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**NEEDS AND RISKS FACING THE
INDONESIAN YOUTH POPULATION**

**by
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Indonesian Planned Parenthood Association and
The Population Council
Asia & Near East Operations Research and
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INTRODUCTION

Youth are the leaders of tomorrow, but right now they face a formidable collection of problems which will determine the quality of their future lives and the lives of us all. Issues of education, jobs, substance abuse, violence, sexuality and marriage are examples of adolescent issues which demand special attention from researchers, youth activists and advocates, parents and policy makers. In attempting to address many of these complex issues, we must be willing to confront ignorance, controversy and cultural obstacles. Clear and focused policy and strategies must play a basic role in tackling these issues facing Indonesian adolescents.

This paper will provide a concise situation analysis of youth in Indonesia, focusing mainly on issues of sexuality and reproductive health. It will also describe the current and future planned efforts by various governmental departments to deal with these issues, and finally a set of recommendations for the priorities and focus of future initiatives to effectively reduce the risks faced by youth and to increase their chances of becoming educated, productive, healthy and fulfilled members of our society.

I. YOUTH DEMOGRAPHIC PROFILE

Indonesia is a vast and diverse nation of over 200 million people and 13,000 islands. While Indonesia is the largest country to be predominantly Moslem, there are also significant numbers of Christians, Hindus and Buddhists. The unevenly distributed population, diverse spectrum of ethnic groups and cultures, over 300 different local languages, and geographic barriers inherent in being an island nation, all pose challenges to program implementation.

Population: In 1995, the Indonesian population of youth, defined as aged 10 - 24 years, was 62,665,900, or approximately 32% of the total population (Ministry of Health, 1997: 172, Appendix II.A.4). By the year 2000, numbers of youth are

projected to rise to 64,830,000 (Central Bureau of Statistics, 1994), or 31% of the projected population. Approximately 62% of the youth are living in rural areas and 38% are living in urban areas.

Education: While education levels in Indonesia have been climbing, there still remains a substantial portion of youth who do not get the opportunity to attend secondary school or benefit from higher education, especially in rural areas where the majority of the population still live. Looking at the participation statistics (i.e., the ratio of youths attending school compared to the total number of youths), we obtain the following description: for junior high school students, aged 13-15, the participation ratio is 87.5% for urban areas and 69.2% for rural areas; for senior high schools students, the ratio is 66% for urban areas and 34.4% for rural areas; and for higher education, the ratio is 21.6% for urban areas and 4.5% for rural areas (Central Bureau of Statistics, 1997a:38). The proportion of the total population which has finished high school or higher is now 14.9% (Central Bureau of Statistics, 1997c: 11). In rural areas, 11.09% of males and 8.2% of females age 10 and up have finished junior high school, while the number who have graduated from senior high school is 8.2% of males and 5.1% of females (Central Bureau of Statistics, 1996; Table 09.4-09.5). Women clearly suffer disproportionately low levels of education in Indonesia compared with men. Among the population in general, 16.9% of women have never attended school, while this is so for only 7.6% of men (Central Bureau of Statistics, 1997b: 34).

Employment and Unemployment: So where are all these youths who are not attending school or University? The majority, including young children, are working. It is difficult to obtain accurate data on the total number of youth who are employed in either the formal or informal sector, as the majority of available data sources on job status group together all people above the age of 10 years, not distinguishing those 24 and under. According to the observation of an NGO activist who works with workers groups, it is estimated that 60-70% of workers in Indonesia are youths aged 15-25 years (pc. Sariroh, 1997). The Intercensal Population Survey done in 1995 indicated that there were 1.8 million children aged 10-14 who were working, 86.6%

of them in rural areas (Central Bureau of Statistics, 1997a: 54). The World Bank observes that the participation level of child workers in urban areas increased 25% between 1986 and 1994. This situation deserves special attention (1995).

Turning to unemployment levels, according to the 1990 Census, unemployment (defined as the ratio of people looking for work compared to the number of people working) was 3.2%, while in 1995 it had leapt to 7.2% (Central Bureau of Statistics, 1996). Taking a closer look by age, this increase in unemployment occurred disproportionately among young people and recent school graduates. The unemployment rate for those aged 10-14 years was 8.6% in 1990, and by 1995 had doubled. Similarly, for those between 15 and 19 years of age, the rate was 8.8% in 1990 and by 1995 had almost tripled. In general, the unemployment rate for all children aged 10-19 in urban areas is high compared to other age groups and to rural areas, both for males and for females.

Furthermore, the assumption that furthering ones education will lead to a better job and standard of living needs to be re-examined. The Indonesia Planned Parenthood Association (IPPA) in Yogyakarta reports that the high rate of unemployment in a particular village (the majority of the unemployed being male) is caused by the fact that after finishing school, many feel it is not their place anymore to help their parents in farming, or to do unskilled labor. Instead they hope to become taxi drivers, or to work in an office or factory. If indeed jobs are available, these educated youth could increase their productivity, but too often no appropriate jobs are available and the productivity of these unemployed youths is instead decreased and they frequently turn to using drugs to overcome their frustration (IPPA, 1997).

Age at First Marriage: Some years ago, the widespread problem of marriage at a very young age became a serious public issue in Indonesia. The phenomenon disproportionately affects youth living in isolated rural areas. Reported rates fluctuate from year to year and clearly this issue still needs special attention. The data for 1995 from the National Socio-Economic Survey (covering all 27 provinces) show that 29% of ever-married Indonesian women had first been married between the very

young ages of 10 to 16, while 28% married at age 17 or 18. This amounts to almost 60% who marry before age 19. The remaining 36% married between age 19 and 24, while only 7% married at the age of 25 or above (Central Bureau of Statistics, 1997c, Table 7.3). The average age at first marriage has increased from 19.4 years in 1971 to 21.6 years in 1990. Studies have shown that, in general, the later a woman first marries, the lower her fertility (i.e. the number of children she bears) (Ministry of Health, 1995: 12). It is hoped that rising education levels will bring a higher proportion of later marriages. But considering the small fraction of youth who receive higher education, it seems that this problem will persist for some years to come.

We have to ask why so many women are marrying early. To illustrate the issue, we can consider the problems faced by youth workers in urban areas. Because of their low salary, many decide to marry young with the hope of supplementing their income and sharing the economic burden of living expenses with their partners. In searching for partners with high earning potential, there is often a competitive atmosphere among female workers (pc. Sariroh, a social worker with female laborers, 1997). A slightly different phenomenon occurs in rural areas, where many youths marry in order to reduce the burden on their parents or families. This decision is based on the fact that women are seen as less productive, or unable to add to contribute significantly to the family income. This in turn is related to the tradition of giving male children in rural areas priority for education.

High-Risk Groups of Youth often Neglected by Services: In Indonesia, many teenagers begin working at factories shortly after leaving school, and may be employed there for 10-15 years. Factory managers prefer youth workers as older workers are assumed to be less productive. However, working in factories is generally low-paid work which can also be detrimental to health. With few opportunities for moving on to higher paid positions, often youth factory workers will be led into sex work in search of a higher income. Another youth group which is often overlooked is street children. Again, their numbers are difficult to determine, partly due to their high mobility, but street children are clearly a growing

phenomenon, especially in large cities. They can be found in the main streets, markets, and shopping areas. According to the observation of an outreach worker, the number of street children continues to grow. Ages range from 5 to 25, but she estimates that about 75% are between 10 and 24 years of age (pc. Harmawaty, 1997).

II. SPECIFIC PROBLEMS OF YOUTH

Above was provided an overall profile of the demographic, educational and employment status of youth, which touched briefly upon some conditions which constitute broad-based problems in themselves, such as unemployment, early marriage and low educational levels. In the remainder of this paper, we will not address efforts to deal with these broad socio-economic issues, but rather we will look at more specific problems facing Indonesian youth who live within the context as described above. These include the increased risk of early sexual activity, pregnancy, sexual abuse, STD or HIV infection, and drug or alcohol abuse.

Sexual Activity and Pregnancy: The emergence of problems associated with youth sexual activity should have been anticipated when the government launched its program to delay the age of marriage. At the time, nobody raised the question of how young people would channel their sexuality if they chose to delay marriage. So how high is the prevalence of pre-marital sex and thus the risks that accompany this? As in any society, it is difficult to obtain accurate data on the increase in the number of youth engaging in premarital sex, since most will not talk about this openly.

Nevertheless, teen pregnancy and abortion statistics can be used as indicators of the prevalence of premarital sex. The publication *Sarinah* (Oct. 3, 1994) featured a review of such data. Research by Widyantoro (1989), cited in *Sarinah*, revealed that of 405 unplanned pregnancy cases at the IPPA Clinics in Jakarta and Bali during one year, 95% were youth between 15 and 25 years of age. Of those, 47% were junior or senior high school students and 37% were university students. Meanwhile, private

clinics and doctors' practices in Magelang (Central Java) dealt with an estimated 1,456 cases of youth pregnancy in one year (Nurokmah & Herien, cited in *Sarinah*, 1994). From among the counseling records of the IPPA clinic in Yogyakarta, there were 99 cases of unplanned pregnancy among unmarried youth aged 15-24 years in 1992, and 112 cases in 1993 (January to October only) (Khisbiyah et al., 1997). A study in Manado randomly selected 663 respondents from 3,106 requests for abortion, and found that 71.3% were unmarried women. Of those, 28.8% were 14-19 years of age and 52% were 20-24 years of age. Furthermore, 15.9% had junior high school education, 33% had senior high school education, and 47.8% were university students.

In the past it has been assumed that sexual activity has only increased among city youth. However, a qualitative research study done in a city and a village in South Kalimantan, by the University of Indonesia's Anthropology Laboratory, suggests that there is no significant difference between sexual behavior of youth in urban and rural areas. The small differences found could be explained purely in terms of physical access (i.e., opportunities to engage in sexual activity). Moreover, youth perceptions of pregnancy, abortion and family planning are the same in urban and rural areas (Saifuddin et al., 1997: 88).

Risk of HIV/AIDS and other STDs: The high rates of youth sexual activity evidenced by the data above is a warning of the vulnerability of this group to HIV/AIDS and other STDs. There were 619 reported cases of HIV/AIDS in Indonesia as of December 31, 1997 (Ministry of Health, 1998). Of those number, 33 cases were among teens aged 15-19, while 291 cases were youth aged 20-29. Actual infection rates of HIV/AIDS in Indonesia, as well as infections of other STDs among youth, can be assumed to be much higher than this reported cumulative number.

Several studies support the conclusion that the increase in sexual activity among youth has not been accompanied by increased knowledge about sexuality, such as anatomy and the reproductive process, AIDS, STDs and contraceptive devices. Results of a needs assessment on healthy reproduction among 3,600 youths,

conducted in 12 cities in 1993, show that their understanding of sexuality is very limited. (Kusuma Buana Foundation & NFPCB, 1994). A youth needs survey in three locations in Java (Sleman, Yogyakarta and Malang districts) supplied similar results (Dwiprahasto, 1992).

An interesting baseline survey was done by Sahabat Remaja (Friend of Youth) at the IPPA-in Yogyakarta, among 500 youths aged 15-25 years, to measure the extent of knowledge among youth about AIDS, STDs and reproductive health. Regarding AIDS, 85.5% of respondents answered at least half of the questions correctly, while only 64.5% answered at least half of the STD questions correctly. For knowledge of reproductive health and contraceptives, 74.6% of respondents answered at least 20 of the 30 questions correctly. However, if the questions are examined individually, it is obvious that their understanding is very incomplete even on the usage of contraceptive devices (Sahabat Remaja, 1995). The fact that the youth seemed to know more about AIDS than about reproductive health, family planning or STDs, may be due to the persistent dissemination of basic AIDS information in recent months. (However, while this may be true in Yogyakarta, AIDS information dissemination is not yet widespread in Indonesia.)

The low level of knowledge among youth is a direct function of the limited availability of information sources. The majority of youth receive their information from friends or from printed or audio-visual media. These sources generally supply minimal and often incorrect information. According to Saifudin et al. (1997), youths' knowledge is a combination of modern knowledge from school classes and local popular beliefs. This combination gives rise to confusion, which is evident from the difficulty youth have in explaining details of reproductive processes when surveyed.

Sexual Abuse and Violence: The problem of sexual abuse and violence is closely related to the issue of youth sexuality. This problem has begun to receive attention recently, primarily due to women activists, since almost 99% of victims of reported rapes in Indonesia are women (Endriana, *Kompas*, 1995). Most victims of rape are women aged 10-29 years (Setiabudhi, *Kompas*, 1995). The proportion of victims in

each age group is as follows: 6% under 5 years, 32.5% from 6-14 years, 26.5% from 15-17 years, and 25% are 18 and over (Sugiharti, *Suara Pembaharuan*, 1995).

The prevalence of violence experienced by female youth can be seen from the number of cases of dating violence handled by Rifka Annisa Women's Crisis Center, an NGO in Yogyakarta. From August 1993 to June 1997, 23 cases of dating violence were reported (July, 1997). These cases are certainly under-reported since very few victims report their abuse, or seek help, often remaining silent to avoid the shame or embarrassment which would result from speaking out. In the case of youth date rape, another reason not to speak out is because their relationship with their boyfriend is not sanctioned by the law or society.

Drug Addiction and Alcoholism: From year to year the number of youth who suffer from drug addiction or alcoholism continues to increase. Table 1 below describes the characteristics of people who have sought care for drug abuse since 1990. Clearly they are predominantly male (85-89%) and predominantly between the ages of 17 and 24, although the younger age group (14-16) are also significantly represented. Very few are over 25 or have university level education (CBS, NFPCB, MOH, and Macro Inc., 1995).

Table 1: Characteristics of Drug Abuse Cases at several Drug Abuse Rehabilitation Centers, Indonesia, 1990/1991 - 1995/1996

Characteristics	1990/1991 (n=485) %	1991/1992 (n=470) %	1992/1993 (n=470) %	1993/1994 (n=480) %	1994/1995 (n=565) %	1995/1996 (n=591) %
Sex						
male	89.0	89.4	89.4	89.6	85.8	86.5
female	11.0	10.6	10.6	10.4	14.2	13.5
Age						
14-16	11.4	16.6	13.8	4.2	10.8	6.9
17-20	49.9	46.2	51.7	46.0	54.2	44.0
21-24	33.5	33.2	30.0	40.4	33.4	25.5
>25	5.2	4.0	4.5	4.4	1.6	1.0
unknown	-	-	-	-	-	22.5
Education						
elementary	21.9	31.2	29.8	38.3	25.3	30.3
junior high	47.4	44.0	39.8	36.3	47.2	44.2
senior high	30.4	24.5	30.0	25.4	27.3	25.4
university	0.3	0.3	0.4	0	0.2	0.2

Source: Ministry of Health. Indonesia Health Profile 1995. Jakarta: Ministry of Health, 1995:80;Table III.C17.

Youth who use drugs tend to do so not only because of peer pressure, but also as a way to escape from other problems they are facing, such as unemployment or lack of opportunity for an improved standard of living. Family problems also can trigger substance abuse in youth. Furthermore, substance abuse is often associated with risky sexual behavior and early sexual activity. There are numerous myths about drugs and alcohol circulating among youth which must be addressed so that youth know the real risks of using drugs or alcohol. All in all, efforts of the government to combat the drug and alcohol problem should be intensified, since the numbers of youth drug addicts will surely increase in the years to come. However, the intervention should not focus on increased arrests or intimidation of offenders but on addressing this as a public health issue involving many serious and sensitive youth and societal problems.

Other Issues Emerging as Youth Problems Through Counseling Services:

Turning to the population of youth who have made use of counseling services in Yogyakarta (based at the IPPA Youth Center “Sahabat Remaja” or Friend of Youth) we find a somewhat different spectrum of problems comprising the most common counseling issues. During its 10 years of existence, Sahabat Remaja has handled approximately 4736 counseling cases. Almost of those have been youth, aged 10-24. Relationship problems were consistently the main counseling issue in all types of counseling (face to face, telephone, mail) for both men and women, and in all age groups (40-69% of all youth counseling issues, depending on type of counseling). Within the category of relationship/dating issues, the most common problems revolved around conflicts with a partner (25-45% of relationship issues) and questions of attraction (19-39%). The second most common problems brought up in counseling related to sex. Here the most likely topics were either pre-marital sex issues (16-43%) or homosexuality (22-55%). Family issues were common also, overwhelmingly concerning parents (54-75%), as were socialization issues, largely problems with friends (36-66%). Telephone counseling was by far the most popular type, with utilization rising from 37 calls in 1987 to 409 in 1996 (compared to 129 face to face). Issues of drug use were the least frequently mentioned in counseling, perhaps because these youths are not in the mainstream group who would access the services to talk about family and relationship problems (IPPA-Sahabat Remaja, 1997; Herdayati & Wahyuni, 1997).

III. RECENT GOVERNMENT PROGRAMS ON ADOLESCENT REPRODUCTIVE HEALTH

The problems experienced by youth as described require attention on many levels, but the primary initiative must come from the government. In May, 1996, the government launched a four part Essential Reproductive Health Care (ERHC) package, of which one component is Adolescent Reproductive Health (ARH). However, this initiative has not yet been implemented. In this chapter, we will examine the policies and strategies which have been implemented in the recent past the Ministry of Health (MOH), the Ministry of Education and Culture (MoEC), and the Ministry of Population/National Family Planning Coordination Board (NFPCB).

A. Ministry of Health

The MOH's ARH program strategy is laid out in "Systems of Fostering Adolescent Reproductive Health in Family Health Programs (Ministry of Health, 1992). This strategy addressed ARH within the broader program for family health. The intention is to foster adolescent responsibility for their own health, in order to increase their endurance, performance, and active participation in national development. The target group is defined as unmarried adolescents 10-19, or up to the final year of high school. The program also involves youth development organizations, parents, teachers, community figures, and youth groups in addition to program administrators and health workers.

Specifically, the MOH plan is to a) increase youth knowledge of their biological development, b) reduce the incidence of teen pregnancy, c) reduce the rates of infant and maternal mortality among young mothers, d) reduce the incidence of STDs among youth, e) increase youth participation in their own health maintenance, f) increase the family and community participation in adolescent health initiatives.

The implementation of this MOH strategy is divided into three steps: Planning, Implementation and Evaluation/Monitoring. The planning phase involved increasing

political support, from the central administration to the regional, and building inter-sectoral cooperation and collaboration among various disciplines, in order to create a supportive climate for ARH program implementation.

Implementation of the project was broadly aimed at increasing knowledge and skills of program administrators, health service workers, the community in general and youth in particular. Specific activities included the research and development of Information, Education and Communication (IEC) programs (materials, youth seminars, radio consultation programs), and basic health services for ARH (counseling, treatment and referrals), currently offered by Community Health Centers (*puskesmas*), with referrals to hospitals. Attempts were made to increase the participation of adolescents, their families, and the community in various activities supporting ARH, such as information sessions for teachers, students, and their parents. Adolescent input was sought in the form of participation in identifying, researching and analyzing the problems, arranging implementation plans and developing future solutions, in addition to generally engaging in healthy behavior.

Evaluation and Monitoring of the project was done by identification of appropriate indicators, developing of an appropriate system of record-keeping/reporting for youth and managing the development of information systems, with companies / NGOs championing elements of health (Ministry of Health, 1996). A program evaluation was done in December 1996 across all 27 provinces, but the systematic monitoring system has not been implemented as planned.

The program began with step by step training, at the provincial and the district level. Implementation was carried out in collaboration with related departments, including the Ministry of Population, NFPCB, the Regional Police, the Office of Religious Affairs, and the Department of Social Services, as well as some cooperation with NGOs and collaboration with the SHI (School Health Initiative) program in junior high and high schools. The range of activities actually implemented in each province varied considerably.

It has been acknowledged by the MOH that the adolescent reproductive health program has met with many obstacles and has fallen short of many objectives. There is a lack of standard ARH services, insufficient youth involvement was achieved and there persists a feeling of taboo among parents, who are the primary sources with whom adolescents can discuss reproductive health problems. Anticipated funding, primarily from the National Income and Expenses Budget (NIEB), was limited.

As a case example, the implementation of the program Yogyakarta has mainly taken the form of a peer education program where each school sends a student representative for training, by groups of 20 students, with the hope that these students will disseminate the information to his/her fellow students. To further mobilize the participation of the young generation, there have also been training sessions for youth groups (outside of school), and there are plans to integrate ARH issues into moral/ethical training curricula, in which two sessions will be devoted to reproductive health. In Yogyakarta, funding from headquarters was cut off in 1994, and the program subsequently received only limited funds from the NIEB, so that all activities have been limited (pc. Dr. Andung, Ministry of Health, 1997).

B. Ministry of Education and Culture

The Ministry of Education and Culture (MoEC) is responsible for implementing both formal and non-formal education in Indonesia. With fairly high participation rates up to high school, schools in Indonesia can reach millions of children and adolescents. This year, the MoEC has planned an intensive reproductive health education program for all public educational institutions. From elementary through high school, the program and material are entitled “Body and Health Education”, while at the higher education level, the program will consist of a peer education program (Dr. Suharto, MoEC, 1997).

The peer education program will utilize a training manual which includes modules on AIDS prevention for university students (MoEC and AIDSCAP Project, 1997). The training manual consists of the following ten modules: (1) Group dynamics; (2) Policy and strategy; (3) HIV/AIDS; (4) Epidemiology and the impact of HIV/AIDS;

(5) Peer education; (6) Morals and Religion in dealing with HIV/AIDS; (7) Behavior change; (8) Reproductive Health and STDs; (9) IEC (Information, Education, Communication) HIV/AIDS; (10) Workplan and activities. The material in these modules is not limited to HIV/AIDS but also relates to other issues of reproductive health and STDs. The modules have been tested on students at several institutions of higher education in Jakarta and Riau, and will be adapted for use in Bali and Lombok.

Ann McCauley, in her review of ARH curricula in Indonesia (1997), notes that the MoEC has already developed a number of previous books and modules containing material on reproductive health, such as: (1) AIDS prevention modules for university students, (2) Outreach modules (package B, Biology), (3) Mothers Club modules (Training for leaders of family education), (4) Curricula for junior high school and senior high school.

In the existing junior and senior high school curricula, the amount of information given on reproductive health is minimal. The biology textbook for the penultimate year of high school only explains the external male and female reproductive organs, and overall, only a tiny fraction of the reproductive health material which should be received by adolescents is presented in the biology textbook.

The main obstacles to school based ARH education have been the lack of aptitude or willingness on the part of teachers to approach these subjects with their students, and a lack of commitment on the part of school administrators to incorporate these subjects into the curriculum. Any curriculum change is slow to occur and public schools and the controversial nature of this change only exacerbates this problem. Furthermore, there is opposition from community leaders, including local religious authorities (Bertrand, 1996: 3). The above problems present significant and persistent challenges to the MoEC in the development of any school-based reproductive health education program.

C. Ministry of Population/National Family Planning Coordinating Board (NFPCB)

The NFPCB (known in Indonesia as the *BKKBN*) bases their ARH program on a Presidential Instruction (No. 3, 1997), on the “Development of the Quality of Indonesian Children.” ARH is addressed within the NFPCB’s program entitled “Building Families of Children and Adolescents” (BFCA). This program uses a family-centered approach, focusing largely on the role and style of parenting for effectively steering the development of children and adolescents (elementary through high school age), including their reproductive health and related behavior. The program also involves teachers, religious leaders, community leaders, and institutions, both governmental and non governmental. BFCA operates at every administrative level, from the central down to the village level.

The implementation activities of the BFCA program include training of facilitators, group activities, such as information sessions, counseling and referral programs and creation of Centers for Information and Services for Families with Adolescents. The program is expected to develop by phases, with increasing coverage and participation of implementors and facilitators, and increasing numbers of service activities and Centers, and increasing levels of training. Another indicator of progress will be the proportion of families who become BFCA members. Success will also be evaluated through qualitative research.

To support the program, BKKBN has published two versions of a book entitled “Reproductive Health Education Material,” for families with children aged 6-13 and 14-21, respectively. These two books contain very thorough information compared with the MoEC textbooks, including among others, information on family functioning, reproductive processes, sex and pregnancy, prevention of premarital sex, risky sexual behavior and STDs.

IV. FUTURE GOVERNMENT STRATEGY FOR ADOLESCENT REPRODUCTIVE HEALTH

In the project proposal entitled, *Partnership on Family Development for Safe Motherhood* (adolescent sub-component), which has been submitted to and approved by the World Bank (in 1997), the strategy for Adolescent Reproductive Health (ARH) will employ four approaches. The “Family Approach” is to be conducted via a Parent Education Program; the “School (Education) Approach” involves in-school peer education program, incorporation of Family Life Education (FLE) into programs (core curricula) in junior and senior high schools and religious schools and non-school-based FLE programs. The “Community Approach” also uses FLE in government organized youth groups (*Karang Taruna*) and other youth and women’s organizations and NGOs while the “Information, Education, and Communication (IEC) Approach” implements reproductive health education through mass media channels.

This project will begin in November, 1997, and run for five years in two pilot provinces, Central and East Java. The project will involve five departments: the NFPCB, the MOH, the MoEC, the Office of Religious Affairs and the Ministry of Social Welfare.

V. ANALYSIS AND RECOMMENDATIONS

Considering the problems facing Indonesian youth and the existing and future government programs for ARH, a discrepancy is evident between needs and services.

With regard to in-school reproductive health education, these efforts are indeed much needed given the documented lack of knowledge among youth. However, clearly current programs are limited and even efforts which have been implemented face obstacles due to the controversial nature of the issue. On one side, there is concern that RH education may have negative effects, such as motivating adolescents to engage in early or pre-marital sexual relations. On the other hand, adolescent sex education receives some support for its intended goal which is that adolescents will

better understand their sexual development, will reduce their risk of unwanted pregnancies and transmission of HIV/AIDS or STDs and will be empowered to determine their own moral standards and reproductive future.

As discussed, the government has made efforts towards provision of reproductive health education but these have been small scale, inconsistent and had limited impact for various reason. For one thing, the concepts and content of reproductive health education materials are not consistent across the range of departments and organizations involved in their development. This inconsistency and lack of collaboration creates confusion, duplicates efforts and reduces quality by an inefficient use and distribution of resources and funding. Moreover, it leaves many recipients of the education with only incomplete information. For example, AIDS and STDs information is not included by all organizations in their ARH materials or programs, and nor is mention of psychological issues involved in addition to physical. Consistency of content needs to be discussed and reconsidered.

As for who is targeted by the various efforts, while the specifics vary slightly (specified by marital status, age or school enrollment), all existing and planned ARH education programs are limited to adolescents who are either in school, have close family units and/or are members of youth organizations. These initiatives thus fail to reach adolescents working in factories or stores, or street kids. The proportion of these youths is indeed less than the mainstream youth, but their numbers are significant and they are at relatively high risk for unplanned pregnancies, AIDS, STDs, in addition to drug use and violence. The responsibility for these groups has been relegated to the Ministry of Social Welfare, and it is difficult to know how many adolescents in these marginalized groups their programs are reaching.

Informational media or IEC materials on reproductive health are not readily available for adolescents. Most of what is available has been produced by NGOs. The development of IEC materials should reflect the broader development of reproductive health programs in Indonesia. Since Indonesia is so large and diverse in cultures, and since needs differ in different groups of youth, IEC materials for adolescents must be

adapted for various audiences, and if possible, youth should be involved in the production.

Besides efforts at educating youth through educational and IEC activities, adolescents need medical and counseling services which are familiar with and willing to serve their needs. Currently, there are very few reproductive health services centers for youth. A 1992 survey of the needs of youth for reproductive health services found that accessibility of reproductive health services and information is still very inadequate and community social norms present barriers to the use of available information and services (Dwiprahasto, 1992). There is a persistent assumption even among health workers that reproduction is a matter only for married people. Health providers are not meant to provide family planning information and services to unmarried people so even without strict enforcement, the fear of humiliation prevents adolescents from accessing the widely available contraceptive services.

As discussed above, the MOH has attempted to use community health centers for some adolescent services, but it is unclear how this new group of clients would be received or served. For example, what attitude will the health worker adopt when faced with an adolescent with sex or contraceptive-related questions? Such situations require an understanding of the complexity of the adolescent sexuality problems is needed, as well as an ability to treat youths as competent individuals. Existing counseling skills among health workers are generally minimal, even for adults.

In recent years, IPPA in Indonesia (*PKBI*) has developed clinics at youth centers in various locations. However, these services have not been highly utilized and youth seem to prefer a private practice to these youth clinics. However, one successful example of IPPA reproductive health services for youth is the youth center “Sahabat Remaja”, in Yogyakarta which offers counseling by letter, telephone and face to face, as previously mentioned. Their records show that the majority of their clients are youths and are students (Herdayati & Wahyuni, 1997). Replicated services like those offered by Sahabat Remaja would be appropriate for urban areas, where access to telephones is high and transportation is available and affordable.

A reproductive health needs assessment conducted in 1993 (Kusuma Buana Foundation & NFPCB) suggested that according to youth, parents would be the ideal sources of reproductive health information, followed by teachers. However, in general the parents did not feel able to fulfill this role. At a focus group discussion among parents of adolescents held at IPPA clinic in Yogyakarta, the reasons for this reluctance were articulated. In general, the parents felt that they lacked correct information to answer reproductive health questions, and that they are unsure of where to set the limit on information which they should provide. Furthermore, they are confused about what age their children should be before they start providing this information. Most difficult to address, however, is that parents have difficulty communicating with their children in a way that fosters an open and comfortable atmosphere and does not sound like advice (IPPA, FGD Report, 1996). The NFPCB's "Building Families of Children and Adolescents" program (BFCA), as described, has tried to address reproductive health through parents, but the classic imbalances between parents and adolescents need to be explicitly addressed, such as differences in communication styles and in sexual morals.

Indeed the shift in morals in Indonesian society is very apparent in the new generation of youth. For example, kissing on the cheek and lips during dating is behavior which is now normal (Sahabat Remaja, 1995; Kusuma Buana Foundation, 1994), but if this is explained to parents, they are surprised, believing that holding hands is far enough. The majority of parents are aware that values have changed, but they do not imagine that this applies to their own children.

In summary, the following very challenging recommendations can be made:

- Stronger and clearer policy and political support is needed for the development of reproductive health programs for youth.
- Other parties such as NGOs should be involved in the new ARH strategy in a network of collaboration from the beginning, rather than only government departments. This would strengthen the programs and increase consistency (in content and concepts) and efficiency through maximum cooperation and minimum duplication of efforts and conflicting messages.

- Reproductive health education materials and curricula, in order to be acceptable and effective, must be sensitive and appropriate to local cultures, religion, urban or rural conditions but also must consistently promote gender equality.
- Special protection and outreach intervention is needed for groups of youth who are at high risk for unplanned pregnancy, AIDS and STDs, drugs and violence. These groups include street children, and youth working at factories.

VI. CASE STUDIES

Case 1

Budi is 22 years old, the child of an area chief. He lives with his family, who are poor, in a village on the outskirts of Yogyakarta. He finished senior high school, but has been unable to find a job. Living at his house are his mother and father, and Noni (21 years old), his cousin from Kalimantan, who is attending a private university.

Their village is very poor but strongly religious. There are routine religious meetings and community social values are based on religion. Since the village is located on the fringe of Yogyakarta, many people from the village go to school or work in Yogyakarta, leaving early in the morning and returning in the evening or later.

Budi is the youngest of two children. His older sister is attending the teachers college, and living in Yogyakarta. His father, besides acting as the area chief, also runs a private business as a broker (land, houses, motorcycles, etc.), so his father is often out and comes home late at night. Recently, the family found out that the father has another wife. Budi's mother is a weak woman, and she just stays at home doing housework, without the strength to make a decision.

Because they are often together, Budi and Noni became romantically involved. At first they took it slowly, but eventually they were bold enough to have sex in the house. This was found out by some friends, and by Budi's parents as well. His friends and parents feel that Budi did this because of stress over the economic condition of his family and because of his father's polygamy. This allows them to better understand and accept Budi's actions. The first time he had sex, Budi was drunk. Budi has many friends from outside the village, who often invite him to drink or use drugs and he has become involved in regular substance abuse. Despite this, he is still active in the religious life of the village.

Case 2

Wati, 22 years old, came to ask her grandmother's advice. She wants to have an abortion. The fetus is 7 weeks old. She lives in Wonosobo, and works as a store clerk. Wati's father is dead, and her mother has gone to Saudi Arabia as a domestic worker. In Wonosobo, Wati lives in a boarding house, and has no other relatives.

Wati met her boyfriend three months ago, and after knowing him for a month, they decided to have sex. The first time they had sex, Wati felt forced by her boyfriend. Afterwards she regretted it, but later was willing to do it again three more times, always in her boyfriend's boarding house. The fourth time they had sex, Wati got pregnant.

Her boyfriend is a coarse type, and when he gets angry he often abuses Wati. This is made worse by the fact that he often uses drugs and drinks. After the last time they had sex, her boyfriend moved to Kalimantan without leaving a forwarding address, or any other information.

Wati does not intend to inform her boyfriend of the pregnancy; aside from not knowing how to contact him, she does not want to marry him. Wati feels that he would not make a good husband, because he is uncouth and irresponsible. Wati also feels that she could not take care of the baby herself, as she does not have enough money to support the baby's needs.

Finally she came to visit her grandmother in Yogyakarta. Her grandmother is the only relative who she feels she can ask for help. Her grandmother lives alone, and has opened a small eatery in order to make a living. Wati asked her grandmother's advice. Both Wati and her grandmother feel that abortion is a sin and forbidden, but they feel that it is permissible since they are forced to do it. If abortion is a sin, the grandmother will bear the sin of her granddaughter.

Case 3

Lastri, 18 years old, is a high school graduate who works as a health worker in a housing complex in the center of Yogyakarta. She came to Rifka Annisa, a women's crisis center in Yogyakarta, to ask for help as she had been raped by her boyfriend. She originally was from Kulon Progo, a region to the west of Yogyakarta. Lastri's boyfriend lives in a boarding house for male university students near her workplace.

After they had been going out for a few weeks, Lastri's boyfriend invited her to his boarding house room. When they were inside, he locked the door, then forced her to have sex with him. When he successfully raped her, and saw from her bleeding that she was a virgin at the time, he laughed with pleasure because he was the first one to experience her body. After that Lastri was held in the room for a day and a night, but eventually she got away and went back to her workplace.

After several days, because she was aware that she was no longer a virgin, she went to her boyfriend to ask that he marry her. At that time, the boyfriend promised he

would marry her, then he forced her to have sex again. A little while after this second time, Lastri realized she was pregnant. She felt panicked because of the pregnancy, and went to her boyfriend to ask that he be responsible. However the boyfriend no longer wanted to marry her, and wanted her to have an abortion, although he didn't give her any money to help with the costs.

Lastri felt very stressed and depressed in facing this problem. Before she had the chance to have the abortion, she had a miscarriage.

Case 4

What follows is an excerpt from a counseling session at Sahabat Remaja (Friend Of Youth: a counseling and reproductive health information center for youth). A couple came in for counseling as the woman, Sari, was 10 weeks pregnant. Her boyfriend, Tono, 21, is doing his pre-job training, while Sari, 19, is in her last year of senior high school. They were surprised, as they felt that they had not engaged in penetration, only petting, so how could she get pregnant?

Counselor: How long have you been going out?

Answer: Two years

Counselor: When did you decide to have sex?

Answer: We have never had sex, because I was afraid Sari would get pregnant. We are not ready to get married.

Counselor: So then how is it now that Sari is pregnant?

Tono:I don't know....I never entered her, I always ejaculated outside of her.

Counselor: So the penis was never inserted in the vagina?

Tono: well.....

Counselor: Have you ever thought that that could get someone pregnant?

Tono: No...it's not possible. I never entered her.

Counselor: So now that she is pregnant, what do you think?

Tono: At first I had other thoughts...

Counselor: Like what?

Sari: He thought I had had sex with someone else.

Counselor: And now?

Tono: Well....now I....

Counselor: Upon ejaculation, did the sperm fall near her vagina?

Tono: Ya.....

Counselor: If a woman is in her fertile period, and stimulated, she excretes a fluid from the vagina which contains a substance which can attract sperm into the vagina. If a man ejaculates near the vagina, and sperm contacts that substance, the chances are the sperm will be taken into the vagina, and if there is an egg ready to be impregnated, the woman may get pregnant. Did you know this?

Tono: No.....never.

Case 5

Ika is an outreach worker at Lentera (an AIDS prevention project) who works with street youth, specifically those who hang around Malioboro St. The youth tend to be store workers, tourist guides, hawkers, and street girls.

The majority of them are sexually active (around 80%). According to Ika, sexual intercourse is a normal thing for them, as long as both people involved are willing. Their partners are usually their friends, store clerks, or foreigners. Sometimes they are engaged in brief relationships, usually with foreign tourists, while the tourists are in Yogyakarta. These relationships can be from a few days to a few weeks.

There are prevalent myths among them about the difference between sex with Indonesians and sex with foreigners. According to them, to have sex with an Indonesian is boring and without variation. When dating an Indonesian, the activities are just going to movies, eating out, wandering around. Whereas when dating a foreigner, there is more variation, a new style, mutual satisfaction. They don't want serious relationships, because they think that short affairs are more fun. If asked what kind of woman they would like to marry, they generally choose a clean-cut, good-girl type.

Ika has done extended work with around 30 street youth, and given information to many more. They range in age from 15 to 26.

Ika usually goes to Malioboro St. twice a week, Tuesdays and Fridays. She starts near the public toilets, and then traces a path around the Malioboro area, interacting with the youths in her target audience.

Usually they ask Ika about sex, health, or general topics. Their questions on sex are about satisfaction, avoiding pregnancy, condoms, AIDS, etc. Some will directly ask for condoms. Ika will only give condoms to those who are sexually active, and who know how to use them properly. She has seen small children use them as balloons. There are many kids around 15 years old who are sexually active and often have sex with sex workers and transvestites.

They used to not care about AIDS and STDs. Now they are more aware of the danger of these diseases, and there are many who ask for condoms. There are some among them who have contracted an STD; usually they ask friends for advice, buy medicine themselves, and do not see a doctor.

Some of the youth who are not sexually active say that they need information about sex, while others say that they do not need this information until marriage. Many of them do not ask their friends or anyone else, they just hope that someone like Ika will come and give them information. If those who are sexually active were to seek information, they would feel embarrassed and fear the stigma.

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