Adolescent and Youth Reproductive Health in Indonesia

Status, Issues, Policies, and Programs

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ADOLESCENT REPRODUCTIVE HEALTH IN INDONESIA

Status, Policies, Programs, and Issues

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POLICY Project

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Abbreviations

ABCs of sex	Abstinence, Be faithful, or use Condoms
AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
BKR	Program Bina Keluarga Anak dan Remaja (Program Support for Families of Adolescents)
CBS	Central Bureau of Statistics
CEDPA	Centre for Development and Population Activities
DIY	Daerah Istimewa Yogyakarta
DOH	Department of Health
FP	Family planning
HIV	Human immuno-deficiency virus
IDHS	Indonesia Demographic and Health Survey
IEC	Information, education, and communication
ILO	International Labor Organization
IPPA	Indonesian Planned Parenthood Association
NFPCB/BKKBN	National Family Planning Coordinating Board
NPWP	Issuance of Principal Tax Number
RSKO	Rumah Sakit Ketergantungan Obat (Drug-dependence Hospital)
RTI	Research Triangle Institute
STARH	Sustaining Technological Achievements in Reproductive Health
STI	Sexually transmitted disease
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
YKB	Yayasan Kusuma Buana
YPI	Yayasan Pelita Ilmu

1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Indonesia is part of a series of assessments in 13 countries in Asia and the Near East.[1] The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Indonesia.

Adolescence can be defined as the bridge between childhood and adulthood. It is a time of rapid development—growing to sexual maturity, discovering oneself, defining personal values, and finding or being assigned vocational and social directions.[2] The period of young adulthood is characterized by a very "demographically dense phase," meaning that it is in this age group that more demographic actions occur than at any other stage in life. Fertility, residential mobility, and marriage are highest in this age group. The density of events during the adolescent years is even more dramatic during periods of rapid social change because "young people are typically the engines of social change." Young people are moving, acquiring more education, and filling new occupations.[3] Young people have more freedom than older people to respond to changing circumstances. What makes this age group different from any other life stage, however, is its emerging reproductive capability; sexuality is a major theme, especially among adolescents.[4]

Young people today face a far more complex world in terms of globalization, the spread of mass media, increased international migration, economic and political crisis, global violence and war, and increasing access to drugs and alcohol. The perception of adolescence as a difficult and problematic stage adds to the social stigma that adolescents must cope with, particularly adolescent males who are labeled by society as prone to risky behaviors.[5] Indeed, young people are highly vulnerable to exposure to various risks and health risks in particular, especially those related to sex and reproduction.

In 2000, there were 43.3 million young people ages 15–24 in Indonesia (Figure 1), comprising 21 percent of the total population. In 2020, the UN projects a population of 41.4 million young people ages 15–24—15.8 percent of the population. Figure 2 shows that educational attainment has increased for both girls and boys. While a larger percentage of boys compared with girls have completed a secondary education or more, larger percentages of girls compared with boys are in the no education, primary incomplete, and completed primary/some secondary school categories. More young men than young women work (Figure 3). Marriage and childbearing are socially important. In 2000, ever-married women ages 15–24 contributed nearly 2.1 million births to Indonesia's total fertility, and that number will continue to rise through 2020 (Figure 4). Unmet need for family planning among ever-married women ages 15–19 declined from 15.6 percent in 1991 to 9.1 percent in 1997, and among ever-married women ages 20–24 it declined from 13.6 percent in 1991 to 8.6 percent in 1997.

[1] The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.
[2] Manaster, 1989.
[3] Rindfuss, 1991.
[4] Chilman, 1980.
[5] Hawkes, 2001.

Since 2000, Indonesia has made some progress in identifying the reproductive health needs of adolescents and in defining policy options. There is a recognized need for better sex and reproductive health education in schools, particularly in light of the growing epidemic of sexually transmitted infections (STIs) and HIV/AIDS in the country. However, due to political sensitivity surrounding the issue of ARH, policy dialogue has yet to be translated into programs serving the needs of adolescents. Urgent policy issues include reviewing the Law on Population Development and Family Welfare, Law No. 10/1992 and revising it to ensure that reproductive health and life skills education are in the school curricula and the restriction of family planning services for single young people is lifted. Reproductive health services for single young people should be provided and offered in a friendly and confidential environment so that those in need may access services without being stigmatized.

Additionally, Law No. 23/1992 defines abortion as illegal. Section 2, paragraph (1 and 2) states:

> *In case of emergency, and with the purpose of saving the life of a pregnant woman or her fetus, it is permissible to carry out certain medical procedures.*
>
> *Medical procedures in the form of abortion, for any reason, are forbidden as they violate legal norms, ethical norms, and norms of propriety. Nevertheless, in case of emergency and with the purpose of saving the life of a pregnant woman and/or the fetus in her womb, it is permissible to carry out certain medical procedures.*

The law, however, contradicts itself. On the one hand, if the life of the pregnant woman is threatened, abortion under certain medical procedures is necessary. On the other hand, such medical procedures for any reason violate legal norms. Thus, if confronted with premarital pregnancies, female adolescents often turn to unsafe abortion and risk their lives in the hands of unprofessional assistants and traditional healers. Marriage Law No. 1/1974, which gives authorization to 16 year-old girls and 19 year-old boys to get married, should also be reviewed.

Although more than one in five Indonesians is between 15 and 24 years old, Indonesia's policy and program agendas have neglected adolescents and have primarily concentrated on improving the survival and development of under-fives and elementary school-age children.[6] Hence, Indonesia's adolescents and youth remain poorly prepared for the reproductive health challenges and responsibilities they will face as they move into their reproductive years.[7]

[6] Government of Indonesia and UNICEF, 2000.
[7] Wilopo et. al., 1999.

Figure 1. Total Adolescent Population
(Ages 15-24)

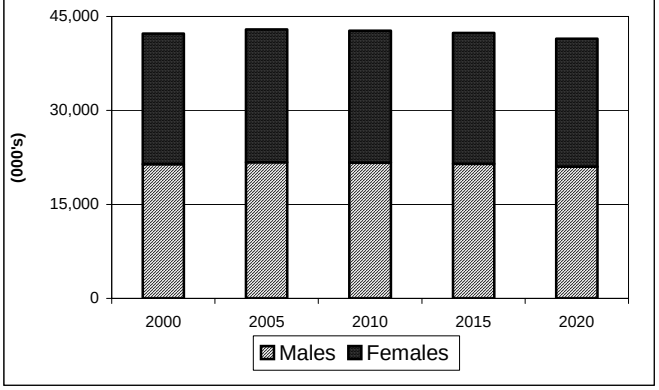


Figure 2. Years of Education Completed
(Ages 15-24)

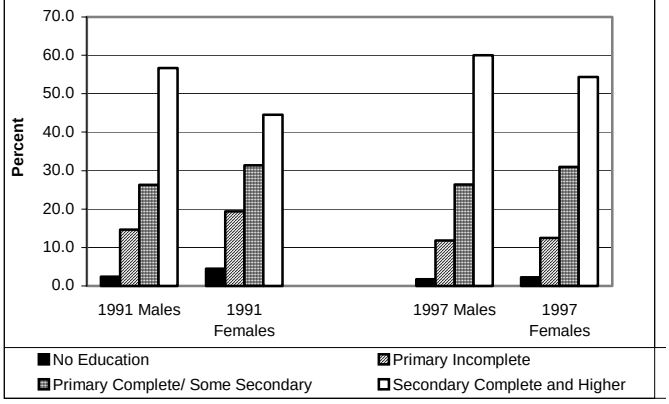


Figure 3. Employment by Sex
(Ages 15-24)

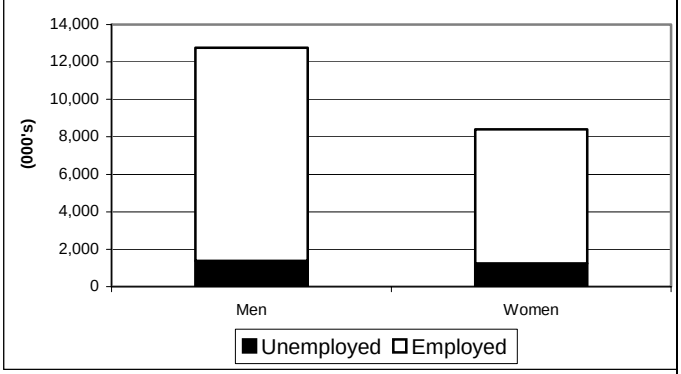


Figure 4. Annual Pregnancies and Outcomes
(Ages 15-24)

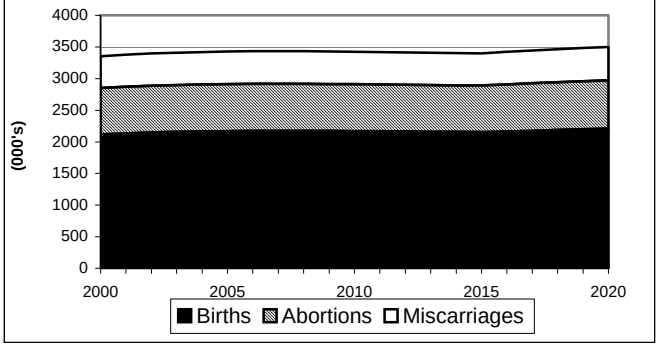
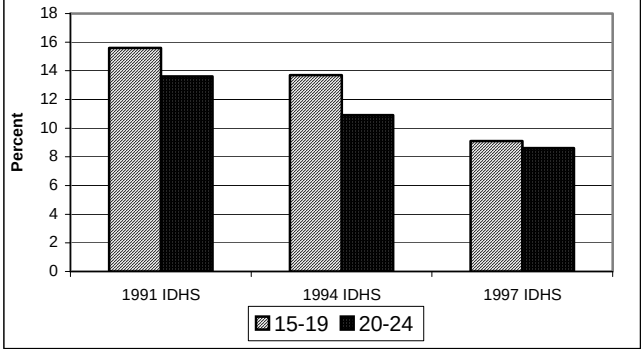


Figure 5. Total Unmet Need for FP
(Ages 15-24)



Note: See Appendix 1 for the data for Figures 1 through 5

2 SOCIAL CONTEXT OF ARH

Gender socialization

In Indonesia's patriarchal society, the socialization process strongly emphasizes that women's roles are in the domestic sphere, including childbearing and childrearing.[8] Even though more Indonesian women in urban areas are educated and are able to develop professional careers, marriage and having and rasing children are still universal norms. Women's voices are generally heard for day-to-day things, while men still dominate most major decisions in the family.[9] The girl children in the family have been trained to be responsible for domestic chores and care giving. For a female, being *nrimo*—passive and trying to accept everything that happens to her—is highly praised by society. An Indonesian woman is taught to submit, maintain harmony in her family, and devote her life to domestic concerns and her family's well-being rather than be concerned with global issues.

Despite policy and laws that have supported women's enhancement and development, these generally have not had an impact on the socio-cultural and religious values that establish the domestic sphere as women's domain. According to popular belief, reproductive health responsibilities, pregnancy and delivery, childrearing, and family care are women's noble duties as prescribed by Allah and enforced by social values. While only a small gap exists in education between young men and young women, larger gender gaps exist in employment, professional careers, and in the social and political arenas (See Appendix: Laws and Policies on Gender in Indonesia). [10]

Education

Nine years of compulsory education—six years of elementary plus three years of junior high school—for both males and females began in 1993. [11] Children start public school at age six. Educational attainment has risen over the years, although a small gap still persists between male and female educational levels and between educational attainment in urban and rural areas. In 1997, in both urban and rural areas, more females than males age 10 and older were illiterate.[12] Table 1 indicates that in 1998, 33 percent of children ages 15–19 in urban areas and 60 percent in rural areas were no longer attending school.[13] Eighteen percent of 20–24 year-olds in urban areas were still in school, compared to 3 percent in rural areas. During the 1994/95 academic year, net enrolment rates were 95 percent in elementary school, 43 percent in junior secondary school, and 35 percent in senior secondary school. The continuation rates were 67 percent for elementary school to junior secondary school and 34 percent for junior secondary to senior secondary school.[14]

[8] Utomo and Hasmi, 2000.
[9] Hardee et al., 1999.
[10] Utomo, 2000.
[11] Wahjoetomo, 1993.
[12] CBS, 1998.
[13] CBS, 1998.
[14] Ministry of Education and Culture, 1998.

Table 1. School attendance status, by residence and age group, Indonesia: 1998

Residence and Age Group	School Attendance Status		
	No Schooling	Attending School	No Longer Attending School
Urban			
5–9	28.3	71.7	0.3
10–14	0.3	95.0	4.7
15–19	0.4	66.4	33.2
20–24	0.6	18.0	81.5
Rural			
5–9	35.5	64.0	0.5
10–14	1.3	87.7	11.1
15–19	1.8	38.5	59.6
20–24	2.6	3.1	94.3
Total			
5–9	33.2	66.4	0.4
10–14	0.9	90.2	8.9
15–19	1.3	49.9	48.8
20–24	1.7	9.7	88.6

Source: CBS, 1998.

Employment

In 2000, of 100 females ages 15–64, 43 were working, 40 were not working, seven were enrolled in school, and 10 were involved with other activities. Of 100 men, 78 were working, one was not working, eight were enrolled in school, and 13 were doing other activities.[15] The number of women working fewer than 35 hours per week is higher than that of men. In 2000, 40 percent of women age 15 years and older were involved in housekeeping as their main activity, compared with 1 percent of men. Women who were working generally worked as unpaid family workers (35%), compared with 9 percent of men.

Table 2 presents the situation of young women ages 10–24 who are either in school or currently working. The past 20 years (1971 to 1990) has seen a significant rise in the percentage of young women ages 10–19 reported as currently in enrolled school. Among women ages 20–24, nearly 40 percent work in the formal sector while 7 percent continue to study (compared to 29% and 3%, respectively, in 1971).[16]

[15] CBS, 2001.
[16] Hull, 2002.

Table 2. Young Indonesian women, by school and work: 1971–1990

Schooling and Formal Work Status	Year		
	1971	1980	1990
Percentage currently in school among:			
10–14 year-olds	57.5	77.6	82.5
15–19 year-olds	17.0	26.0	37.3
20–24 year-olds	3.0	3.9	7.2
Percentage currently working in the formal sector among:			
10–14 year-olds	10.8	9.0	8.1
15–19 year-olds	26.6	29.8	30.3
20–24 year-olds	29.1	32.7	39.3

Source: Calculated by Hull (2002) from census reports published by the Central Bureau of Statistics. Results for 2000 due out in early 2002.

Few women are involved in political life, so young women have few female role models in the political sphere. Political decision-making power has always been within the male domain, although the current President of Indonesia is a woman—Megawati Sukarnoputri (the daughter of the late President Sukarno). Nevertheless, before her appointment, Megawati was opposed by many religious leaders who think that having a women president is not acceptable under Islam.[17] Megawati was also not popular among women activists because she was not particularly sensitive to gender issues; even though she is a woman president, women's issues and welfare may not be a high priority in her policy agenda.[18] In 1999, out of 25 officials of the First and Second Echelon,[19] only one was female. The Indonesian Legislatives Bodies also have few women. In 1999, the People's Consultative Assembly and the House of Representatives had an 11:1 ratio of men to women, the Supreme Advisory had 37:1, and the Supreme Court had 8:1.[20]

Marriage and fertility

Getting married and having children are still universal norms in Indonesia. Even though "love marriages" are now more common than arranged marriages (which were very common until the late 1970s),[21] young women and men who are economically independent and have secure professional positions still consider marriage and children a must and wouldn't feel complete remaining single. The socio-cultural and religious pressures are quite strong in this regard, thus parents, relatives, friends, peers, and work colleagues motivate people who are still single to marry. Young girls have been traditionally socialized to be good wives and mothers, and maintaining a beautiful appearance to attract a future husband and preparing for marriage represents its own type of career path, to which many young women aspire.[22]

[17] Sen, 2002.
[18] Oey-Gardiner, 2002.
[19] The First and Second Echelon are high government officials' positions directly under the Minister. Officials in this category are entitled to several benefits, including housing, cars, and additional monthly routine expenses in addition to their monthly salaries.
[20] CBS, 2001.
[21] Hull, 2002; Jones, 1994; Hull and Hull, 1984.
[22] Nilan, 2001.

Indonesian Marriage Law No. 1/1974 prescribes the minimum legal age for women to get married as 16 and 19 for men.[23] The actual estimated mean age at marriage is higher for urban areas compared with rural areas and has increased over time. In 1971, the mean age at marriage in rural areas was 18.8 years while in urban areas it was 21.1 years. In 1990, the mean age at marriage increased to 20.5 in rural areas and 23.5 in urban areas.[24] Table 3 shows median age at marriage among women ages 25–49 in 1994. The median age at marriage is higher among younger women ages 25–29 compared with women ages 45–49.

Table 3. Median age at first marriage for women ages 25–49, by current age and residence, Indonesia: 1994

Residence	Current Age					
	25–29	30–34	35–39	40–44	45–49	Total (25–49)
Urban	22.0	19.6	19.7	18.8	18.5	20.0
Rural	18.1	17.6	17.1	16.7	16.5	17.4
Total	*19.2*	*18.2*	*17.9*	*17.3*	*17.2*	*18.1*

Source: CBS et al., 1994.

Fertility and age at first birth

The total fertility rate (TFR) for Indonesia has decreased dramatically from 5.6 births per woman in 1971 to 2.8 in 1997. It is projected that by 2020, the TFR will reach replacement level (2.1 births per woman).[25] Even though the TFR is decreasing, Indonesia's maternal mortality rate is among the highest in Southeast Asia. It is estimated that two women die in Indonesia every hour due to pregnancy and childbirth complications. The leading cause of these deaths is bleeding related to pregnancy and childbirth, which can be fatal after just two hours.[26]

Fertility data among teenagers and young adults who are still single are not available in Indonesia because the Indonesia Demographic and Health Surveys (IDHS) only covered married women of reproductive age. Table 4 describes the age-specific fertility rates (ASFR) in 1991, 1994, and 1997. Analyzing the ASFR among 15–19 year-olds and 20–24 year-olds, ASFR have decreased over time. But there is concern about births among 15–19 year-old women, because studies show that teenage pregnancy increases the risk of maternal mortality by two to four times compared with pregnant women age 20 and over.[27] Studies have also revealed that infant morbidity and mortality of babies born to teenage mothers is higher.[28] The concern is more problematic as teenage premarital pregnancies are strongly stigmatized by society. Thus it is assumed that because the government only provides reproductive health services to married women and men, unmarried teenagers experiencing pregnancy will seek illegal and clandestine abortions, which are more life-threatening.[29]

[23] Kantor Sekretariat Negara RI, 1989.
[24] Hull, 2002.
[25] Wilopo et al., 1999.
[26] State Ministry of Women Empowerment, Republic of Indonesia, 2002.
[27] Network, 1997.
[28] McDevitt et al., 1996; Population Reference Bureau, 1996.
[29] UNICEF and the National Development Agency Republic of Indonesia, 2000.

Table 4. ASFR and TFR reported by IDHS 1991, 1994, and 1997

Age Group	0–2 Years Prior to Survey		
	1991 IDHS	1994 IDHS	1997 IDHS
15–19	67	61	62
20–24	162	147	143
25–29	157	150	149
30–34	117	109	108
35–39	73	68	66
40–44	23	31	24
45–49	7	4	6
TFR (ages 15–49)	3.022	2.856	2.788

Source: CBS, et al., 1991; CBS et al., 1994; CBS et al., 1997.

3 ARH ISSUES

Indonesian young people, who are entering their reproductive years, face tremendous social change. In an era of industrialization, Westernization, information, globalization of transport and communication,[30] and social change, transformation of cultural values and traditional norms is inescapable. Indonesian youth today grow up in different surroundings from those of their parents or grandparents. Today's generation has more freedom given Indonesia's current political-economic situation. It was not until recently that Indonesian young people had the space and freedom to develop their own individuality. In the past, young Indonesians' frame of reference did not extend far beyond their immediate family and ethnic group. Today, young Indonesians, particularly in urban areas, are more exposed to education, mass media, and government programs. Thus, young Indonesians have new points of reference: their peers, families, counterparts in the Western world, schools, teachers, national identities,[31] globalization of information, and computer networks. Young people are therefore freer than their parents and grandparents in the ways they can express themselves.

In recent years, Indonesia has faced enormous social change in terms of socialization between the sexes before marriage. This has been marked by delayed first marriage, more freedom of spousal choice, an increasing number of love marriages, delayed birth of the first child, and increasing freedom for daughters, especially to get higher education and develop a career. Although high value is still attached to parenthood and marriage, today's parents encourage their children to get higher education, develop a broad perspective on knowledge, and find a career. That is why, at least among the middle and upper class, investing in a child's education by sending them to an expensive school or by sending them abroad to study is becoming an increasingly common practice. Although young Indonesians are freer to engage with the opposite sex, problems occur because they still have to cope with a lengthy period of strong sexual drive before marriage and girls try to meet the value of "staying a virgin until marriage."[32]

In the area of sexuality, young Indonesians face a conflicting situation. On the one hand, their knowledge of sexuality is limited because sex education is not formally given at school, except in certain schools—usually Catholic and Protestant religious schools. Communication between parents and children on the nature of sex is rare because of cultural, psychological, and communication problems and also because parents never had the experience of receiving this information from their own parents. Thus, most parents feel embarrassed to talk about sex with their children. Talking about sex in public is still taboo; at the state level, there is a strong belief that sex should be treated as a private matter and not a public concern. This is why policies related to sexuality are rarely designed to suit health or educational concerns. On the other hand, information on the 'Western' way of life, specifically on sexually-related information from television, films, movies, videos, magazines, books, pornographic materials,[33] and computer networks, cannot be restrained. Therefore, while young people are provoked by the media about sex and sexuality, they lack accurate information about sex, reproduction, and reproductive health. With the increasing incidence of premarital sex, pregnancies, abortions, STIs, and especially HIV/AIDS and drug use,[34] many young Indonesians, particularly in urban areas, are facing an uncertain future.

[30] Jones, 1993
[31] McDonald, 1984.
[32] For boys, however, virginity is not questioned, although they prefer to have a virgin wife. It is more acceptable for them to have paid sex with CSWs or premarital sex.
[33] Mohammad, 1981; Suyono, 1981; Suyono, 1981; Surapaty, 1991; Utomo, 1997.
[34] Brotowarsito and Roesmin, 1994; Utomo, 1995; Utomo et al., 1997; Utomo, et. al., 2000.

Premarital sexual relationships

Measuring the incidence of premarital sex in Indonesia is not easy; various small-scale studies have given different estimates of premarital sex ranging from 2 to 27 percent.[35] A 1998 study, "Adolescent reproductive health and premarital sex in Medan," showed that of unmarried young people ages 15–24 who were still in school, working, or unemployed, 27 percent of males and 9 percent of females had experienced premarital sex.[36] Table 5 provides information on sexual experiences among urban middle-class young people ages 15–24 in 1995. Among middle-class Jakartan high school and university students, 7 percent of males and 2 percent of females reported that they had ever had premarital sex. Non-Muslims were more likely than Muslims to be involved in premarital sexual behavior, although the difference is not statistically significant.[37]

Table 5. Sexual experience among young people in Jakarta, by age, sex, and religion: 1995 (percent)

Sexual Experience	Age		Sex		Religion	
	15–19	20–24	Male	Female	Muslim	Non-Muslim
Holding hands	7.7	93.3**	83.9	80.4	81.4	84.0
Hugging	57.3	82.3**	68.6	61.8	62.4	76.6*
Intense hugging	44.6	77.8**	59.7	50.7*	52.0	67.0*
Kissing cheeks	46.0	74.1**	55.9	53.6	52.0	66.0**
Lips kissing	23.5	59.5**	41.1	29.3**	33.2	41.4
Breast fondling	18.3	44.9**	33.1	21.1**	25.4	30.9
Intercourse	1.4	10.8**	6.8	2.1	3.5	7.4

Note: Test of significant difference is based on Chi Square, ** significant difference at less than 1 percent, * significant difference at less than 5 percent.
Source: Data are from the 1994/1995 Jakarta Marriage Values and Sexuality Survey. Utomo, 1997.

Interestingly, Table 6 shows that among men age 30 and older, 7.3 percent had been involved in premarital intercourse compared with 6.8 percent of young men ages 15–24.[38] For young women, the percentage reporting premarital intercourse was slightly higher (2.1%) among younger women (ages 15–24) than among women ages 30 and older (1.6%). Thus, this study did not show that the incidence of premarital sex is increasing among younger men, but it did show the incidence of premarital intercourse increasing among younger women. Utomo's (1997) study revealed that as a relationship between a man and a woman becomes more committed and moves closer toward marriage, it is more likely that a young couple from Jakarta will be involved in premarital intercourse.

[35] Utomo, 1997.
[36] Situmorang, 2001.
[37] Utomo, 1997.
[38] Utomo, 1997.

Table 6. Reported premarital sexual intercourse, by sex and age, Jakarta: 1995[a]

Experienced Sexual Intercourse	Reported Premarital Behavior Ever Experienced[b]		
	Male	Female	Total
Single Young People (15–24, N=519)	6.8	2.1	4.2
Married Older Respondents (30 and older, N=120)	7.3	1.6	4.2

Notes: The test of significant difference between the young people and the equivalent cell for older respondents is based on Chi Square, **significant difference at less than 1 percent, * significant difference at less than 5 percent.
[a] The older respondents who reported premarital behavior were asked about their experiences when they were still young and not yet married. Hence, during the older respondents' youth, age at marriage was much lower than today.
[b] Ever experienced premarital sexual behavior with the opposite sex.
Source: Data are from the 1994/1995 Jakarta Marriage Values and Sexuality Survey. Utomo, 1997.

Premarital pregnancy and premarital abortion

In Indonesia, there is still a strong stigma attached to premarital pregnancy. Thus, many premarital pregnancies result in marriage. A 1997 qualitative study found that among 44 women ages 15–24 who were or had ever been unmarried and pregnant, 26 respondents carried through with their pregnancies while 18 respondents had an abortion. Of those who continued the pregnancy, 21 respondents married while they were pregnant and 5 remained single. [39] A survey undertaken by the Department of Health in 1996 showed that 7 percent of teenage girls ages 13–19 in West Java acknowledged having experienced extramarital pregnancies, while this was true for 5 percent in Bali.[40]

The 1994/95 Jakarta Marriage Values and Sexuality Survey of high school and university students[41] found that 23.3 percent of students ages 15–19 and 68.2 percent of students ages 20–24 knew at least one friend who had experienced premarital pregnancy and had married as a result (Table 7). More male respondents (40%) and non-Muslim respondents (38%) knew of a friend or friends who had been pregnant before marriage than female (35%) and Muslim (37%) respondents. Approximately 6 percent of 15–19 year-olds and nearly 10 percent of 20–24 year-olds knew of a friend who had experienced a premarital abortion. Almost none of the respondents knew of any relative who had had a premarital abortion. The majority of respondents strongly disapproved of premarital abortion and argued that a girl should continue her premarital pregnancy even when the father of the baby does not want to marry her. Only a small percentage of the respondents agreed with the idea of a premarital abortion.

[39] Khisbiyah et al., 1997.
[40] Wilopo et al., 1999.
[40] Utomo, 1997.

Table 7. Percentage of respondents knowing of premarital pregnancy among their friends and relatives by age, sex, and religion in Jakarta: 1995

	Age		Sex		Religion	
Knowledge of Premarital Pregnancy Among Friends	**15–19**	**20–24**	**Male**	**Female**	**Muslim**	**Non-Muslim**
Yes, she married the man and had the baby	23.3	68.2**	39.6	34.6	36.6	38.3**
Yes, but she had an abortion	5.5	9.6	5.1	8.2	6.6	7.4
No	71.2	22.3	55.3	57.1	56.8	54.3
Knowledge of Premarital Pregnancy Among Relatives						
Yes, she married the man and had the baby	24.7	46.5**	26.4	35.7*	28.5	43.6*
Yes, but she had an abortion	0.6	0.0	0.0	0.7	0.5	0.0
No	74.8	53.5	73.6	63.6	71.0	56.4

Note: Test of significant difference is based on Chi Square, ** significant difference at less than 1 percent, * significant difference at less than 5 percent.
Source: Data are from the 1994/1995 Jakarta Marriage Values and Sexuality Survey. Utomo, 1997.

The 1994/95 Jakarta Marriage Values and Sexuality Survey also included qualitative in-depth interviews with counselors, psychologists, and psychiatrists that complement the quantitative survey.[42] While their experiences are personal and cannot be generalized, they do draw attention to the impact of social and sexual changes. A public high school counselor claims that in his school, on average, one to two students experience premarital pregnancy every year. A senior psychiatrist estimated that, on average, he sees 20 to 50 cases each year of male and female young people with depression or feelings of guilt regarding their experiences either with premarital pregnancy, abortion, AIDS phobia, or involvement with high-class prostitution. The psychiatrist claimed that the number of cases related to these problems has risen since 1980. A counselor working in a family planning clinic revealed that in 1993 she saw one to three clients a day who were pregnant, unmarried, and wanting an abortion. She also had several clients who had had repeated abortions and wanted to have access to permanent contraception.[43]

Qualitative studies among various groups revealed that premarital abortions are becoming more common among young adults.[44] Data from 10 Indonesian Planned Parenthood Association (IPPA) clinics located in cities throughout Indonesia show that the percentage of abortions performed on females ages 15–24 increased from 9 percent of the abortion cases (N=7,683) in 1992 to 35 percent in 1993 (N=4,314 abortion cases).[45] Hull and others (1993) estimated the total number of abortions in Indonesia each year ranges from 750,000 to one million. Further, Hull and others (1993) calculated that there are 18 induced abortions per 100 conceptions with the assumption that there were 4.5 million live births in Indonesia in 1989.[46] Ramona Sari, Director of the IPPA Clinic in Jakarta, stated that of the 750,000 to one million abortions each year in Indonesia, 89 percent were among married women and 11 percent were among single women.[47] It is estimated that 70 percent of women who have had an abortion were trying to abort using traditional herbs (*jamu*), traditional massage, or an object or sought an abortion from a traditional healer (*dukun*) before coming to the clinic. This is a cause of concern because these attempts can be life-threatening and dangerous for women's health.[48] Another 1997 study in Indramayu-West Java showed that 40 percent of village women who sought abortion services (mostly unsafe abortions) were unmarried adolescents.[49]

[42] Utomo, 1997.
[43] Utomo, 2002.
[44] Warouw and Wowor, 1987; Kristanti, 1996.
[45] Kristanti, 1996.
[46] Hull et al., 1993.
[47] Media Indonesia, 2001.
[48] Media Indonesia, 2001.
[49] Marcus study cited in Wilopo et al., 1999.

Contraceptive use

Only married couples can access family planning services. In 1997, among currently married women ages 15–19, 42 percent were using some kind of modern contraception compared with 57 percent of currently married women ages 20–24 (Table 8).

Table 8. Current use of contraception among married women, Indonesia, 1997

Age	Method of Contraception			
	Using a Method		Not Currently Using a Method	Total
	Any Method	Any Modern Method		
15–19	42.4	42.2	57.6	100 (1,310)
20–24	58.3	57.0	41.7	100 (4,061)

Source: CBS et al., 1998. Table 5.1:69.

STIs and HIV/AIDS

Little is known about STIs and HIV/AIDS among young people in Indonesia, although the issue is of concern. Overall prevalence of HIV/AIDS among young this group is low (an estimated 0.07 for males ages 15-24 and 0.08 for young women), according to UNAIDS estimates.[50] There is cause for concern, however, since the prevalence rates among high risk groups including sex workers and injecting drug users have been increasing rapidly over the past few years.[51] Injecting drug use is also on the rise in the country (see next section). Dursin notes that "the sector of the population most at risk these days to the twin dangers of drugs and HIV/AIDS is the country's adolescents and young adults."[52]

Drug use and reproductive health

Over the past several years, more young people—mostly young men—have become involved with drugs, needle sharing, and unprotected sex.[53] Drug use is a problem in urban areas, but it is also spreading to rural areas. Table 9 shows the growing number of young people being treated at one drug dependence hospital in Jakarta. The increase in numbers of drug rehabilitation centers for young people reflects the increased drug abuse; such institutions were not as urgently needed in the past. Of the 72 patients in one of the rehabilitation centers visited,[54] 40 percent were HIV-positive and all were infected with hepatitis C. The youngest patient was nine years old and was from a family in which the three children were all HIV positive.[55] Only 10 percent of the patients were female, a fact reinforced by data from the 1994 Indonesian health profile. Interviews with medical doctors and psychologists who are responsible for the center stated that female drug users are able to "look after themselves" and get drugs and accommodations by providing sex to drug dealers.[56] Because of their limited access to funds, male users,

[50] Source: UNICEF, UNAIDS and WHO. "Young people and HIV/AIDS: Opportunities in Crisis," www.unicef.org/pubsgen/youngpeople-hivaids.pdf. Various data sources.
[51] Monitoring the AIDS Pandemic (MAP) Network. 2001. "The Status and Trends of HIV/AIDS/STI Epidemics in Asia and the Pacific. www.fhi.org; www.unaids.org; www.census.gov/ipc.
[52] Dursin, Richard. 2000. "Growing Drug Use Pushes up HIV/AIDS Figures." Interpress Service. January 2.
[53] Center for Health University of Indonesia, 2000.
[54] Field observation was conducted by the author for one week in Jakarta and Bogor (14-21 April, 2002).
[55] Field observation was conducted by the author for one week in Jakarta and Bogor (14-21 April, 2002).
[56] Field observation was conducted by the author for one week in Jakarta and Bogor (14-21 April, 2002).

on the other hand, often resort to theft and related crimes to keep up with their need for drugs. They are often caught by the authorities and easily identified by family members as drug users.

Several forces may explain why young Indonesians are involved with risky reproductive health behaviors as well as criminal and drug-related problems. Peer pressure seems to be very strong while, at the same time, there seems to be a lack of control and supervision from parents or adults.[57] This condition is made worse by the lack of government enforcement against underage driving, buying cigarettes, entering bars and discotheques, involvement in drug use or trafficking of drugs, and youth violence (*tawuran*).[58] While the government has recently begun developing policies and programs related to reproductive health and the use of drugs for Indonesian youth, Indonesian young people are not getting the support and services that they need due to limited financial and human resources.

Table 9. Patients receiving treatment at Drug-Dependence Hospital (RSKO), 1996–1998

	1996		1997		1998	
Sex and Age	**Out-patient**	**In-patient**	**Out-patient**	**In-patient**	**Out-patient**	**In-patient**
Total	*1,779*	*311*	*3,652*	*655*	*5008*	*733*
Sex						
Male	1629	294	3,349	575	4483	654
Female	150	17	303	80	525	79
Age						
< 16 years	225	10	172	6	139	6
16–19	759	123	1,563	239	1,937	252
20–24	468	103	1,322	277	2,048	336
25–29	194	43	401	85	626	107
30–34	87	17	117	33	144	16
> 34	46	15	77	15	114	16

Source: Drug-Dependence Hospital, Jakarta, 1996–1998 in UNICEF 2000, Table 7.3: 124.

[57] Field observation was conducted by the author for one week in Jakarta and Bogor (14-21 April, 2002).
[58] The Australian, 2002.

4 LEGAL AND POLICY ISSUES RELATED TO ARH

Legal barriers

The following laws need to be reviewed if policy and programs on ARH are going to be implemented in Indonesia.

Law No. 2/1979 makes nine years of basic education compulsory for all. It would appear apropos to add into this law a *Peraturan Pemerintah* (Government Regulation) underlining the importance of reproductive health and gender education during these nine years. Policymakers have recently begun to discuss the mainstreaming of gender concepts in the curriculum; all discussions are still in a preliminary phase.[59] Preliminary materials have been developed by the National Center for Physical Quality Development in the Ministry of National Education.[60] It would be ideal to incorporate both reproductive health and gender concepts in the school curricula given that unsafe sexual behaviors persist because of, at least in part, limited information and knowledge on sexuality and reproductive health. Inclusion of this information is also important given that sexual double standards, harassment, sexual assault, and crime continue as a partial result of a deep gender gap between females and males.

Various societal structures support a detrimental image of women. Ideologically, the state views Indonesian women as the nurturers of their offspring, their husbands, their communities, and the state. To a real extent, women's sexuality and reproductive health are regulated by the state. Family planning campaigns and practices are mostly targeted to women. Childbearing, childrearing, and other related reproductive health decisions are mostly the responsibility of women.[61] Sexual double standards persist and women are still expected to be virgins when they marry. The unequal standards are reflected in the media.

If reproductive health and gender education were included in school curricula, future generations would have a better understanding of reproductive health, sexuality, and gender. As a result, the upcoming younger generations would understand the risks involved in unsafe sex and drug-related behavior. Shared responsibility of reproductive health matters by males and females would also be made a greater possibility.

Law No. 1/1974, the Marriage Law, declares the minimum legal age at marriage is 16 for women and 19 for men. The legal age at marriage for women should be raised so that more women marry after they are at least 18 years old and graduated from high school. Law No. 10/1992 restricts family planning services for single people. Regardless of one's marital status, men and women should have equal rights to family planning and reproductive health information and services. Shared reproductive health responsibilities between men and women should be encouraged from early adolescence and again before the entry to marital life. The latter may be institutionalized and popularized through education and media and community campaigns.

Law No. 23/1992 defines abortion as illegal even though it is public knowledge that abortions are widely provided in Indonesia by both medical and nonmedical personnel.[62] Article 15, Section 2, paragraph (1)

[59] Suharto, 2001.
[60] Suharto, 2001.
[61] Utomo and Hasmi, 2002.
[62] Utomo et al., 1982; Hull et al., 1993.

states, “In the case of emergency, and with the purpose of saving the life of a pregnant woman or her fetus, it is permissible to carry out certain medical procedures.”

Hence, it is only if a woman’s life is in danger that an abortion can legally be performed. This helps explain why young women who have become pregnant outside of marriage often turn to traditional healers or other nonprofessional health practitioners when they seek abortions.

5 ARH PROGRAMS

Existing ARH policies and programs

***ARH programming developed by the government*:** Regardless of the international recognition of the Indonesian family planning program, which has been successful in promoting contraceptive use and fertility decline, the program has been exclusively directed toward married women. The government began implementing the Population Education School Program curricula nationwide in the 1980s, when policies related to ARH were first put in place. The main objective of this program was to help the younger generation enhance its awareness and increase knowledge of, change attitudes about, and change behavior with regard to reasonable and responsible reproductive health while enhancing understanding of the issues associated with population concerns. Because the entire push was an effort to internalize and institutionalize the Small, Happy, and Prosperous Family Norm,[63] the information given was heavily geared toward family planning instead of reproductive health matters.[64] In 1997, because of the increasing risk of HIV/AIDS, the Ministry of National Education initiated policies for school-based HIV/AIDS programs. Unfortunately, whether HIV/AIDS education will be incorporated in the national education agenda is still in question.

A study titled "HIV and Sexual Health Education in Primary and Secondary Schools: Findings from Selected Asia-Pacific Countries"[65] revealed that in Indonesia, where such education is delivered, the focus is on the biology of sexual reproduction and not on sexual practice in social context. Sexual activity is sanctioned only between husband and wife, and sex outside marriage is strongly discouraged. If sex-related topics are taught in elementary schools, the focus is on reproduction, differences in male and female anatomy, and physical changes associated with puberty. However, sex-related education is framed as "science" even though there is also a "moral" positioning. In secondary education, family planning methods are mentioned and the advantages and disadvantages for the user are presented. In regard to the transmission of HIV, HIV is referred to as the AIDS virus but at times the information given fails to differentiate between HIV and AIDS. The ABCs of sex (Abstinence, Be faithful, or use Condoms) is not taught to students but delivered through NGO health groups visiting schools and delivering one-off presentations. Even though innovative pilot projects are currently underway, not all young people who attend school in Indonesia have access to such information and knowledge.

The *Programme of Action* from the 1994 ICPD in Cairo stressed the importance of reproductive health, reproductive rights, sexual health, and family planning.[66] As mandated by ICPD, ARH policy and programs should include both information, education, and communication (IEC) programs and services. In Indonesia, for socio-cultural, religious, and political reasons, the government only encourages the availability of ARH education but not services. While donor agencies like UNFPA and the World Bank have begun funding ARH trial and pilot projects in several provinces, which add to the existing activities provided by NGOs, ARH programs in Indonesia are not planned as and do not constitute a national program. The efforts to focus on ARH as a national issue began only in 1999 with the 1999 National Development Program (*Propenas*)[67] and its inclusion of ARH issues.

[63] The Small, Happy, and Prosperous Family Norm is the family planning national policy developed by BKKBN. The Small, Happy, and Prosperous Family consists of a mother, father, and two children with equal sex preference. This national policy has been in place since the 1980s.
[64] Hasmi, 2002.
[65] Smith et al., 2000.
[66] UN, 1995; Suyono, 1997.
[67] Hasmi, 2002.

Table 10 provides an overview of the government sectors that have initiated ARH IEC programs and services programming, as of 1999.[68] Whether these programs are in operation and whether services are actually given to meet adolescents' reproductive needs, however, is still questionable. In any case, they are not nationally implemented. For provinces that have been provided with pilot projects by the National Family Planning Coordinating Board (NFPCB/BKKBN), school students are the primary recipients of information about ARH. An evaluation of ARH education stated that it was provided in some schools in DKI Jakarta, West Java, and Daerah Istimewa (DI) Yogyakarta.[69] In these provinces, ARH education was implemented in 21 primary schools, 67 lower secondary schools, 66 upper secondary schools, and 25 vocational schools. In these schools, ARH concepts have been integrated into other subjects—biology, religion (topics of marriage and sexuality), and social studies—by teachers trained as counselors by the NFPCB or IPPA. These programs are only implemented where NFPCB pilot projects were implemented.

Table 10. ARH workplan, by government organization, Indonesia: 1999

Sector	National Level	Provincial Level	District Level
NFPCB	• *Program Bina Keluarga Anak dan remaja* (BKR) "Program Support for Families of Adolescents"	• Program BKR: train parents with ARH information so that they can talk to their children about these issues	• Program BKR • Via a family planning hotline, already getting calls from youth about sex, such as from pregnant youth seeking abortion services
Department of Health	• Youth friendly clinic services—still waiting for a needs assessment to determine what services will be provided	• Reproductive health presentations in schools and in youth groups (such as *Karang Taruna*) • Will prepare hospitals as a "youth clinic" for referrals from health clinics (*PUSKESMAS*) to give nutrition, counseling, STI, and prenatal care to youth	• Teacher training • Youth group (*Karang Taruna*) training • Reproductive health education in schools (including AIDS and narcotics (awareness) wants to develop a "Youth Consultation Center" working with hotline NFPCB/BKKBN
Department of Social Welfare *	• Program via youth group (*Karang Taruna*)	• Five youth per village were trained as peer educators; youth were selected by *Karang Taruna* (youth group) or nominated by the village leader; peer educators were trained mostly in reproductive health	• Training peer facilitators from *Karang Taruna* (youth groups) and social organizations such as Girl and Boy Scouts

[68] MacLaren, 1999.
[69] Yuwono and Roque, 1999.

Table 10 (continued).

Sector	National Level	Provincial Level	District Level
Department of Religion	• Program via *pesantren* (religious schools) • Program via religious youth groups	• Activities via the mosque (such as studying the Quran) • 10 percent of mosques have an economic activity for youth (such as a telephone calling center) • Nonformal education • Support positive relationships between youth • Premarital nutrition program (iron supplement, TT, etc.)	• Programs via *pesantren* (religious schools) • Programs via religious groups
Department of National Education	• Program via schools; still requires needs assessment to develop the program	• Reproductive health education via schools and via out-of-school education programs for school dropouts; already have IEC materials, waiting for needs assessment to further develop program	• NA

Note: * Department of Social Welfare has been restructured to be under the Coordinating Ministry of People's Welfare ever since the Reform Era.
Source: MacLaren, 1999.

The 2000 fiscal year marked a significant shift for ARH in Indonesia when Ibu Khofifah Indar Parawansa (former Minister of Women's Empowerment and Head of the NFPCB during Abdurahman Wahid's Presidential Era) initiated a new Adolescent and Reproductive Rights Protection Directorate at the NFPCB and a division responsible for ARH at the State Ministry of Women's Empowerment. Six years after the ICPD *Programme of Action* and after more than a decade of debate on the need for ARH policy and programs, Khofifah had the courage to define national strategies pertaining to ARH. Up to that point, both the Department of National Education and donors, primarily UNFPA and the Ford Foundation, had conducted some important but sporadic out-of-school ARH projects in several provinces. The Department of National Education has been less successful in developing and implementing ARH education in schools.

Khofifah advocated for another remarkable policy shift when she declared that pregnant students should be given a chance to finish their schooling.[70] She declared that they should not be expelled from school but be given a break from school during their pregnancy. In this way, two goals would be achieved: 1) staying in school would give the pregnant student an opportunity to proceed with her education and career development, and 2) such an allowance would reduce the incidence of premarital abortion. Although some did not approve of this statement because they assumed that the policy would encourage more students to become pregnant, Khofifah strongly disagreed and noted that people would be more likely to take preventive steps to avoid pregnancy. She also strongly emphasized that emergency contraceptives should be given to those who have experienced premarital abortions.[71,72] This stand provided support to an idea that was once controversial and about which discussion has been taboo. Toward the end of 2000,

[70] *Kompas,* 2000; Media Indonesia Online, 2000.
[71] Indonesian society would not approve of an explicit policy of providing emergency contraceptives to all single young women. Khofifah's statement that emergency contraceptives should be distributed to only those women who have experienced premarital abortion is, in fact, a suggestion that if there is no alternative, emergency contraception is acceptable.
[72] *Kompas,* 2000; Media Indonesia Online, 2000.

policymakers in the Health and Education departments held discussions on the need to emphasize the importance of providing reproductive health education in the school curriculum.[73]

Other government agencies that are trying to develop ARH programs are the Department of Health (DOH), Department of National Education, and Department of Religious Affairs. Recently, the Ministry of Health started ARH programs that are largely based in schools. The focus of the DOH plan is to train students as peer educators. This program also includes programming for out-of-school adolescents. The Department of National Education has been trying to implement reproductive health education in the school curricula but even though the process started more than a decade ago, programming has not taken place. Other approaches have been developed by the Department of Religious Affairs, which has focused its efforts on trying to develop reproductive health education for religious schools.[74]

The programs developed by the NFPCB for 2000–2001 are shown in Appendix 3. The NFPCB plays an important role in coordinating meetings between government agencies (Departments of National Education, Religious Affairs, Health, and Social Welfare), NGOs, and donor agencies to plan for ARH policy and programs. Funding for policy programs related to ARH is mainly from donor agencies such as UNFPA, World Bank, and Population Council as well as from the national development budget. Activities in progress are related to policy on ARH, ARH rights and protection, guidelines for implementing ARH programs for community groups, various IEC materials, and sectoral and coordination meetings both with government institutions and NGOs alliances. The strengthening and popularization of ARH policy and programs are being targeted both to government officials and NGOs, and for various programs that are being implemented as a pilot project in 10 districts (Pamekasan, Sampang, Ngawi, Jombang, Trenggalek, Brebes, Pemalang, Cilacap, Jepara, and Rembang).[75]

While ARH policy accomplishments by the NFPCB have been quite promising since 2000, there is still no government institution willing to pressure the government to put ARH curricula on the national education agenda. The Indonesian government's view on ARH remains conservative and its focus is likely to remain on providing information on RH and/or HIV/AIDS to this age group through talks, advocacy, and discussions by experts, NGOs, and guest speakers from universities. ARH services should also be made available, whether located in youth centers, school-based clinics, or other clinics where friendliness and confidentiality can be guaranteed.

***ARH programs developed by NGOs*:** Compared with ARH programs developed by the government, NGOs have been innovative and up-front in dealing with ARH issues for two reasons. First, they do not have barriers to designing more liberal programs and second, most NGO personnel are still relatively young and hence understand and are more attached to young people. Because most NGOs are project-oriented in nature, the documentation, monitoring, and evaluation of these projects are limited and of poor quality, making it problematic to standardize best project approaches or share information among NGOs. One drawback is that NGOs continue to work individually and often reinvent the wheel in terms of progress. Nevertheless, from 21 NGOs surveyed in Jakarta, East Java, South Sulawesi, North Sulawesi, Riau, West Nusa Tenggara, and East Nusa Tenggara, most have been working in the field of ARH for six to 12 years, with a range of one to 30 years. Regardless of availability of funding from donor agencies, the surveyed NGOs are passionate about devoting time and work to ARH-related programs. Future action must be taken to support NGOs' ARH activities with more sustainable funding.[76]

[73] *Kompas*, 2000.
[74] Hasmi, 2001; Suharto, 2001.
[75] NFPCB, 2002b.
[76] Mepham, 2001.

Program activities developed by NGOs can be grouped into four fields: education and information services; clinical services and support; programs integrated into existing community programs, and other youth support programs (see Appendix 4). Education and information services programs that have been developed by the NGOs that were surveyed include the following:

- School-based education
- Community-based education
- Workplace education
- Street outreach
- Peer approaches
- Drop in/youth center
- New technology programs, Internet
- IEC materials development
- Mass media

Clinical services and support provided by NGOs are less common. Clinical services are only provided by the IPPA, Yayasan Pelita Ilmu (YPI), Yayasan Kusuma Buana (YKB), Kra AIDS, CMR/IPPA, Yayasan Humaniora, YMKK, and TRUK-F. Services provided include the following:

- Family planning and clinical services;
- Health referrals;
- Voluntary counseling and testing for HIV/AIDS;
- Counseling and psychological services; and
- Condom distribution.

With regard to abortion, the majority of NGOs' philosophy toward abortion is pro-life, which is consistent with the government policy. Thus, young single people who would want to terminate their pregnancies are often "alone" and may turn to traditional unsafe abortion.

6 OPERATIONAL BARRIERS TO ARH

Even though sporadic programs by both the government—in this case through NFPCB and the Department of National Education—and NGOs have tried to address ARH in Indonesia, a strong political commitment that can be accepted culturally and religiously should be put forth to underline the importance of including reproductive health education in the national education curricula and providing youth-friendly ARH services. The Indonesian government has, in fact, recognized the situation faced by young people. While the government has issued policy pronouncements on ARH, for a number of political, social, and cultural reasons, it has proved difficult for the government to match the policy pronouncements with actual programs to meet the needs of young people. The government has been reluctant to pressure the national education system to include ARH education in the education agenda.

To overcome operational barriers to ARH policy and programs, a national task force should be established consisting of policymakers, political leaders, academicians, researchers, psychologists, curriculum specialists, religious leaders, young people, NGO activists, social workers, teachers from various levels, and parents to define the scope of ARH education in the school curricula and at various levels of education at which the subject should be addressed.

Themes of ARH education also need to be expanded. As noted above, the focus for population education has been solely on population problems and family planning. HIV and sexual health education has focused on the biology of sexual reproduction, differences in male and female anatomy, and physical changes at puberty. The HIV/AIDS-ABC campaign (not to mention the new "D" aspect – don't do drugs) is not being taught because officials fear that it will be interpreted as an invitation to liberalize the country's sexual mores. The moral theme that is delivered is that marriage is the only relationship in which sexual intercourse is permissible. However, the moral aspects of sexuality, understanding relationships between the sexes, negotiating sexual decision-making power, gender equality in reproductive health matters, and understanding reproductive and drug-risk behavior is as essential as understanding the biological aspect of reproduction. Sexuality is a natural phenomenon; what is needed is IEC. Sexuality as a means for reproduction and pleasure should be balanced with the emphasis on safe sex messages and minimizing sexual risk behavior.

Various mechanisms have been used to accommodate IEC on ARH: peer education, community education through programs developed by NFPCB, families/parents as an important source of education, NGOs, youth groups (youth centers, youth religious groups, and *Karang Taruna*), and school-based programs where pilot projects are being implemented. Unfortunately, a major program aspect is still missing: policy enforcement to guarantee that ARH education and services are part of the national agenda. Policies need to be implemented without any further delays.

7 RECOMMENDATIONS

In Indonesia, ARH programs have been implemented sporadically. A successful, national ARH program is still absent. The following strategic elements for addressing ARH policy and programs should be considered:

- ***Implement the policy on expanding sex and reproductive health information and education in schools.***

- ***Emphasize and use the family as an important source of information on ARH.*** The Indonesian government wants to use the family as an important source of information on sexuality and reproductive health. The problem is that parents do not have enough knowledge in this field. It is also problematic because parents feel reluctant to talk to their children about sexuality because of cultural, psychological, and communication barriers (also, parents were never taught as children about these issues and thus do not have the knowledge or experience to impart the information.[77] Educational programs for parents should be developed if the government would like to rely on parents as a source of reproductive health education.

- ***Increase adolescent participation in policy and program formulation.*** ARH programs, whether focused on IEC or services, are for adolescents. Thus, it is crucial to include young people in the process of developing the policies and programs.

- ***Expand research, documentation, recording, and data collection systems.*** Data on adolescent sexuality is limited. Thus, the reproductive health survey needs to include young people who are still single. A monitoring and assessment system for ARH should also be developed. (Indonesia is not alone in its need; a data collection system for ARH is lacking in many areas of Asia and the Pacific.[78])

- ***Increase education campaigns and advocacy for policymakers, program implementers, politicians, religious leaders, and parents on the importance of ARH education and services.***

- ***Increase access to ARH education and services for young people regardless of their marital status.***

- ***Include the social aspects of reproductive health in educational efforts*** such as moral values, relationship-building skills, sexual negotiating skills, gender equity in reproductive health behavior responsibilities, drugs and sexual risk reduction skills, and dealing with peer pressure.

- ***Increase the availability of confidential and friendly reproductive health clinics for young people.***

[77] Utomo, 2001.
[78] Gubhaju, 2001.

APPENDIX 1. Data for Figures 1 through 5

1. Adolescent Population (ages 15–24) (000's)	2000	2005	2010	2015	2020
Males	21,415	21,741	21,659	21,486	21,036
Females	20,853	21,170	21,044	20,855	20,416

2. Level of Education (%)	1991 Males	1991 Females	1997 Males	1997 Females
No Education	2.4	4.5	1.7	2.2
Primary Incomplete	14.7	19.4	11.9	12.5
Primary Complete/Some Secondary	26.3	31.3	26.4	30.9
Secondary Complete and Higher	56.6	44.6	60.0	54.4

3. Employment (000's)	Males	Females
Employed	11,358	7,158
Unemployed	1,389	1,239

4. Pregnancy Outcomes (000's)	2000	2005	2010	2015	2020
Total Pregnancies	3,353	3,428	3,424	3,401	3,500
Births	2,120	2,171	2,170	2,155	2,208
Abortions	730	743	740	736	767
Miscarriages	503	514	514	510	525

5. Unmet Need (%)	1991	1994	1997
Total Unmet Need (ages 15–19)	15.6	13.7	9.1
Total Unmet Need (ages 20–24)	13.6	10.9	8.6

Assumptions and Sources:

Figure 1. Total size of the adolescent population was taken from the UN medium population projection, *World Population Prospects, The 2000 Revision.*

Figure 2. Level of education was taken from the 1991 and 1997 IDHS reports. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Employment statistics were taken from LABORSTA, the Labor Statistics Database operated by the International Labor Organization (ILO) Bureau of Statistics. Unemployment and labor force size (by age and sex) were taken from the ILO Yearbook of Labor Statistics. Labor force size is defined as the economically active labor force. The number of employed was estimated by subtracting the number unemployed from the labor force size.

Figure 4. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR and abortion and miscarriage rates) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by

summing the total number of births, abortions, and miscarriages. TFR and ASFR for the base year were taken from the 1997 IDHS report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 35 per 1,000 (Profiles estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttenmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 5. Levels of unmet need were taken from the 1991, 1994, and 1997 IDHS reports.

APPENDIX 2. Laws and policies on gender in Indonesia[79]

1. The 1945 Constitution (Article 27): Women and men have the same rights and obligations within the family, society, and development.

   Article 27
   - All citizens have equal status before the law and in government and are obliged to uphold them without exemption.
   - Every citizen has the right to employment commensurate with human dignity.

   Article 7 Universal Declaration of Human Rights
   All are equal before the law and are entitled without any discrimination to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

2. GBHN (Garis-garis Besar Haluan Negara – National Planning Guidelines) 1999–2004 National Development Program (Propenas): In October 1999, the People's Consultative Assembly (MPR) for the first time identified gender equality and gender equity as national development objectives in the government's new GBHN.

GBHN of 1978, 1983, 1988, and 1993 on the Role of Women in the Nation's Development

Women, as citizens and as human resources for development, have the rights and responsibilities as well as opportunities equal as men in all aspects of development.

3. Law No. 22/1999: Decentralization.

4. Law No. 25/1999: Balance national funding for provincial level.

5. Presidential Decree No. 101/1998 on main responsibilities, function, structural organization and working manner for State Ministerial Offices.

6. President Instruction No. 5/1995 on women's role in development at the provincial level.

7. Ministry of Women's Affair Decree No. 45/KEP/MENUPW/VI/1997 on Women's Role in Development at the National Level.

8. Ministry of Women's Affair Decree No. 11/KEP/MENPERTA/VI/1999 on National Meeting on Women's Affair Development operational committee.

9. Ministry of Internal Affair Decree No.17/1996 on Technical Guidelines on Development Management Program on Women's Roles in the Provincial Development.

10. Law no. 2/1998: National Education System: The nine-year compulsory education program beginning in 1994. Parents are encouraged to send their children to school, regardless of their sex, at least until they complete junior high school.

11. Article 11 of the Convention on the elimination of all forms of discrimination against women (ratified as Act No. 7 of 1984): elimination of discrimination against women in the field of employment.

[79] Utomo, 2000; Insan Harapan Sejahtera, 1998; CBS, 2001.

12. Labor market:

- Regulation of the Minister of Labor No. Per-03/Men/1989 prohibits the firing of women due to reasons of marriage, pregnancy, and maternity.
- Regulation of the Minister of Labor No. Per-04/Men/1989 consists of regulations for the protection of women working at night.
- Article 3 Government Regulation No. 8/1981–Renumeration Protection: Employers shall not discriminate between women and men workers in determining the rates of remuneration for work of equal value.
- Article 16 Government Regulation No. 7/1977–Salaries of Civil Servants: To married employees shall be given spouse allowances of five percent of monthly basic salaries.
- Act No. 80/1957–Ratification of the ILO Convention No.100: Equal remuneration for men and women workers for work of equal value.

13. Labor regulations that have discriminatory effects on women workers:

- Government Decree No. 37 of 1967: Wage system for employees in state companies. Only male workers can have dependants (wife, children). Consequently, a female worker's dependents are not eligible for benefits enjoyed by dependents of male workers.
- Ministerial Decree no. 2/P/M/Minig/1971: All married women working in mining state companies and mining foreign enterprises in Indonesia are regarded as single and all benefits apply only to themselves but not their families. Married women will be considered as the main income earner only if certified as widowed or their husbands are unable to work. Such status is conferred to her upon her request.

Legal Areas of Concern

There are three legal areas of concern: the labor law, which is still under discussion by the government; the tax reform decree, which reinforces women's subordinate status within the family; and the marriage law, which serves as basis for gender relations within the family and therefore also in society.

Labor laws: Current labor laws and regulations do not recognize labor rights and protection for workers in the nonformal sector (home-workers, workers in the putting-out system, domestic workers, workers in agriculture and in estates, workers in small-scale industry, minor workers, etc.). Many workers in the nonformal sector are women.

Legal reforms of regulations limit the rights of female workers to wages and benefits:

- Government Decree No. 37 of 1967 on Wage Systems in State Companies;
- Ministerial Decree No. 2/P/M/Minig/1971;
- Ministerial Decree No. KU/440/01/Agriculture/2/1984;
- Ministerial Decree No. 01/Agriculture/EKKU/3/1978;
- Minister of Manpower Circulation No. 7 of 1990 on Wages; and
- Minister of Manpower Circulation No. 4/1998, especially points 2 and 3 on health allowances.

There is no protection of migrant workers (particularly women migrant workers working as domestic workers) in the countries where they work.

Tax reform: Decision of the Director General of Taxes No. KEP 78/PJ-41/1990 on the Issuance of Principal Tax Number (NPWP) to a wife of a tax subject undertaking a business activity and independent

work, specifies that she is to rely on her husband's Tax Number. This decree specifies that married women having a business or involved in independent work cannot file her income tax as an individual, separate from her husband, irrespective of whether the husband earns any income or not.

Marriage law: Indonesia enacted the Marriage Law in 1974. Weaknesses in implementing the law have been identified. Proper implementation of the Marriage Law requires substantial institutional capacity building, such as:

- Strengthening capacities and capabilities of legal-aid centers to help women in divorce cases in religious and general courts, especially to secure alimony for ex-wives and children; and
- Strengthening of institutional capacities and capabilities (including human resources) of general and religious courts up to the subdistrict level.

APPENDIX 3. NFPCB programs on ARH

NFCB 2000 Program on ARH

Handbook under construction

- Technical policy on ARH program
- Technical policy on RH rights and protection program
- Guidelines in implementing ARH program for community groups
- National Action Plans for ARH program
- Guidelines for monitoring and evaluation system on ARH program.

IEC materials

Nine different IEC materials have been developed:

- Reading for young people entitled: "Understanding Being a Teenager" (Remaja Mengenali Dirinya).
- Reading for facilitators entitled: "Helping Young People in Understanding Their Being" (Membantu Remaja Memahami Dirinya).
- Reading for parents entitled: "Understanding the World of Young People" (Memahami Dunia Remaja).
- Comic for young people: "Being a Healthy Teenager" (Gaya Sehat Remaja).
- Video cassette/VCD on drugs, entitled: "Drugs" (Narkoba).
- Video cassette/VCD on HIV/AIDS, entitled: "Fight for the Red Field" (Rebut Lapangan Merah).
- Poster on abortion, sexual harassment, and reproductive rights.

Sectoral and NGO alliance[80]

- Quarterly meeting with the Health and Social Welfare Department, National Education Department, and Department of Religion regarding the implementation of ARH project funded by World Bank VI Project
- Quarterly meeting with the Health and Social Welfare Department, National Education Department, and Department of Religion, IPPA, donor agencies, and NGOs regarding monitoring and the evaluation of ARH program funded by UNFPA (INS/99/P03)
- Twenty-six ARH orientation programs for Indonesian Scout Movement in addition to ARH orientation programs in 10 districts: Pamekasan, Sampang, Ngawi, Jombang, Trenggalek, Brebes, Pemalang, Cilacap, Jepara and Rembang (funded by Worlfd Bank VI Project)
- Twelve ARH orientation program for youth groups
- ARH orientation program for NGOs affiliated to religious groups: Aisyiah, Muhammadiyah, LKK-NU, and Fatayat-NU
- Strengthening and support program for the above NGOs in addition to the Indonesian Scout Movement in 10 districts

[80] Directorate for Adolescent and Reproductive Rights Protection-NFPCB, in developing its policy and programs, worked closely with other sectoral departments including: the Health and Social Welfare Department, Department of Religious Affairs, and National Education Department.

Strengthening and socialization program

- Strengthening and popularizing ARH programs in the 10 districts mentioned above including subdistricts in those regions.
- Monitoring and evaluating the implementation of ARH programs in the 10 districts mentioned above.
- Reproductive health rights orientation for NFPCB officials (Echelon II and III), related sectoral department, and NGOs.

NFPCB 2001 Program on ARH

Handbooks and guidelines

- During 2001, a review was conducted of books that were published last year.
- Five handbooks have been written consisting of guidelines for the development of information and a counseling center, information on the protection of reproductive health rights, ARH for the student and parent association, and peer education, although it is still in a draft format.
- The ARH information and counseling center guidelines were written in collaboration with the Health Department, National Education Department, Department of Religious Affairs, and several professional associations (midwife and psychologist), and NGOs (AIDS Indonesia, PKBI, Yayasan Melati, Fatayat NU, Aisyah, dan Muhammadiyah).
- The protection for reproductive rights handbook was written by Yayasan Mitra Perempuan, an NGO specializing on women's rights.
- The ARH handbook for the student and parent association was developed in collaboration with the related sectoral departments mentioned above while the peer education handbook was written with the Indonesian AIDS Foundation.
- The training manual for program design, a handbook targeted for ARH program management at the NFPCB, was targeted at both the national and provincial level. For this manual, the Directorate for Adolescent and Reproductive Rights Protection was assisted by the STARH (Sustaining Technological Achievements in Reproductive Health) program-USAID and the Training Center-NFPCB.

IEC materials

- *Handbook for counselors*. This handbook drew from a compilation of existing materials and experiences dealing with ARH-related problems that have been dealt with by Ami Syamsidar (psychologist).
- *Handbook for parental guidance*. The book includes a focus on parental understanding about the world of teenagers, how to communicate with teenagers, and ARH problems most often encountered by young people. This handbook is being prepared in alliance with the Melati Foundation.
- *Handbook for young people* that includes questions and answers relating to ARH. This book is designed for family planning fieldworkers and has been distributed to the provincial NFPCB officers. Teamwork with Mitra Foundation was established in developing this handbook and the handbook on protection for reproductive rights.
- *Handbook on protection for reproductive rights* (questions and answers).

- *Videos on various topics*, including "Reproductive Health," "A–Z," "You and I," "Do Not Enter," "Three Close Friends," "No One Cares," and "Gender Issues." These videos were developed based on videos that have been published by the Foundation of Adolescent Development, the Philippines. In addition, each film includes a manual for discussion. These films will be disseminated to the provincial levels, including districts covered by the World Bank Project.[81]
- *Audio visuals for parents* entitled, "The Gateway (Pintu Hati)" and "Encouraging Footsteps (Langkah-langkah Indah)."

Sectoral and NGO alliance

- Six monthly meeting with the sectors highlighting the implementation of the World Bank Project.
- Meetings with the sectors and NGOs in regard to the ARH monitoring and evaluation project funded by UNFPA. Acting as an implementing agency, the IPPF through the UNFPA Sixth Country Program (2001–2005) will build 11 youth centers in the following cities: Bandung, Cirebon, Tasikmalaya, Manado, Semarang, Surabaya, Kupang Pontianak, Singkawang, and Palembang. NFPCB has the responsibility of monitoring the implementation of this project and coordinating quarterly meetings both in the cities where the youth centers are being built and at the national office in Jakarta.
- ARH Jamboree in Baturaden, Central Java. This activity was attended by the Indonesian Scout Movement. Various approaches were used including quizzes, informal talks, and group discussions. The quiz was analyzed and the results concluded that from 1,774 participants, the majority have a good understanding of ARH (88.3%) while issues related to sexual harassment were the least understood. The concept of puberty was well understood by the participants (96.3%).
- Teamwork with Mitra Perempuan and Mitra Inti in developing IEC materials.
- Collaboration with Melati Foundation in developing IEC materials for street children, foster homes, youth garbage collectors, and youth laborers. This activity was related to the celebration of World's AIDS Day. Another, related event was sending 10 married couples and 10 youth couples to participate at the World's AIDS Day parade. Advocacy theme chosen: "Quality Family awareness on HIV/AIDS."
- Training for peer educators from Fatayat NU (Pemalang and Jombang Districts). The training is provided by the Indonesian AIDS Foundation in collaboration with NFPCB.
- Training for peer educators (N=80) and peer counselors (N=40) from the World Bank's project districts. In addition to this, 8 peer trainers from Central and East Java were trained. The peer educators were selected from 200 applicants in the age range 18–30.

Strengthening and socialization program

- Strengthening and popularizing ARH programs in the 10 districts mentioned above including subdistricts in those regions.
- Monitoring and evaluating the implementation of ARH programs in the 10 districts mentioned above.
- Reproductive health rights orientation for NFPCB officials (Echelon II and III), related sectoral department, and NGOs.

[81] World Bank's districts are ten districts included for study sites or for the implementation of World Bank-funded projects. These districts are Pamekasan, Sampang, Ngawi, Jombang, Trenggalek, Brebes, Pemalang, Cilacap, Jepara, and Rembang.

APPENDIX 4. Breakdown of NGO activities and support services in ARH (by activity and percentage)

	PKBI	Yay Pelita Ilmu	YKB	YIK	Aisyiyah	Yayasan Gentar	Kra-AIDS	PGRI	YMM	Yay. Harpa	Yayasan Galatea	CMR/ PKBI	PKPA	Yay Humaniora	Yayasan Utama	YMKK	YKSSI	FPKCH	TRUK-F	YPS	YCH	TOTAL*
School based Education	√	√					√	√		√		√	√	√	√		√				√	**52.3%**
Community based Education	√	√	√		√	√			√	√		√		√	√		√	√	√	√	√	**71.4%**
NGO Based Education	√	√	√	√		√			√			√				√		√			√	**47.6%**
Workplace based Education			√													√						**9.2%**
Drop in / Youth Center	√	√	√	√		√						√				√						**33.3%**
Street Outreach		√	√	√		√	√		√	√	√		√								√	**47.6%**
Peer Programs	√	√	√			√	√		√	√		√		√	√	√	√	√	√	√	√	**76.1%**
FP & Clinical Services	√	√	√				√					√		√		√			√			**38.0%**
Health Referrals	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	**100%**
Voluntary Counseling & Testing for HIV/ STI	√	√	√				√					√		√		√			√			**38.0%**
Counseling / Psych Services	√	√					√					√				√	√	√	√			**38.0%**
Condom Distribution	√	√	√				√		√	√	√	√		√		√					√	**52.3%**
Drug prevention programs	√	√	√	√		√	√	√	√		√	√			√						√	**57.1%**
Youth Participation	√	√	√	√		√			√	√	√	√			√	√	√	√	√	√	√	**76.1%**
Community Mobilization	√	√		√	√	√			√			√	√	√	√		√	√	√	√	√	**71.4%**
Parent Programs	√				√	√			√			√					√	√				**33.3%**
Youth Education & Support Programs				√		√								√								**14.3%**
Program linkages with livelihood & employment		√				√	√		√					√		√	√	√				**38.0%**
IEC material Development	√	√	√	√			√		√	√	√	√	√	√	√	√	√			√	√	**76.1%**
Mass Media usage	√	√	√				√					√			√	√	√					**38.0%**
New Information technology	√											√			√							**14.3%**
Youth in sex industry		√	√			√	√		√	√	√		√			√					√	**47.6%**
Marginal / At risk youth		√	√	√		√	√		√	√	√		√			√	√	√	√	√	√	**71.4%**
Rural Youth					√									√			√	√	√	√		**33.3%**
Urban Youth	√	√	√	√		√	√	√	√	√	√	√	√		√	√	√		√	√	√	**85.7%**
Regular Coordination with BKKBN	√	√	√						√					√	√							**28.6%**
Implemented with BKKBN	√	√	√									√		√	√		√					**33.3%**
Precious capacity building experience with other NGOs	√	√	√	√			√				√	√		√	√		√					**47.6%**
Advocacy/ Policy initiatives (National or Local)	√	√	√	√		√	√		√	√		√	√	√	√	√	√	√	√		√	**80.9%**
Research Experience	√	√	√				√						√	√		√	√				√	**42.8%**

* The percentages refer to percent of NGO support to ARH services.

Source: Mepham, 2001.

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