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The Journal of International Women's Studies is an online, open-access, peer-reviewed feminist journal that provides a forum for scholars, activists, and students to explore the relationships among theories of gender and sexuality and various forms of organizing and critical practice.

Dear JIWS authors and readers: the JIWS has received such a robust number of submissions that our issues are full through January 2024. We will continue to publish special issues through 1/15/24, as well as our regular issues in January 2023, August 2023, and January 2024. As a result, we are closing submissions until December 2023 when the submission link will again be opened. As many of you know, we are a small team; the Executive Editorial team and our Editorial Review Board are volunteer positions. This suspension period will allow us to produce high quality issues that we hope will educate and inspire. Thank you for your understanding—the JIWS Editorial Staff.

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Aims and scope

The Journal of International Women's Studies is an on-line, open-access, peer reviewed feminist journal that provides a forum for scholars, activists, and students to explore the relationships among theories of gender and sexuality and various forms of organizing and critical practice. The journal seeks both multidisciplinary and cross-cultural perspectives, and invites submissions in the form of scholarly articles, essays, book reviews, and works of fiction. In addition, the Journal supports multi-media submissions through streaming audio capability, embedded video, and links to video sites to display short films and other visual materials. Through its diverse collection, the journal aims to create an opportunity for building bridges across the conventional divides of scholarship and activism; "western" and "third world" feminisms; professionals and students; men, women and all genders and the hegemony of ableism. Toward this end, the editors welcome your constructive and insightful comments in response to our publications.

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December 2019

Women's Reproductive Rights Under Marriage Contract

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Women's Reproductive Rights Under Marriage Contract

By Sri Endah Kinasih¹, Toetik Koesbardiati² and Siti Mas'udah³

Abstract

In Indonesia, marriage contracts are still common. In addition to culture, women's reproductive rights are also strongly associated with poverty. The poverty factor is very influential in relation to quality of life and women's reproductive health. This article investigates the reproductive health rights of women under a marriage contract. Employing the descriptive qualitative method, the research was conducted in Pasuruan, East Java and Bogor, West Java, Indonesia. The selection of the research contexts was done purposively. This study shows that a marriage contract does not always imply the occurrence of sexual intercourse. Sexual intercourse in a marriage contract may happen or be done by the couples involved if it becomes part of the terms agreed. Couples who engage in a marriage contract may not establish a sexual relationship if it is not part of the deal. The condition of women in a marriage contract who are generally poor and less educated impacts on their low level of awareness of the importance of reproductive health. Knowledge about reproductive health is often not a priority because they are more focused on working for the sake of survival. They are generally not able to access health care because they do not have the money to do so. In addition, poor women who live in remote villages also have problems accessing the health centres. This study indicates that the marriage contract in Indonesia is temporary or only for a certain agreed duration. This has a negative effect on the reproductive health of women. Pregnancy, birth and the presence of children born into a marriage contract are part of the agreement. Women do not fully have control over their reproductive rights in a marriage contract. Poverty and a lack of education of the women in such a marriage of course impacts on their low level of awareness of the importance of understanding their reproductive consciousness. Thus, in the marriage contract, the reproductive rights of women are not controlled by the women themselves. Rather, they need to be considered by the male partner. Reproductive health is not a priority because they are more focused on working for the sake of survival.

Keywords: marriage contract, reproductive health, poverty, women

Introduction

In Indonesia, marriage contracts are still common, especially in the Rembang sub-district, Pasuruan regency and Cisarua sub-district of Bogor regency. Contractual marriage is a trademark of the phenomenon of foreign men working seasonally in Indonesia (Handoyo & Rohayuningsih,

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2013). Tourists who engage in this type of marriage are Arab tourists where they can avoid adultery and only intend to get married for a certain duration of time (Harahap, 2011). In Cisarua Bogor, prostitution is hidden behind the practice of contract marriage in order to be considered *halal* and wrapped in various tour packages in Bogor Regency for Middle Eastern tourists (news.detik.com/14 September 2019). In addition, contract marriages are also found in Pontianak, West Kalimantan, which was successfully thwarted by the local police and West Kalimantan Immigration involving Indonesian citizens and a number of foreigners (Pontianak.tribunnews.com/13 June 2019). Previous studies showed that contract marriages are a phenomenon in which there are business practices and cultural shifts which, as happened in West Kalimantan, mean that contract marriages occur as a result of the opening of plantations and logging so then the local communities are easily exposed to migrants (Tanasaldy, 2007). Suwartini's study (2007) shows that the contract marriages that occur in Jepara are actually approved by the parents who have children that are to be married with the aim of them having a better life because the value of the contract and dowry is very high.

Marriage contracts are carried out because the procedure is easy and not convoluted. The cost of the marriage is very easy because the perpetrators of the marriage are not burdened with the implementation of the marriage (Handoyo & Rohayuningsih, 2013). Such contracts are considered to be unfair to women; men have freedom, but women are like slaves who are vulnerable to subordinate relationships (Pateman, 2016). If there is no agreement on the duration and dowry, then the marriage is considered to be invalid. In marriage contracts, there are conditions related to limiting the time mentioned in the marriage contract itself (Rais, 2014).

In marriage contracts, the consequences for the women are that there is no obligation for the husband to support his wife and there is no mechanism for there to be an inheritance between the husband and wife (Handoyo, 2013). In addition, women cannot sue for domestic violence by their husbands and the husbands easily escape from their responsibilities (Adillah, 2011).

Women are known to be infected by sexually transmitted diseases caused by sexual violence, the marriage taking place at an early age, and unsafe sexual relations (Mulia, 2018). The Natsal Survey notes that HIV / AIDS cases in Indonesia are very high due to commercial sexual relations and improper medical treatment (Johnson, *et al.* 2001). In addition, women will not easily tell others of their complaints related to sexual diseases for reasons of shame, taboo, and violating the rules of decency which occurs due to the patriarchal society (Braun, 1999).

In fact, the task of health care is to provide services accurately from when the patient arrives without making mistakes (Anjaryani, 2009). This limited knowledge results in the women never detecting sexually transmitted diseases early which means that the women are at a greater risk of contracting sexually transmitted diseases than those who detect diseases early (Saraswati, 2011). Women prefer this type of treatment because of their pragmatic attitude in addition to the geographical fact of social life that is still very traditional (Bhasin, 2004).

Information about sexuality cannot touch on these issues in society because of the taboo and dangerous assumptions that are controlled through moral and religious discourse. This means that the women do not get access to information on their reproductive health (Pakasi & Kartikawati, 2013). Even the health programs aimed at dealing with sexual diseases make people worried about the negative effects of the programs or health discussions, so the women often receive incorrect information (Malekafzali, 2004). Women's reproductive health is considered to be 'taboo' by Muslim clerics as it relates to the concept of 'nakedness'. The concept is caused by the dominance or the strength of the taboo myths in society about women's bodies and sexuality which cannot be released from the symbolic power and prevailing gender relations (Saptandari,

2013). As a result, they do not understand much about reproductive health information for women due to these stereotypes (Chrisler, 2013).

Due to the "taboo" of discussing sexual and reproductive issues publicly and openly, women do not adequately receive related information (Syaefudin, 2003). During this time, sexual problems are only understood as something that is pornographic and personal in nature. The notion of sexuality is still interpreted very narrowly as it is only limited to intimate relationships (Sugiasih, 2011). Moyer-Guse, Chung, & Jain's study (2011) explains that individuals and communities often avoid talking about sexual history and reproductive health which means that they do not have knowledge of various sexually transmitted diseases. The role of religious ideology in maintaining political control is the most powerful manifestation in the field of reproductive health issues related to the sexual control over women. This situation is part of a patriarchal ideology that exerts social control over women including over their body and sexuality which is very unfavourable for women (Purnomo, 2012).

Brewster et al. (1998) explained that religion has become a control variable. The community recognizes the importance of its aspects without understanding its impact in detail. Religion is more widely seen as a conservative force. One feminist argues that because the regulators are almost all male, it is not surprising that religion and religious change rarely has an emancipatory nature in relation to women (Moore, 1998). This can be seen in the religion of Islam in which only a few women appear in history and history is recorded by men (Nurmila, 2015). Hopkins (2009) stated that masculinity in men is easier to build as part of a gender identity than it is in women. It is easily built in terms of the power and control within the patriarchy that the participants religiously agree to. As a result, the interpretation of the teachings and laws of religion, which puts women lower than men, affects the norms, habits and actions of the community, which is known as the patriarchy (Fakih, 1997; Khotimah, 2009).

In addition to culture, women's reproductive rights are also strongly associated with poverty. They also find it difficult to get access to social support which is very important for their emotional health (Susanti, 2018). The poverty factor is very influential in relation to the quality of life and women's reproductive health. Economic dependence makes it difficult for women to control themselves so as not to be infected with sexual disease, which often drags women into risky sexual behaviour (State Ministry for Women's Empowerment, 2008). Kaufman's study (2002) in China states that disease has a strong correlation with poverty which is the reason why women have reproductive problems. Incompetence and ignorance related to gaining access and information are related to reproductive health, buying qualified contraceptives, and paying for USG. This is so then abnormal conditions in the womb can be detected, resulting in the neglect of the reproductive rights of women. This leads to a very high maternal mortality rate (307:100.000 or the highest in ASEAN). The UN AIDS Agency or UNAIDS says that more than 1.7 million women in Asia are living with HIV and 90% are infected by their husbands. This vulnerability occurs due to the ignorance of women on sexual relations problems. They are reluctant to find out the problem from their partner. This, coupled with economic inequality, causes the women's bargaining position to still be low (Dalimoenthe, 2011). Roa's study (2016) states that women do not have control over their sexual and reproductive life because of the poor quality of their sex education, their lack of access to contraception, the very high prevalence of rape, and the cultural barriers that result in women being unable to negotiate their own reproductive health. Reproductive health is one of the determinants (cornerstone) of development programs in a country. This is in accordance with the millennium development goals to be achieved by Indonesia.

Studies on reproductive health have been carried out by previous researchers but studies on reproductive health in contract marriages have not been studied much. This study explores how reproductive health rights for women who experience marriage contracts are socialized in Cisarua, Bogor, West Java Province and Rembang, Pasuruan, East Java Province, Indonesia.

Method

To obtain the empirical data, this research used the descriptive qualitative method. There were several steps involved in this study. First, there was the determination of the research settings done in a purposive manner, ie Kalisat village, Rembang subdistrict, Pasuruan regency and Warungkaleng region in South and North Tugu, Cisarua subdistrict, Bogor regency. The two settings of the Pasuruan and Bogor regencies were selected because these two regions have forms of marriage that are different from the other forms of marriage in society. This can be seen from the fact that most women in the overall setting practice marriage contracts. The populations, especially the women, were primarily categorized as poor in 2012, i.e. 15,760 individuals in Pasuruan and 42,328 people in Bogor. In addition, the majority of the population in the regencies are Muslim, who obey the teachings of Islam. Reproductive health problems are also quite common, and they have always been silenced because they are considered to be a taboo to talk about. The second stage of the data collection consists of observations and in-depth interviews.

In the observation, social interactions were used to find out about the reproductive health issues of women who are in a marriage contract, how they access reproductive health services as well as religious texts and the *kyais'* responses to the problem of reproductive health of women who are in a marriage contract. In-depth interviews encompass the views of the women who are in a marriage contract despite their own reproductive health as well as the discourse of *kyais* against the marriage, which impacts on the women's reproductive health. The researchers conducted in-depth interviews with 112 (one hundred twelve) informants: 76 (seventy six) women who were in a marriage contract that impacts information on the women's reproductive health, 6 (six) *kyais* that have knowledge about marriage contracts, 6 (six) brokers, 4 (four) villa guards, 4 (four) tour guides, 10 (ten) motorcycle drivers, 2 (two) doctors and 4 (four) midwives who control reproductive health among the women in a marriage contract.

The third stage was the determination of informants, i.e. women who are in a marriage contract and who have problems with their reproductive health. This was in addition to the *kyais* who engage in religious discourse and who respond to reproductive health problems. This also included the midwives, cadres and heads of the health centres and related agencies and local NGOs linked to reproductive health problems. The last phase was the data analysis. The data was collected, classified, and identified by giving meaning to the themes and sub-themes in accordance with the purpose of this research.

Results and Discussion: The Reproductive Health Conditions of Women under Marriage Contracts

This study shows that the marriage contract does not always imply the occurrence of sexual intercourse. Sexual intercourse in the marriage contract may happen if it becomes part of the terms agreed. The practice of contract marriage is justification based on male sexual needs that are not being met and it prevents the practice of prostitution (Safitri, 2013). Sexual

intercourse has become legal because of marriage so intimate contact is made only with men who are legitimate husbands (Mikhail, 2002). Couples who are in a marriage contract may not establish a sexual relationship if it is not part of the deal. A religious figure named Hilal stated that the main purpose of a marriage contract is to prevent adultery. The statement clearly shows that a marriage contract does not necessarily imply the occurrence of sexual intercourse. In the event of sexual relations, one of the goals is economic orientation, especially for women (Arsal, 2012). As Hilal stated, *"For example, if there is a consensus in the marriage to do sexual relationship, it means the intercourse is legal. What if she's pregnant?! Well, it's okay. It's their risk."* When sexual intercourse becomes part of the agreement, the consequences (pregnancy and childbirth) remain the responsibility of the men. In essence, there is a similarity between a marriage that is contractual and permanent in terms of men's responsibilities regarding the wife's pregnancy. The consequence that is pregnancy is determined according to a joint agreement (Nurlimah, 2013). Meanwhile, in Sunni marriage, mut'ah has the risk that a woman cannot refuse sexual intercourse. However, she is burdened with the responsibility of preventing pregnancy while the husband has the ability to deny that he is the perpetrator of the pregnancy (Kara, 2011; Safitri, 2013; Turnbull, 2019).

This study also looks at the status of children born through a marriage contract, which is different to that of children of a legal marriage. Children born under legal marriage are directly registered to the Religious Affairs Office and the Civil Registry Office. Meanwhile, for children born from marriages in siri or a marriage contract, they have an illegitimate status before the law which results in their birth certificates stating that they are out-of-wedlock children (Nama, 2014; Adillah, 2011). The same thing happens in Iran where the marriages are not registered through state law. Therefore, a father cannot recognize their child through an illegitimate marriage, which has an impact on their inheritance rights (Ansari-Pour, 1999; Handoyo, 2013; Shafra, 2010). According to Hilal, the clarity of the status of children born under a marriage contract must be done through a particular arrangement. This is especially the case with the rights of children who have the same position as children born in permanent marriages (Rais, 2014). A marriage that is not registered in the country is prone to the emergence of the stigma of "illegitimate child" if the marriage results in a child (Isnaini, 2014). Shrage's study (2013) stated that although contract marriages cause the status of children not recognized by the state, in reality the state is still present when it comes to protecting the welfare of children with various facilities. *"So, if the contract wants to be compromised by the law in Indonesia, it should be arranged in a certain way"*. As in legal marriage in general, the reproductive rights of women in a marriage contract are also of concern. Hilal asserted that all forms of women's reproductive rights such as the desire to be pregnant or not, even though they still perform sexual activities, in addition to the desire to impose contraception or not, are based on the agreement of both parties in the marriage contract. If women and men engage in sexual activity in the contract marriage, then it is necessary to wait for the iddah period after divorce. If there is no sexual activity in the agreement then there is no need to wait for the iddah period (Ribowo, 2017). Al-Ali's study (2016) on sexual activity in contract marriages is that it not only occurs to legalize prostitution but that it is also used to provide mutually beneficial sexual relations.

The reproductive health conditions of women in marriage contracts who are generally poor are very alarming. Contract marriages involving female commercial sex workers who are underage certainly has a large impact, including the likelihood of dying from pregnancy and sexual activity due to the health of their reproductive organs (Djamilah & Kartikawati, 2014). Decker's study (2010) in China found that women who work with multiple partners can be said

to be included in human trafficking who are at risk of being threatened with HIV / AIDS. Unfortunately, there have been no investigations into human trafficking in the sphere of reproductive health concerning the victims. This was as stated by Emma, who resides in Warungkaleng and works as a midwife in the village. In addition to being a midwife, she also works as a nurse at Cisarua Hospital, Bogor. At her house, there is a maternity clinic.

"I've been asked by a woman named Elis to give her a birth planning injection. Before injecting, I asked her where she lived and whether she had already had a husband. When I asked her, she admitted that she lived in Warungkaleng and that she already had a husband. After some time, she came back to my house and requested to be injected again. I suspected something because she came too often to ask for the injection. So, I asked about her origins and she finally admitted that she is a prostitute from Sukabumi."

Based on Emma's statement above, her clinic is rarely visited by a patient who is a prostitute and who has problems with her reproduction organs. In fact, the practice of contract marriages that has led to covert prostitution ignores women's health and reproductive rights such as the threat of HIV / ADIS, acts of sexual violence, unwanted pregnancy, and safe choices of contraception (Suryandaru, 2011). Royce (1997) found that in Thailand, the practice of commercial sex work has resulted in a mandatory condom policy. The condoms are distributed free of charge and sanctions are imposed if they are not used. Emma's statement is similar to Doctor Urip's statement. He is a public doctor at a clinic located in Tugu (Warungkaleng area):

"The prostitution practice often happens in Warungkaleng so there are many venereal disease problems such as vaginal discharge. The detection of vaginal discharge in women is difficult, because women hide the disease. Cases of vaginal discharge often happen in Warungkaleng area. It does not only affect sex workers, but also housewives. Treatment is given via antibiotics and injecting a drug into the vagina."

Rita Nauli Tambunan, as a nurse at Lung Hospital (skin and venereal diseases department) in Cisarua, Bogor, also explained that the *"disease that is commonly suffered by the women in Cisarua is vaginal discharge, which causes spots of blood every day"*. For women who have a better education, they know the symptoms of sexually transmitted diseases and they can mention the characteristics of the disease. For women with low education, they do not know about sexually transmitted diseases; all they know is that vaginal discharge is a disease (Matahari, 2012). Znazen et al. (2010) showed that 33.5% of female sex workers had genital tract infections and that they were susceptible to upper genital tract infections and required gynecologic surgery. Furthermore, Rita Nauli Tambunan added that:

"The hospital around here does not provide counseling about sexually transmitted diseases or reproductive health to the citizens because it specializes in lung disease. Incomplete equipment is also the reason the hospital does not perform advanced handling. The treatment at the local hospital is limited to the initial treatment, especially of diseases that are not categorized as a critical illness. This is by the means of compression by using PK/ red liquid / NaCl. Then the patients

are told to come back a week after the initial treatment to be given further treatment by being giving an ointment. To speed up the treatment, if there is a patient who wanted a speedy recovery then there is another treatment that involves injecting a drug into the genital's left and right parts."

Doctor Urip also declared that *"the task of the clinic is only identifying and curing, so there's no effort to prevent a disease."* A lack of socialization on the importance of reproductive health and the difficulty related to accessing health care for women in a marriage contract who also happen to be poor is the main cause. To monitor the spread of sexually transmitted diseases, there are various types of HIV / AIDS infection counselling services, pap smears and STI tests. However, many women are still reluctant to use these services because of their low self-awareness (Siwi, 2018). Gage's study (1998) in Zimbabwe showed that sometimes socialization related to reproductive health is hindered by the customs and culture in the community which considers the use of condoms to reduce sexual satisfaction. Besides that, information about how to maintain good health at a low cost is also limited. Marriage contracts allow for multiple partners so then there is a risk of transmitting sexually transmitted infections. This is where pimps and marriages contracts are not concerned with health factors but instead, they have a money orientation (Matahari, 2012). According to the Women's Development Index (WDI), the number of poor women in Indonesia is high, i.e. around 111 million individuals. The vulnerability experienced by women who are in marriage contracts is because they face a higher level of risk of HIV / AIDS. This can be said to be a violation of health and human rights (Decker *et al.* 2011).

It can be seen that reproductive health is not always about the physical problems that can be solved medically. Even though the contracting woman is afraid of sin and God and so she is intensely engaged in religious activities, this action only slightly reduces the psychological burden (Putri & Sutarmanto, 2009). The psychological burden experienced by these women tends to lead to the stigma given by society, their emotions, and anxiety (Vanwesenbeeck, 2005). Alif's study (2015) shows that the psychological burden of women who are in a contract marriage is caused by a lack of legal protection and the poor rights of the women as wives. The marriages that occur between young women and older foreign men place a psychological burden on the women (Ahmady, 2019). In addition, their status must also be of a socially healthy condition, meaning that each person has the right to access the health services that will enable them, especially women, to use their reproductive functions in a healthy manner. Furthermore, there is the additional factor of being economically viable, meaning that the women should be in a good economic condition in order to fulfill their reproductive health as stated by Dr. Urip: *"When a patient was told to come back again, she did not return. Probably she is contemplating her illness. In most cases like this, the patients do not know about the cause of their reproductive health because of the educational background factor. They still indicate money as being the most important thing to earn."* When infected with a sexually transmitted disease, these women only rely on antiretroviral drugs as these drugs weaken the development of the virus (Demartoto, Gerilyawati, & Sudiby, 2014).

Thus, talking about reproductive rights means talking about a broad spectrum, thus covering the relationship between men and women in both the public and domestic areas. The focus of reproductive health is divided into marital problems, pregnancy, birth, nursing and childcare. The equality of contract marriage with adultery is the lack of commitment to have children. But if in a contract marriage the woman gives birth to a child, then child care depends

on the attitude of the parents. Sometimes the parents react negatively so the child makes the assumption that he was born unloved (Stevani, 2016). It also includes the issue of abortion, sexually-transmitted disease (STD), HIV and AIDS, family planning, contraception, and sexual behavior problems. A lack of access to information by the temporarily-married women who are poor results in their lack of understanding of the meaning and significance of reproductive health. Rita Nauli Tambunan said that:

"Before being taken to the hospital, the patients tend to treat the disease themselves by getting medicines sold in local shops. Once they cannot treat it further, they are taken to hospital. For the initial handling, there is also a treatment that involves using betel leaf but such a treatment, if done carelessly, can lead to decomposition. Sex workers who suffer from venereal disease or those who are in the guise of a marriage contract mostly prefer to trust doctors at the local clinics because the costs incurred in the hospital when compared with the costs incurred in the clinic are significantly different. This is because the hospital requires the patients to do a laboratory test in advance if the disease is critical, while at a clinic they are only given brief treatment that is not time-consuming and costly".

The condition of women in a marriage contract is that they are generally poor and less educated. This impacts on their low level of awareness of the importance of reproductive health. Knowledge about reproductive health is not a priority for them because they are more focused on working for the sake of survival. They are generally not able to access health care because they do not have the money to do so. Meanwhile, the purpose of her working as a sex worker is to make money that can only be used for living expenses and other necessities (Munawaroh, 2010). Marseille et al. (2001), on sex workers in rural South Africa, showed that the cost of treating a sex worker is far above their compensation or insurance, which is nine dollars from their compensation. The treatment of syphilis and gonorrhoea is twelve dollars. In addition, poor women who live in remote villages also have access problems concerning the health centres. The environment in which the women live also contributes to the women's health. This is because their social networks do not support the women's health factors (Kurniawan, Asmika, & Sarwono, 2013). Utomo's study (2007) explains that the HIV / AIDS epidemic (spread rate) in Indonesia is increasingly worrying in several provinces such as DKI Jakarta, Bali, Papua and the Riau Islands. The HIV prevalence rate in commercial sex workers is between 5% and 20%, and the rate of injecting drug abuse is between 50% and 70%. The facility of Community Health Insurance, in its involved processes, is difficult to implement. The cumbersome procedures become obstacles for a woman who wants to get their health care sorted quickly. Some of the complaints from people who have their health insurance issued by the state is the long queue for services, the patients not being handled immediately, the referral procedures still being complicated, and delays in the distribution of insurance cards (Siswoyo, Prabandari, & Hendartini, 2015). D'Ambruso et al. (2009) illustrated that the patients in rural areas do not have an understanding of insurance and they are prepared for only a few health ailments. They are also unaware of the benefits of health insurance and there is no established community as seen by looking at the village's preparedness.

The Use of Contraceptives Among Women in a Marriage Contract

With regard to the issue of contraception, the health care workers who are assigned to provide counselling to women do not provide sufficient information. For example, when a health care worker provides counselling on contraception, the information provided is only limited to the examples and how to use them. They often do not explain the impact of the use of contraception. They also do not explain the appropriate choices in accordance with the physical condition of the woman, as every woman has a different physical condition. Meanwhile, the reproductive rights of women do not only consist of marriage, pregnancy, birth and child care. Reproductive rights also include discussions on abortion, prostitution, sexually-transmitted diseases including HIV / AIDS, and contraception and all of the related problems (Mulia, 2018). Kurniawan, Asmika, & Sarwono (2013) found that sex workers who have a history of parity have good knowledge about contraception and they often visit the clinic to get information about cervical carcinoma. Meanwhile in Cambodia, the absorption rate of contraceptives for sex workers is very low at only 3%. The reason for this is that they are forced by their clients to have unprotected sex and consequently their HIV / AIDS prevalence is higher than sex workers who have children and who use contraception (Morineau et al. 2011).

Women in a marriage contract who are generally contraception users are not equipped with an understanding of the risks of using contraception. They do not know the impact of each contraceptive on the disease that they are suffering from which could grow pathogenic bacteria, which can cause serious illness (Nindrea, 2017). Matahari (2012) found that sex workers with a good understanding of condoms know them not only to be a type of contraception but also as a contributor to the spread of sexually-transmitted diseases. Sex workers with a low understanding only know condoms as a "safety" tool related to pregnancy. Female sex workers prefer oral contraceptives (birth control pills) because they are cheap, but they have risks if consumed for more than 4 years. They can increase the risk of uterine cancer by 1.5 - 2.5 times (Retnowati, Rauf, & Masadah, 2006). Another problem is a lack of contraception as they cannot be accessed by the poor for free. A lot of the contraceptions provided by the midwives or pharmacies are expensive. Contraception services are a lucrative business for medical personnel in the villages. Once the women in a marriage contract come to the clinic, they will be directly asked whether they want the contraception at Rp 10,000 or Rp 15,000. There is no explanation of what to choose and what their impact is. When being asked about the risks, the women easily answer that if it does not fit their need, then they are to just change it for the other one. It is simple and easy--as simple as their knowledge of reproductive health. The choice of safe contraception is expensive compared to their cheap sex costs, so they ignore this (Morineau et al. 2001). Delvaux's study (2003) in Cambodia stated that sex workers prefer contraception in the form of pills and condoms whereas IUDs and injections are very rare. They only stop using contraception when there is no menstruation, if they have a stomach ache, when there are price problems or because they don't have a boyfriend.

Another problem is that many of the medical workers are not gender sensitive. When a woman wants to get a pap smear check, the question that immediately arises is whether her status is "Missus (Mrs)" or "Miss"? If the answer is "Miss", then the questions would continue on to things that are personal, thus discrediting the patient with a negative stigma. This makes the women think twice about seeing a doctor even if it was on their own consciousness. Some of the reasons why women don't want to have a pap smear is that their knowledge of cervical cancer is still low, that they are lazy, and they think that they don't require a doctor (Kurniawan, 2013). This is in line with the study conducted by Ramadhan, Ade, & Suyanto (2016) explaining that

the early detection of cervical cancer in Indonesia is very low. Only 5% of Indonesian women are exposed to pap smears and IVA due to the low knowledge of Indonesian women about the dangers of cervical cancer.

Conclusion

The marriage contract in Indonesia shares some similarities with marriages in a number of developing countries where women are considered to be merchandise. The difference is that the marriage contract in Indonesia is temporary or only for a certain agreed duration which has a negative effect on the reproductive health of women. Pregnancy, birth and the presence of children born in a marriage contract are part of the agreement. Women do not fully have control over their reproductive rights in the marriage contract. Poverty and the lack of education present in such a marriage has an impact on the low level of awareness of the importance of understanding reproductive consciousness.

In the marriage contract, the reproductive rights of the women are not in control of the women themselves. Rather, they need to be considered by the male partner. It has been proven that women do not fully have control over their reproductive rights in a marriage contract. Their reproductive health is not a priority because they are more focused on working for the sake of survival.

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