

The 2010 Greater Jakarta Transition to Adulthood Study

Policy Brief No. 5

Reproductive Health Services for Single Young Adults

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Contrary to the assumptions of many citizens and government officials, premarital sex and premarital pregnancy are evident throughout the nation, and across all social classes and ethnic backgrounds. With increasing education and modernization over the past half century the average age at marriage has steadily increased and young adult women and men are spending long periods of their fecund life in a state of singlehood. By and large they lack the knowledge and access to services that would assist them to avoid unwanted pregnancy and sexually transmitted diseases. This is an area where government has a unique opportunity to improve citizen's health status, but this will require the promotion of respect for reproductive and sexual rights. Without a major change in the attitudes underlying reproductive health policies, tens of thousands of women in Indonesia will continue to find themselves with unwanted pregnancies, forced into undesired marriages, or risking unsafe pregnancy terminations.

In Indonesia, a married 16-year-old girl can have sex, become pregnant, and have access to reproductive health services and be considered a responsible adult and mother-to-be. In contrast a 17-year-old (of legal voting age) who is single and pregnant is considered a sinner and is disrespected. She can be expelled from school, stigmatized, and isolated from her friends and relatives. The ostracism of an unmarried pregnant girl extends to her family, especially her parents, who are seen as people who have not reared their daughter properly. The girl may try to hide her pregnancy from her parents and avoid going to a health clinic to consult about her pregnancy. In desperation, she might go to a traditional healer for a dangerous induced abortion. Her partner in the pregnancy can easily avoid the threats of stigma and ostracism. The girl's extended family and friends and even the government leave her on her own without support (Utomo and McDonald, 2009:140).

The above quote reminds us of the many young women who experience premarital pregnancy in social isolation. The politics of providing reproductive health education and services for young single adults is controversial in Indonesia but

not overwhelmingly negative. Because strong religious and cultural norms promote marriage, family formation and childbearing as universal values, the promotion of reproductive health services for singles is generally discouraged, despite the government's international commitments to uphold reproductive and sexual rights for all citizens. Even reproductive health education is regarded as 'sensitive'.

There are continuing disagreements about the need for comprehensive reproductive health education and safe sex knowledge in school. School textbooks, specifically Sport and Healthy Living (PENJAKES), Biology and Science, Social Sciences and to some extent Islamic Religion provide information on reproductive health issues and HIV and AIDS (Utomo et al., 2011). Not all parents or religious leaders approve provision of such education in school.

International studies as well as research in Indonesia have demonstrated that providing reproductive health education in schools results in

more responsible sexual behaviour and safe sex practices (Diarsvitri et al. 2011; Kirby, 2002; Kirby et al. 2007; Utomo, 1997). Unfortunately many in Indonesia believe that reproductive health education would increase students' sexual activities, but this is incorrect. Research shows that ignorance is not a good policy to prevent premarital sex, but rather that it is often the ignorant child who falls victim to unwanted pregnancy and dangerous sexually transmitted diseases. Information, by contrast, provides protection.

By law (*Population and Family Welfare Law no. 52/2009*), government family planning and reproductive health services are provided only for those who are legally married. However the Ministry of Health provides these services to single women in the context of pilot projects in a small number of select PUSKESMAS.

Take for example a PUSKESMAS in East Lombok with available funds of as little as Rp. 50,000 (less than A\$7) it started a service to address the needs of young people. Due to the dedication of the head of the PUSKESMAS, plans could be put in place to paint a room that was specifically modified to accommodate the service.

Another innovative and progressive example is the senior high school health clinic in Ogan Komering Ilir (OKI), South Sumatra, which provides reproductive health services for students. In this case, a decision by the school principal reflected her commitment to provide reproductive health education, counselling, peer-group education (PIK-RR) and services for her students. Such examples are possible in East Lombok and OKI because they are located in one of the nine districts covered by UNFPA pilot projects on adolescent reproductive health.

Nevertheless, most PUSKESMAS rely on local policymakers for their resources. The adoption of the model services is strongly dependent on the initiative and commitment of the heads of the PUSKESMAS and local government leaders. If they see that such service is important and urgent they will be likely to commit funds for the purpose. Encouragement is needed in all 520 districts nationwide to stimulate similar pioneers to change local policies and practices.

With increasing prevalence of HIV and AIDS spreading throughout the provinces especially among young adults, even in provinces that are

considered as having very strict religious values such as Aceh, West Sumatra and West Nusa Tenggara, providing reproductive health education and services is a must. Many young single people are at serious risk if their reproductive health needs are not met. Increasing age at marriage causes young Indonesians to have to deal with their sexual needs much longer as they remain single for a longer time period compared to their parents (Situmorang, 2011). Their parents married at much younger ages and were able to start having sex within marriage as early as in their teens for mothers and early twenties for fathers. Today's young adults have to refrain for much longer.

Data from **the 2010 Greater Jakarta Transition to Adulthood Survey** of respondents aged 20-34 years old (N=3006) shows that 14 per cent of males and 7 per cent of females who are currently dating are having sex with their boyfriend/girlfriend. Further analysis investigated respondents who had had sex with their current spouse before marriage, by time spent dating/or engaged before marriage. The results show that 15 per cent of men who were dating their future wives for over 12 months had had sex before marriage compared to 8 per cent of those who were dated or were engaged for less than 6 months. Thus many 20-34 years olds engage in sex while single and, for their own safety and security, require access to reproductive health services.

Problems related to access to sexual and reproductive health services for those who are still single are not prioritised by the government though Indonesia has ratified the covenants on sexual health and rights affirmed in CEDAW (1979), ICPD Program of Actions (1994), Beijing Platform for Action (1995), the Millennium Development Goals and, even more fundamental, the 1948 Human Rights Universal Declaration on rights including sexual rights. The Millennium Development Goals include the target "to achieve universal access to reproductive health by 2015, this new target sets an unprecedented task for governments and health systems" (WHO, 2011:1). The 1994 ICPD Program of Action stressed the importance of information and reproductive health services for those aged 14-24 years old including access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. It suggested that services might provide access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up. As a country that has ratified the above

covenants, Indonesia has to take on the responsibility to put these principles into practice (Wardhani, 2009). But until this date, reproductive health services for single young adults are still absent from the policy dialogue and agenda.

Sex and premarital sexual behaviour

Evidence from the 2010 Greater Jakarta Transition to Adulthood Survey shows that 11 per cent of never married respondents and around 10 per cent of ever-married respondents had had sexual relationships before marriage. Among the never married, only 5 per cent of females reported experience of sexual intercourse compared to 16 percent of males. The authors speculate that reported premarital sex incidence among respondents is understated.

Further analysis of time to first sex indicated that the odds of first intercourse outside of marriage are significantly higher for males. In terms of the respondent's age or cohort, the analysis showed that compared to those aged 25-29, 20-24 year olds had higher odds of first intercourse outside of marriage indicating that the incidence is increasing across time. Relating to parental education, the results show that respondents who grew up in households with more educated parents were *more* likely to have their first sexual intercourse before marriage.

All respondents that had ever had sex were asked whether they were married to their sexual partner when they first had sex. Overall 16 per cent were not married at the time, but there were significant differences by sex, age and relationship status. For example, about one third of males were not married to their sexual partner the first time they had sex compared to under 10 per cent of women. Those with higher levels of education are significantly more likely to have sex outside marriage possibly because they marry later.

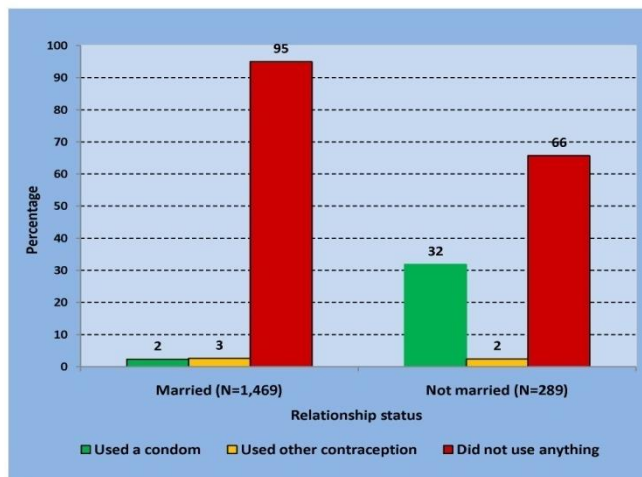
Condom and contraception used among singles

The survey results show that among single, sexually active respondents, 34 per cent used contraception with the majority using condoms (32%) at the time of first sexual intercourse. This evidence means that one third of sexually active singles are aware of safe sex practices, the other two thirds are not protecting themselves.

Respondents were more likely to judge their perceived knowledge at the time of first intercourse

to have been higher, the higher their education level and the older they were at the time of first intercourse. Those with tertiary education were twice as likely to have knowledge on safe sex and contraception compared to those with a senior high school degree.

Figure 1. Percentage of respondents who used contraception at the time of first sexual intercourse, by relationship status at the time.



Source: The 2010 Greater Jakarta Transition to Adulthood Survey

Interestingly, there is also some evidence that compared to somewhat religious individuals, those who were more religious had more knowledge about contraception and safe sex, but the effect of religiosity was significant only for females.

Premarital conception and marital birth

Of all respondents, 1,386 respondents had at least one child and had been married at least once. Of these, 1,382 had enough information on the date of marriage to allow calculation of the timing of conception of children in relation to the date of marriage. The date of conception was defined as the date of birth minus nine months. Table 1 shows that 10 per cent of births were premarital conceptions and 5 per cent were premarital births. These percentages were higher for those who had conceived at younger ages.

In further analysis, we compared premarital conceptions patterns from the 2010 Greater Jakarta Transition to Adulthood Survey with six Indonesian Demographic and Health Surveys carried out over the two decades from 1987 to 2007 (Figure 2). All these surveys show similar results regarding the proportion of conceptions occurring before marriage.

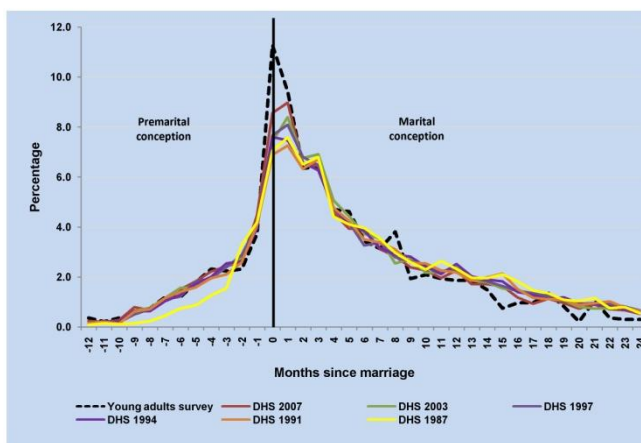
The relatively high proportions pregnant at marriage indicate that the nuptials may be a direct result of the pregnancy. International evidence shows that such ‘forced’ marriages have a very high divorce rate. Thus, young single people are not only at risk of disease, pregnancy or abortion if their reproductive health knowledge and access to services is poor; they are also at risk of being forced into a marriage that they did not plan or desire.

Table 1. Distribution of the relationship context of conception, by age at conception for women

	<17	18-19	20-23	24+	Total
	%	%	%	%	%
Premarital conception → premarital birth	9.7	7.3	3.9	3.8	5.1
Premarital conception → marital birth	18.1	13.5	7.1	7.1	9.4
Marital conception & marital birth	65.3	77.7	87.5	88.0	83.7
Birth same year or one year after marriage, but not possible to define further	6.9	1.6	1.5	1.1	1.8
Total %	100	100	100	100	100
Total N	72	193	337	267	869

Source: The 2010 Greater Jakarta Transition to Adulthood Survey

Figure 2. Time from conception to marriage, Transition to Adulthood Survey and DHS



Source: The 2010 Greater Jakarta Transition to Adulthood Survey

Conclusion and policy discussion

Indonesia has ratified many international agreements on sexual reproductive health services and rights. Political and social leaders have spoken out in support of efforts to improve reproductive health in the community and to prevent maternal morbidity and mortality. Both the Ministry of Health and the National Population and Family Planning Board have units committed to the promotion of better reproductive health services and they have large budgets to pursue these aims.

Nonetheless, data from the 2010 Greater Jakarta Transition to Adulthood Survey shows that many

single young adults are having premarital sexual intercourse without using condoms for disease prevention or other forms of birth control to avoid pregnancy. Premarital conceptions and premarital births are today and have long been common. The analysis also demonstrates that those who had their sexual debut at an older age and those having higher education perceived themselves as having better knowledge on contraception and safe sex. But for almost half of the sample, the highest achieved education is senior high school, and many started their sexual relations at a young age. These are the people in greatest need of education and services.

The policy agenda needs to concentrate on providing both sexual and reproductive health education and services for all young people to ensure that they are able to cope effectively with the risks associated with sexual intercourse. In Indonesia this responsibility lies primarily with the Ministries of Education and Health, and the Population and Family Planning Board. Marge Berer (2005), the editor of the authoritative journal *Reproductive Health Matters*, has called on such institutions to treat the sexual behaviour of young people with greater realism:

*The greatly increased attention now being paid to HIV treatment compared to ten years ago is both remarkable and long overdue. However, the family planning community has still not acknowledged that had they broadened their outreach to **young people** and those most vulnerable to HIV infection and been willing to promote condoms from the beginning, the face of the HIV epidemic might have been vastly different. **It is time that they too begin to promote condom use widely, not only as a form of STI/HIV prevention but also for contraception....with the back-up of emergency contraception and safe abortion.** (Berer, 2005:8).*

The 2010 Greater Jakarta Transition to Adulthood Survey shows that, even in the most cosmopolitan communities of Indonesia, single young adults remain inadequately informed and poorly served regarding the options they face for reproductive and sexual health. It can only be assumed that the situation of their peers in rural and remote regions would be even worse.

The institutions responsible for reproductive and sexual health information and services need to collaborate more effectively to formulate realistic and effective interventions to ensure that sexually transmitted diseases are prevented, unwanted pregnancies are eliminated, and psychological pressures on young adults are relieved. This will mean facing up to conservative forces and arguing

for the civic rights of all adults to have access to reproductive and sexual health services, irrespective of their marital status. Unless this is done soon, the dysfunctional situation seen today will continue to grow and women in particular will continue to suffer health and psychological problems that are totally preventable.

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The 2010 Greater Jakarta Transition to Adulthood Study Description:

This study on transition to adulthood is being conducted in Jakarta, Bekasi and Tangerang. This study is the first comprehensive survey on transition to adulthood conducted in Indonesia. The study is funded by the Australian Research Council, WHO, ADSRI-ANU and the ARI-NUS. The sampling involved a two-stage cluster sample using the probability proportional to size (PPS) method. In the first stage, 60 *Kelurahan* (District) were selected using PPS. In the second stage, five counties (*Rukun Tetangga*) were chosen within each selected *Kelurahan* by systematic random

sampling. The 300 selected RT were then censused and mapped. The census collected information on the age, sex, marital status and relationship to head of household of all household members. From the census, a listing of all eligible respondents (aged 20-34) living in the *Rukun Tetangga* was compiled. Eleven eligible persons were then selected by simple random sampling from the eligible county population. This resulted in a sample of 3,006 young adults.

Two survey instruments were employed. The first questionnaire administered by a trained interviewer covered all demographic aspects of the respondents, including their parents and spouse (if the respondent is married): education, work and migration histories; income and economic status; working conditions; living arrangements, relationships and marriage; number of children, family planning practices and abortion; physical-mental health related issues and happiness; smoking and drinking; religiosity and affiliation to religious and or political organizations; gender norms, values of children and world views. The second self-administered questionnaire covered issues relating to sexual practices and behaviour, safe sex practices, STDs/HIV/AIDS knowledge, access to reproductive health services, and drug use. After completion, the respondent sealed this questionnaire in an envelope before returning it to the interviewer. The study also includes 100 in-depth interviews with randomly selected respondents from the survey.

This study will produce a series of policy briefs and if funding is made possible will be continued as a longitudinal panel study following the livelihood, demographic and career aspects of the respondents over 10 years. The same respondents will be interviewed once every three years.

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