (question 3.7.), almost all respondents stated that “yes” it is possible (13 checked “yes” and 2 checked “no”).

However, at a majority of prisons medical consultations could not be done without the presence of an operational staff, thus making it difficult for women prisoners to discuss personal or sensitive topics (only 6 said “yes” it is possible without an operational staff, while 9 said “no” it is not possible).

Regular contact and communication between the prison health staff and the prison management is the norm at most prisons, and at a majority of prisons a senior member of the health care staff is part of the prison management team (question 3.8.). The provision of gender-specific specialist services still provides a challenge to most prison health services.

The whole range of specialist services, which includes services related to violence and abuse, post-traumatic stress disorder, HIV and STIs, hepatitis A, B and C, TB, pregnancy-related issues, chronic conditions, and pediatric services, are only available at two prisons. Two prisons did not offer any specialist services at all, with most (11) falling somewhere in between.

As a result of the chaotic lifestyles of many of the women who enter prison, their time in prison is often the first time in their life that they have access to health care, social support and counselling services. Health information, prevention, and screening programmes for women in prison are hence essential and provide a valuable opportunity for women to improve health-seeking behaviors that may extend beyond

the time they spend in prison (Zoia 2005). The Declaration therefore also stipulates that women in prison should be able to access screening services as much as women in the community, and that they should be provided with access to health education and health promotion.

A third (1/3) of respondents were of the opinion that women in prison have as much access to regular screening services as women outside prison (5 checked all sub-categories with "yes", 1 checked all with "no", and the remaining 9 provided mixed answers). The availability of health education and health promotion also varied between prisons, with some covering a wide range of health related topics (4 checked all sub-categories with "yes"), and others not having any programmes at all (1 checked all sub-categories with "no").

The last four questions of the checklist concern pre-release procedures and links between prison health staff and health and community services outside of prison to ensure continuity of care upon release. Continuity of care is crucial not only for the women themselves but also for public health and should be the responsibility of prison staff, health care staff and social care authorities in the community together (WHO and UNODC 2009). However, this continuity of care is often not guaranteed, as also reflected in the responses of the checklist.

Again, the situation and arrangements related to pre-release and ensuring the continuity of care vary considerably from prison to prison. Most prison staff does have some degree of professional contact with community services outside prison (2 checked "yes" for all categories, 11 check "yes for some categories, and 2 checked "no" for all categories, meaning that they did not maintain any professional links to outsiders).

Most respondents (13 out of 15) stated that they have some degree of regular professional contact with community services so that continuity of care is facilitated. Of these, 3 checked all sub-categories with "yes", thus providing comprehensive pre- and post-release services. However, more than half (8 out of 15) were of the opinion that there is no adequate system to ensure that women prisoners are fully aware of the risk of post-release early death and infectious diseases and how these can be prevented.

Responses from the checklist show that health services vary considerably from prison to prison. In other words, health services in prison differ in terms of what kind of services they provide and how they are provided, how they are equipped and staffed, and how they are connected to other health and community services outside of prison. The lack of an overarching gender sensitive legislation and prison policies, very limited budgets for health care, overcrowding, and insufficient awareness among prison personnel (including prison health staff) about the specific needs of women prisoners, makes it difficult for prison health staff to provide services in accordance with UN standards and rules for the treatment of women prisoners.

05.
Recommendations

The last section of this report puts forward a number of recommendations, which are aimed at creating a more gender-specific and gender-sensitive criminal justice and prison system, with adequate attention paid to the rights and specific health care needs of women in prison. The suggested measures are meant to be implemented at a policy and or practical level and are based on the findings of this mapping exercise and the standards outlined in the Declaration on women's health in prison and the Bangkok Rules. The recommendations have been discussed and validated by selected representatives of the DGC.

- To formulate and ratify a national regulation, which specifically addresses the special needs of women in prison (similar like the law on juvenile prisoners). Such a law should be based on the standards and principles outlined in the Declaration on women's health in prison and the Bangkok Rules. The development and subsequent ratification of a national law addressing the specific needs of women in prison would be a crucial step forward towards improving outcomes for women prisoners, their children and their communities.

- To review current laws, policies and practices to identify areas which do not comply with standards of gender equality, and once identified, take the necessary steps to revise and or do away with those aspects which are discriminative (e.g. policies on parole/probation are more lax for men).

- To formally socialize the Bangkok Rules to key stakeholders in Indonesia, including key figures from the Ministry of Justice and Human Rights, the Directorate of Corrections (including decision and policy makers, senior prison staff, and prison health staff), and the Ministry of Health.

- To develop a comprehensive action plan (e.g. using the action plan template provided by the Thai Institute of Justice) and design a framework for implementing the Bangkok Rules and other international standards in Indonesia.

- To provide capacity building for prison health staff, policy makers, senior prison managers and others who engage with women in the criminal justice system with the goal of bringing about a change in awareness, attitudes and practices, and most of all commitment. Such capacity building must focus on raising awareness and develop participants' knowledge on women prisoners' health. This focus on improving the education and knowledge of those responsible for the care of women prisoners will make it more likely for them to develop health plans that actually meet the needs of women in prison.

- To create a national platform for complaints related to women's health in prison.

- To include the views and opinions of women in prison into a future review on women's health in prison (e.g. by conducting interviews and FGDs and or creating a checklist targeted at inmates).

06.
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07.
Appendix

Across the globe, the prevalence of HIV, sexually transmitted infections, hepatitis B and C and tuberculosis in prison populations is 2 to 10 times as high (or higher) as in the general population (WHO, UNODC and UNAIDS 2007). In most countries HIV rates are particularly high among women prisoners, with Indonesia not being an exception to this. As stated previously, according to a bio-behavioral survey conducted in 2010, HIV prevalence in the surveyed prisons was found to be more than five times higher among female prisoners (6%) than among male prisoners (1.1.%) (Blogg *et al.* 2014).

In order to support countries in developing and implementing an effective response to HIV and AIDS and other infectious diseases in prisons the UNODC, the WHO and other partners put forward a comprehensive package of 15 key interventions for prisoners. The 15 interventions are essential for effective HIV prevention and treatment in closed settings. While each of these interventions alone is important in addressing HIV in prisons, together they form a package and have the greatest impact when delivered as a whole (UNODC *et al.* 2013).

Women have a considerably greater risk of contracting HIV, other STIs and hepatitis C from sexual activity than men. This is due to a combination of biological, cultural and social factors. Therefore, the UN key interventions should be tailored to the gender-specific needs of women when implemented.

The following table provides an overview of the 15 UN key interventions and what is available in Indonesia based on the respondents of the three checklists:

Key interventions	Situation in Indonesia
1. Information, education and communication	Indonesian laws and policies (see right column) guarantee access to information, education and communication material about HIV, other STIs, viral hepatitis and tuberculosis for all citizens, including prisoners. Respondents of the checklists confirmed this, with roughly 3/4 confirming that health promotion and education is available to prisoners. However, there might be differences in how and to what extent information, education and communication material is delivered at each prison facility. Moreover, there are still prisons where health promotion and education is not available (1/4 of surveyed prisons).
2. Condom programmes	Condoms constitute an important tool of HIV prevention and as such should be available to all men and women in prisons. The promotion and usage of condoms in Indonesian prisons is highly controversial. Current laws and policies are not specific on the issue of condoms and results from the mapping exercise indicate that condoms are generally not available in Indonesian prisons (3/4 of respondents stated that condoms are not available at their prison facility). Yet, at a small number of prisons condoms are available to prisoners. Moreover, based on a discussion with a prison health staff, some prison health staffs apply a more pragmatic approach and provide condoms to prisoners based on request or in specific situations.
3. Prevention of sexual violence	Policies and strategies for the prevention, detection and elimination of all forms of violence, particularly sexual violence, should be implemented in all prisons. In Indonesian prisons, efforts related to the prevention of sexual violence are still limited, with only about half of respondents stating that such efforts are covered under current policies. Moreover, less than half of respondents stated that at their facility the taking of a history of violence or abuse are part of the comprehensive health assessment.

4. Drug dependence treatment, including opioid substitution therapy	Evidence-based drug dependence treatment with informed consent should be made available in prisons in line with national guidelines, considering that opioid substitution therapy is the most effective drug dependence treatment for people dependent on opiates. In Indonesia there are currently no laws or regulations on harm reduction in prison, including no regulations on needle exchange for prisoners. However, the Indonesian Ministry of Justice and Human Rights is committed to addressing drug related challenges for inmates despite limited funding. It has produced guidelines for comprehensive services for HIV-AIDS and STIs in correctional institutions, which include sections on opioid substitution and other drug related services. Currently, a small number of prisons offer access to methadone programmes, run by staff trained in the treatment of drug dependency (available at 2 out of 15 surveyed prisons). Other forms of drug dependence treatment are available at another three of the surveyed prisons, however, respondents did not indicate more details on what kind of treatment.
5. Needle and syringe programmes	Prisoners who inject drugs should have easy and confidential access to sterile drug injecting equipment, syringes and paraphernalia, and should receive related information. Indonesia has no regulations covering needle and syringe exchange programmes as part of harm reduction interventions. This has also been confirmed by 3/4 of checklist respondents (level policy and decision makers). The lack of related policies is reflected in the field, with easy and confidential access to sterile drug injecting equipment only being available at a small number of prisons (1/4 of surveyed prison health staff stated that sterile needles and syringes can be accessed at their prison). Only at 1/3 of surveyed prisons bleach for disinfection is available, so that prisoners can clean injecting equipment.

6. Prevention of transmission through medical or dental services	HIV and hepatitis can be easily spread through contaminated medical or dental equipment. Therefore, it is crucial that prison health staffs adhere to strict infection-control and safe-injection protocols. Health services in prisons must comply with national standards and guidelines, therefore adhering to strict infection-control and safe-injection protocols. However, in practice not all health services are strictly adhering to the principles of infectious diseases control during medical and dental procedures. More than 1/4 of checklist respondents (level policy and decision makers) stated that there were no policies on infectious disease control in medical and dental facilities within prison. However, it could be that respondents answered “no” due to limited knowledge rather than based on actual facts.
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration	Prison authorities should reduce and prevent the sharing and reuse of equipment used for tattooing, piercing and other forms of skin penetration in order to prevent the spread of infections. In Indonesian prisons hardly any measures or initiatives are implemented to prevent the transmission of HIV and viral hepatitis through tattooing, piercing and other forms of skin penetration. This comes as no surprise, as needle and syringe programmes are almost non-existent in Indonesian prisons. Only 1 prison health staff respondent (1 out of 15) stated that such measures were taken at their facility.
8. Post-exposure prophylaxis	Post-exposure prophylaxis should be made accessible to victims of sexual assault and to other prisoners exposed to HIV. In Indonesia, post-exposure prophylaxis (PEP) is generally reserved for occupational exposure due to needle stick or other injuries during the provision of health services. Usually, PEP is not available for sexual exposure, with the exception of victims of sexual assault. According to a majority of checklist respondents, PEP is not provided to prisoners exposed to a risk at their prison facility (PEP is only available at 20% of surveyed prisons).

9. HIV testing and counselling	Prisoners should have easy access to voluntary HIV testing and counselling at any time during their detention. All forms of coercion must be avoided and testing must always be done with informed consent, pre- and post-test counselling, protection of confidentiality, and access to follow up services, including HIV-AIDS care and treatment. Voluntary HIV testing and counselling is available at a majority of surveyed prisons, however, slightly more than 1/4 do not yet offer voluntary HIV testing and counselling. The reason for this is that these relatively new prisons have not yet been included in the national HIV program.
10. HIV treatment, care and support	HIV treatment, including antiretroviral therapy (ART), care and support, should be equally available to prisoners as to communities outside of prison. While coverage of ART services in Indonesia has greatly improved in recent years, including in prisons, only slightly more than half of surveyed prisons currently offer ART for prisoners living with HIV-AIDS. Thus, efforts to expand ART services to all prisons in Indonesia should be a prioritized.
11. Prevention, diagnosis and treatment of tuberculosis	Given the high risk for transmission of tuberculosis and high rates of HIV-tuberculosis co-morbidity in prisons, active case-finding, treatment, and effective tuberculosis control measures should be available and implemented at all prisons. In recent years, the national tuberculosis control programme has been expanded to more and more prisons. However, not all prisons have a comprehensive TB programme in place and some prisons still lack TB related services. Based on checklist respondents, 3/4 of surveyed prisons offer TB services, while 1/4 have not TB services available.

12. Prevention of mother-to-child transmission of HIV	The full range of prevention of mother-to-child HIV transmissions interventions, including family planning and antiretroviral therapy, should be accessible to women living with HIV in and outside or prison. According to respondents of the checklists, only slightly more than a 1/3 (6 out of 15) of surveyed prisons currently offer services related to the prevention of mother-to-child transmission of HIV. It is thus of great importance that efforts are intensified to increase coverage of such services to all prisons housing women.
13. Prevention and treatment of sexually transmitted infections	Sexually transmitted infections increase the risk for transmission and acquisition of HIV, apart from causing a multitude of other serious health problems. Early diagnosis and treatment of such infections should therefore be part of HIV prevention programmes in prisons. Services for sexually transmitted infections can be accessed at a majority of surveyed prisons, but more than 1/3 do not provide any STI related services. This means that a large number of women prisoners at risk of or already suffering from STIs do not receive the care and treatment they need.
14. Vaccination, diagnosis and treatment of viral hepatitis	Prisons should have a comprehensive hepatitis programme, including vaccination (for hepatitis A & B), diagnosis and treatment of hepatitis A, B and C. Currently, hepatitis related services are not well developed in Indonesian prisons. Hepatitis B vaccination is only available at 2 of 15 surveyed prisons. Testing and treatment of hepatitis B and C is equally scarce, with only 1/5 of surveyed prisons (3 out of 15) offering related testing services and less than 1/5 (2 out of 15) providing hepatitis B and C treatment.
15. Protecting staff from occupational hazards	Occupational safety and health procedures on HIV, viral hepatitis and tuberculosis should be established for all prison staff and workers. Universal precautions for the prevention of transmission of HIV, viral hepatitis and other bloodborne viruses at healthcare facilities are dictated by the standards of universal precautions set forward by the Indonesian Ministry of Health. However the checklists used in this mapping exercise do not specifically cover this area.

Related legislation and policies

Prisoners are considered citizens and thus have the same rights as people outside of prison to access health care, including having the right to be protected from HIV transmission and to receive comprehensive care, support and treatment services. However, current legislation does not specifically address the specific health needs of women and their children in prison.

The Directorate General of Corrections and the Ministry of Justice and Human Rights of the Republic of Indonesia have the obligation to fulfill, guarantee and protect the rights and health of prisoners, including related to HIV-AIDS.

Following is an overview of laws and regulations related to the health of prisoners, including those which specifically address the provision of HIV-AIDS related services:

- Law No 12/1995 on Corrections (Undang Undang RI No 12 Tahun 1995 Tentang Pemasyarakatan)
- Law No 39/1999 on Human Rights (Undang Undang RI No 39 Tahun 1999 Tentang Hak Asasi Manusia)
- Law No 23/2002 on Child Protection (Undang Undang RI No 23 Tahun 2002 Tentang Perlindungan Anak)
- Law No 29/2004 on Medical Practice (Undang Undang RINo 29 Tahun 2004 Tentang Praktik Kedokteran)
- Law No 35/2009 on Narcotic Drugs (Undang Undang RI No 35 Tahun 2009 Tentang Narkotika)
- Law No 36/2009 on Health (Undang Undang RI No 36 Tahun 2009 Tentang Kesehatan)
- Law No 24/2011 on Social Security (Undang Undang RI No 24 Tahun 2011 Tentang Penyelenggaraan Jaminan Sosial)
- Government Regulation No 32/1999 on Terms and Procedures of the Implementation of Prisoner Rights (Peraturan Pemerintah RI no 32 Tahun 1999 Tentang Syarat dan Tata Cara Pelaksanaan Hak Warga Binaan Pemasyarakatan)
- Government Regulation No 57/1999 on Collaboration in Providing Guidance for Prisoners (Peraturan Pemerintah RI No 57 Tahun 1999 Tentang Kerjasama Penyelenggaraan Pembinaan dan Pembimbingan Warga Binaan Pemasyarakatan)
- Government Regulation No 58/1999 on Terms and Procedures for the Implementation of Authority, Duties and Responsibilities of Care for Prisoner in Detention center (Peraturan Pemerintah RI No 58 Tahun 1999 Tentang Syarat-syarat dan Tata Cara Pelaksanaan Wewenang, Tugas dan Tanggung Jawab Perawatan Tahanan)
- Regulation of the Minister of Health No 21/2013 on HIV-AIDS Control (Peraturan Menteri Kesehatan RI No 21

Tahun 2013 Tentang Penanggulangan HIV dan AIDS)

- Regulation of the Ministry of Interior No 18/2016 on Regional Government Guidelines for Development, Control and Evaluation of Work Plans 2017 (Peraturan Menteri Dalam Negeri RI No 18 Tahun 2016 Tentang Pedoman Penyusunan, Pengendalian, dan Evaluasi Rencana Kerja Pemerintah Daerah Tahun 2017)

- Regulation of the Ministry of Health No 43/2016 on Minimal Standards for Healthcare Services (Peraturan Menteri Kesehatan RI No 43 Tahun 2016 Tentang Standar Pelayanan Minimal Bidang Kesehatan)

- National Action Plan on the HIV-AIDS Response for Health 2015 – 2019 (Rencana Aksi Nasional Pengendalian HIV dan AIDS Bidang Kesehatan 2015-2019)

- National Action Plan on HIV-AIDS Control for Prisoners and Detainees in Indonesia, 2017-2019 (Rencana Aksi Nasional Pengendalian HIV-AIDS bagi Warga Binaan dan Pemasyarakatan dan Tahanan di Indonesia Tahun 2017–2019)

Apart from the laws and regulations related to prisoners' health listed above, the Indonesian Ministry of Justice and Human Rights have produced guidelines for comprehensive services for HIV-AIDS and STIs in correctional institutions. The guidelines can be accessed under the following link:

https://www.ditjenpas.go.id/standar/ (Pedoman Layanan Komprehensif HIV-AIDS dan IMS di Lapas)

In late 2017 the Department of Corrections, in partnership with UNODC, produced an updated and more practical version of the 2012 guidelines, called "Practical Handbook: Implementing HIV-AIDS Control for Prisoners". It is available under the following link:

https://www.ditjenpas.go.id/standar/ (Panduan Praktis: Pelaksanaan Pengendalian HIV-AIDS Bagi Tahanan dan Warga Binaan Pemasyarakatan)

Overview of Checklist Participants

Decision and Policy Makers

No	Provincial/Regional Office	Checklist sent	Checklist returned	Contributor
1	Directorate General of Corrections	Yes	Yes	Secretary of DGC
2	Directorate General of Corrections	Yes	Yes	Director of Healthcare and Rehabilitation of DGC
3	Nanggro Aceh Darussalam	Yes	No	-
4	Sumatera Utara	Yes	No	-
5	Sumatera Barat	Yes	No	-
6	Riau	Yes	Yes	Head of Sub-Unit of Directorate Healthcare
7	Kepulauan Riau	Yes	No	-
8	Jambi	Yes	Yes	Head of Provincial Office
9	Bengkulu	Yes	No	
10	Sumatera Selatan	Yes	No	
11	Lampung	Yes	No	
12	Bangka Belitung	Yes	Yes	Head of Provincial Office
13	Banten	Yes	Yes	Head of Provincial Office
14	DKI Jakarta	Yes	Yes	Head of Provincial Office
15	Jawa Barat	Yes	No	
16	Jawa Tengah	Yes	No	
17	Daerah Istimewa Yogyakarta	Yes	Yes	Head of Sub-Unit of Care and Management of State Confiscated Goods
18	Jawa Timur	Yes	Yes	Head of Provincial Office
19	Bali	Yes	Yes	Head of Provincial Office
20	Nusa Tenggara Barat	Yes	No	-
21	Nusa Tenggara Timur	Yes	Yes	Head of Provincial Office

22	Kalimantan Barat	Yes	Yes	Head of Sub-Unit of Care and Management of State Confiscated Goods
23	Kalimantan Tengah	Yes	No	-
24	Kalimantan Selatan	Yes	No	-
25	Kalimantan Timur	Yes	No	-
26	Sulawesi Utara	Yes	No	-
27	Gorontalo	Yes	No	-
28	Sulawesi Tengah	Yes	Yes	Head of Provincial Office
29	Sulawesi Barat	Yes	No	-
30	Sulawesi Tenggara	Yes	No	-
31	Sulawesi Selatan	Yes	No	-
32	Maluku	Yes	No	-
33	Maluku Utara	Yes	No	-
34	Papua Barat	Yes	No	-
35	Papua	Yes	No	-

Senior Prison Managers

No	Name of Prison	Checklist sent	Checklist returned	Contributor
1	Lapas Perempuan Kelas IIA Medan	Yes	No	-
2	Lapas Perempuan Kelas IIA Palembang	Yes	Yes	Head of prison
3	Lapas Perempuan Kelas IIA Bandar Lampung	Yes	Yes	Head of prison
4	Lapas Perempuan Kelas IIA Batam	Yes	No	-
5	Lapas Perempuan Kelas IIA Pekanbaru	Yes	Yes	Head of prison
6	Lapas Perempuan Kelas IIA Tangerang	Yes	Yes	Head of prison
7	Lapas Perempuan Kelas IIA Jakarta	Yes	Yes	Head of prison
8	Lapas Perempuan Kelas IIA Bandung	Yes	No	-
9	Lapas Perempuan Kelas IIA Semarang	Yes	No	-
10	Lapas Perempuan Kelas IIA Malang	Yes	Yes	Head of prison
11	Lapas Perempuan Kelas IIA Denpasar	Yes	Yes	Head of prison
12	Lapas Perempuan Kelas IIA Pontianak	Yes	Yes	Head of prison
13	Lapas Perempuan Kelas IIA Martapura	Yes	No	-
14	Lapas Perempuan Kelas IIA Palangkaraya	Yes	No	-
15	Lapas Perempuan Kelas IIA Samarinda	Yes	No	-
16	Lapas Perempuan Kelas IIA Sungguminasa	Yes	No	-
17	Lapas Perempuan Kelas IIB Padang	Yes	No	-
18	Lapas Perempuan Kelas IIB Bengkulu	Yes	No	-
19	Lapas Perempuan Kelas IIB Jambi	Yes	Yes	Head of prison
20	Lapas Anak Wanita Kelas IIB Tanggerang	Yes	No	-
21	Lapas Perempuan Kelas IIB Yogyakarta	Yes	Yes	Head of prison
22	Lapas Perempuan Kelas IIB Manado	Yes	No	-
23	Lapas Perempuan Kelas III Sigli	Yes	No	-

24	Lapas Perempuan Kelas III Pangkal Pinang	Yes	Yes	Head of prison
25	Lapas Perempuan Kelas III Mataram	Yes	No	-
26	Lapas Perempuan Kelas III Kupang	Yes	Yes	Head of prison
27	Lapas Perempuan Kelas III Gorontalo	Yes	No	-
28	Lapas Perempuan Kelas III Palu	Yes	Yes	Head of prison
29	Lapas Perempuan Kelas III Mamuju	Yes	No	-
30	Lapas Perempuan Kelas III Kendari	Yes	No	-
31	Lapas Perempuan Kelas III Ambon	Yes	No	-
32	Lapas Perempuan Kelas III Ternate	Yes	No	-
33	Lapas Perempuan Kelas III Manokwari	Yes	No	-
34	Lapas Perempuan Kelas III Jayapura	Yes	No	-
35	Rutan Perempuan Kelas IIA Medan	Yes	No	-
36	Rutan Kelas IIA Jakarta Timur	Yes	Yes	Head of prison
37	Rutan Perempuan Kelas IIA Bandung	Yes	No	-
38	Rutan Perempuan Kelas IIA Surabaya	Yes	Yes	Head of prison

Prison Health Staff

No	Name of Prison	Checklist sent	Checklist returned	Contributor
1	Lapas Perempuan Kelas IIA Medan	Yes	No	-
2	Lapas Perempuan Kelas IIA Palembang	Yes	Yes	Doctor
3	Lapas Perempuan Kelas IIA Bandar Lampung	Yes	Yes	Paramedic
4	Lapas Perempuan Kelas IIA Batam	Yes	No	-
5	Lapas Perempuan Kelas IIA Pekanbaru	Yes	Yes	Doctor
6	Lapas Perempuan Kelas IIA Tangerang	Yes	No	-
7	Lapas Perempuan Kelas IIA Jakarta	Yes	Yes	Health staff
8	Lapas Perempuan Kelas IIA Bandung	Yes	No	-
9	Lapas Perempuan Kelas IIA Semarang	Yes	No	-
10	Lapas Perempuan Kelas IIA Malang	Yes	Yes	Doctor
11	Lapas Perempuan Kelas IIA Denpasar	Yes	Yes	Health staff
12	Lapas Perempuan Kelas IIA Pontianak	Yes	Yes	Functional staff healthcare
13	Lapas Perempuan Kelas IIA Martapura	Yes	No	-
14	Lapas Perempuan Kelas IIA Palangkaraya	Yes	Yes	Functional staff
15	Lapas Perempuan Kelas IIA Samarinda	Yes	No	-
16	Lapas Perempuan Kelas IIA Sungguminasa	Yes	Yes	Midwife
17	Lapas Perempuan Kelas IIB Padang	Yes	No	-
18	Lapas Perempuan Kelas IIB Bengkulu	Yes	No	-
19	Lapas Perempuan Kelas IIB Jambi	Yes	Yes	Head of Sub-directorate Healthcare
20	Lapas Anak Wanita Kelas IIB Tanggerang	Yes	No	-
21	Lapas Perempuan Kelas IIB Yogyakarta	Yes	No	-
22	Lapas Perempuan Kelas IIB Manado	Yes	No	-
23	Lapas Perempuan Kelas III Sigli	Yes	No	-

24	Lapas Perempuan Kelas III Pangkal Pinang	Yes	Yes	Functional staff
25	Lapas Perempuan Kelas III Mataram	Yes	No	-
26	Lapas Perempuan Kelas III Kupang	Yes	Yes	Nurse
27	Lapas Perempuan Kelas III Gorontalo	Yes	No	-
28	Lapas Perempuan Kelas III Palu	Yes	Yes	Functional staff
29	Lapas Perempuan Kelas III Mamuju	Yes	No	-
30	Lapas Perempuan Kelas III Kendari	Yes	No	-
31	Lapas Perempuan Kelas III Ambon	Yes	No	-
32	Lapas Perempuan Kelas III Ternate	Yes	No	-
33	Lapas Perempuan Kelas III Manokwari	Yes	No	-
34	Lapas Perempuan Kelas III Jayapura	Yes	No	-
35	Rutan Perempuan Kelas IIA Medan	Yes	No	-
36	Rutan Kelas IIA Jakarta Timur	Yes	Yes	Midwife
37	Rutan Perempuan Kelas IIA Bandung	Yes	No	-
38	Rutan Perempuan Kelas IIA Surabaya	Yes	Yes	Doctor

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