IPPF International Planned Parenthood Federation

East & South East Asia and Oceania Region

From choice, a world of possibilities

Photo by UNFPA

Overprotected and Underserved

The Influence of Law on Young People's Access to Sexual and Reproductive Health in Indonesia

Who We Are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals in more than 170 countries.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

Our Vision

All people are free to make choices about their sexuality and well-being, in a world without discrimination.

Our Mission

To lead a locally-owned, globally connected civil society movement that provides and enables services and champions sexual and reproductive health and rights for all, especially the underserved.

Foreword

Overprotected and Underserved:
The Influence of Law on Young People's Access to Sexual & Reproductive Health in Indonesia

The Regional Director with youth participants of the "Youth Leadership and Advocacy Workshop on SRHR", organised by IPPF ESEAOR and supported by UNFPA

Across the world, laws create significant barriers to sexual and reproductive health services for youth yet little research exists about the role of law in influencing and shaping access. In 2012, International Planned Parenthood Federation (IPPF) commissioned "Over-protected and under-served: A multi-country study on legal barriers to young people's access to sexual and reproductive health services". Three countries, El Salvador, Senegal, and the UK, that represent different legal systems and contrasting social, cultural, religious and political traditions, were chosen for the pilot study. Youth were the main respondents, with their views, opinions and perceptions on the role of the law remaining central to the findings and recommendations. Research conducted in these three countries, helped raise awareness about the direct and indirect impact laws can have on youth.

IPPF East, South East Asia and Oceania Region (ESEAOR) recognized the urgent need for a similar study in our region. Despite the overall progress on SRHR, youth's SRHR remains a problem. For example, teen pregnancy, child bride and female genital mutilation continues to exist in ESEAOR region.IPPF ESEAOR and our Member Associations will use the evidence generated to inform our SRHR advocacy efforts. The analysis will be used with policymakers to advocate for changes to the legal system, to expand instead of restricting access, to all youth. The research will also guide the content of our youth programming, to address misunderstandings about SRHR and the law, and empower youth to advocate for a youth-friendly SRHR environment.

UNFPA Asia Pacific Regional Office's *Reaching out to Young People Project*, which is committed to addressing the legal and policy barriers to young people's SRHR, made it possible for IPPF ESEAOR and Coram Children's Legal Centre to carry out the study in Indonesia. Indonesia is a developing country steeped in religious and cultural beliefs. The study addresses the barriers for youth to access sexual and reproductive services in Indonesia. The research shows that there are significant direct and indirect legal barriers to young people's SRHR and existence of facilitative laws, which have the potential to empower youth. IPPF ESEAOR plans to conduct similar research in Philippines and Malaysia.

A special thanks to Maurice Dunaiski, the researcher of this report and ESEAOR Program Team especially Gessen Rocas and Davina Isaac.

Best Wishes
Nora Murat
Regional Director
IPPF East, South East Asia and Oceania Region

Youth commemorating "World AIDS Day" in Kuala Lumpur

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The methodology for this research draws and expands upon a pilot multi-country study conducted by Coram International and the International Planned Parenthood Federation in El Salvador, Senegal and the United Kingdom in 2012 - 2013.

IPPF ESEAOR would also like to thank our Member Association in Indonesia, the Indonesian Planned Parenthood Association (IPPA) for their assistance and guidance throughout the study and for their feedback on earlier drafts of this report. In particular, we would like to thank Davina Isaac, Veby Yusevya, Erry Kamka and Indira Laksmi. appreciation to Kat Watson for her feedback on the review of the relevant legislation. Lastly, the authors would like to thank the volunteers at the local PKBI chapters in Semarang and Jakarta as well as all the young people and service providers interviewed for this study.

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1 Executive Summary

The overall objective of this study was to determine the impact of the law on young people's access to sexual and reproductive health services in Indonesia. In addition, this research project explored young people's and health service providers' knowledge, perceptions and understanding of various areas of law; and how these affect young people's access to sexual and reproductive health (SRH) services in Indonesia. In order to achieve these objectives, researchers employed a number of methodological approaches, including a desk-based review of existing laws, regulations and policies on SRH in Indonesia, as well as qualitative and quantitative methods of in-country primary data collection and analysis.

This study found that a number of laws and regulations directly affect young people's access to SRH services in Indonesia; in particular, laws regulating access to contraceptives and abortion services. Articles 72 and 78 of the Health Law, as well as Articles 21, 24 and 25 of the Population and Family Development Law provide that contraceptives and family-planning services are intended for legally married couples. By excluding *unmarried* people from the legal remit of contraceptives and other family planning services, these provisions create direct legal barriers that disproportionately affect young people, as they are less likely to be married. In *practice*, service providers appear to make some exceptions to this rule based on pragmatic medical considerations. However, in combination with dominant cultural and religious norms, this study found that the relevant provisions generally have a restrictive impact on access, especially for unmarried young women.

In relation to access to abortion services, the restrictive impact of the law is even more pronounced. Articles 346-348 of the Penal Code, Article 21 of the Population and Family Development Law, and Article 194 of the Health Law criminalise accessing and providing abortion services in Indonesia, whereas Article 75 of the Health Law creates two limited exceptions to this prohibition for cases of rape and medical emergencies. In combination with additional legal barriers relating to spousal consent and reporting requirements, these provisions render access to legal abortion highly rare in practice. The law requires the consent of a husband for legal access to abortion in cases of medical emergencies, which denies women and girls access to legal abortion services even to save their own lives, should their husbands deny consent. Furthermore, the law is mute on consent requirements related to *unmarried* women who seek abortion services in medical emergencies, which, in practice, appears to be interpreted by service providers to deny unmarried women abortions even where pregnancy is life threatening because no spousal consent can be obtained. The law also imposes significant barriers on rape survivors who want to legally access abortion services, such as the requirement to obtain a doctor's letter as well as an official statement from a police investigator, psychologist or other expert, and still be within 40 days of pregnancy.

Whilst this study found that unmarried young people are frequently denied SRH services as a result of specific laws and regulations, dominant cultural and religious norms also severely restrict access to SRH services for unmarried young couples. This appears to be largely because

sexual activity outside of marriage, often referred to as "free sex", is considered unacceptable and in violation of cultural and religious norms – both by service providers and young people themselves. As a result of these dominant norms, service providers are often reluctant to provide SRH services to unmarried but sexually active young people, or unmarried young people are too ashamed or afraid to ask for these services. The legal age of marriage, which currently stands at 21 (without parental consent), *indirectly* restricts access for young people. These areas of law have an indirect influence on young people's access to SRH services given that they shape perceptions amongst service providers and young people about when it is appropriate (and legal) for young people to engage in sexual activity and, by extension, to access SRH services.

Importantly, even though premarital sex was found to be heavily stigmatised in Indonesia, many unmarried young people are sexually active before they are married. For example, according to the 2010 Greater Jakarta Transition to Adulthood Survey amongst young people aged 20-35, around 5% of unmarried females and 16% of unmarried males reported that they had sexual relationships. Indeed, it appears that young people in Indonesia are often forced to navigate conflicting norms and values around sexuality. Understanding the disconnect between dominant social norms and young people's realities is crucial because, as this study shows, sexually active but unmarried young people face significant barriers to accessing SRH services based on their marital status. The interactions between conservative social norms around sexuality; young people's engagement in sexual activity; and barriers to accessing SRH services, serve not only to undermine young people's sexual and reproductive health, but may also have broader consequences for young people's rights, in particular the rights of unmarried young girls.

Lastly, this study identified a number of 'facilitative' laws, specifically in relation to confidentiality and access to SRH education, which have the potential to empower young people to make informed decisions about their sexual health without discrimination and in confidentiality. However, this study also shows that these 'facilitative' laws are generally not implemented in practice, due to misperceptions about the law and the influence of other socio-cultural barriers.

2 Introduction

Every state around the world has legislation that regulates and restricts both the expression of sexuality and access to sexual and reproductive health (SRH) services for different groups of people, including young people. In addition, social and cultural norms tend to regulate youth sexuality and sexual behaviours, which in turn stigmatises young people's seeking of/access to sexual and reproductive health services. The intermingling of legal and social norms often results in confusion for both young people and health professionals regarding who has a legal right to access sexual and reproductive health services, and the confidentiality of such services.

While existing research has begun to explore the social, cultural and economic barriers to young people's access to SRH, much less is known about the influence of law, and knowledge and perceptions of the law, on young people's access. This study explores the impact that the law has on young people's access to sexual and reproductive health services in Indonesia. The study was designed to examine the legal rules that exist and how they are applied, as well as what young people and health professionals know about the law; and how they perceive or interpret such laws as relating to themselves. Finally, the research sought to understand how the law, and knowledge and perceptions of the law, influence young people's abilities and willingness to seek out and access sexual and reproductive health services.

The methodology for this research draws and expands upon a pilot multi-country study conducted by Coram International and the International Planned Parenthood Federation in El Salvador, Senegal and the United Kingdom in 2012 - 2013.

3 Key Concepts and Definitions

Adolescents, youth and young people: For the purposes of this study, a **young person** is defined as anyone between the ages of 10 and 24 years, as per UN definition.[1] **Adolescents** are defined as persons between 10-19 of age and **youth** are defined as persons between 15-24 of age, as per UN definition. The Indonesian government uses a different age-bracket to refer to youths.[2] The Youth Law of Indonesia (Law No 40 of 2009) defines a 'youth' as anyone between 16 and 30.[3]

A **child** was defined as any person under the age of 18 years, in accordance with Article 1 of the UN Convention on the Rights of the Child (UNCRC).[4]

Sexual and reproductive health was understood to encompass two related but distinct elements: health related to sexuality, and health related to reproduction.

- **Sexual health** implies that an individual has the freedom to have a pleasurable and safe sexual life, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[5]

- **Reproductive health** implies that an individual has the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this definition is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant.[6]

SRH services: in line with the above definitions, this study considers young people's access to services that are relevant to promoting and protecting sexual and reproductive health (SRH). These include, but are not limited to: education and counselling in relation to sexual and reproductive health, contraception, family planning, abortion, pre-natal and postnatal care, maternal and infant mortality, gender/sex reassignment services, and services related to the prevention and treatment of sexually transmitted infections (STIs) and sexual violence. This definition implies that the provision of education and knowledge about SRH can be considered a 'service', as much as, for example, the provision of medical treatment.

Sexuality: is a broad term which refers to the way in which individuals express themselves as sexual beings. It may include a person's feelings, thoughts, attractions, preferences, as well as behaviour.[7]

Gender: refers to ideas, norms, roles and identities associated with being 'male' or 'female'. In this study, the term 'gender' is used to describe socially constructed roles and identities that are assigned and negotiated on the basis of social and biological sexual differences.

Transgender: is an umbrella term used to describe people whose gender identity and expression does not conform to the norms traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received other gender-related medical interventions (e.g. hormone therapy) and

individuals who identify as having no gender, multiple genders or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities.

Waria: are 'male-bodied' individuals who generally dress and act in a normatively feminine manner.[8] There is no direct English translation of the term *waria*. The word is derived from the two Indonesian words *wanita* (woman) and *pria* (man). While waria are often referred to as 'transgender', it has been pointed out that the term 'transgender' does not neatly fit with the waria subject position, as waria do not necessarily wish to 'transcend' gender boundaries.[9]

LGBTI: is a broad term that refers to individuals who are either lesbian, gay, bisexual, transgender or intersex.

MSM: ('men who have sex with men') refers to all men who engage in sexual and/or romantic relations with other men. As used in this report and in line with the definition used by UNFPA, UNDP, UNAIDS, WHO and the World Bank, the term is "inclusive both of a variety of patterns of sexual behaviour by males with members of the same sex, and of diverse self-determined sexual identities and forms of sexual and social associations ("communities"). MSM can include men who identify as gay or bisexual, transgender men who have sex with men, and men who identify as heterosexual."[10]

Lesbian: refers to a woman who is sexually attracted to other women. Not all women who have sex with women identify as lesbian.

Bisexual: refers to an individual of any sex who is sexually attracted to both men and women.

Sexual and gender-based violence (SGBV): is a broad concept that refers to any action that is perpetrated against an individual because of his or her sex, gender or sexuality and that results in, or is likely to result in, physical, sexual or psychological harm or suffering; including threats of such action or coercion. SGBV is committed for the purposes of maintaining (heterosexual) male/masculine privilege, power and control over women, and others whose identity and behaviour does not conform to dominant ideas about gender, sex and sexuality.[11]

Sex work: refers to the exchange of sexual practice for money, goods or services by male, female or transgender individuals, aged 18 and over, who consider this activity to be a source of income, irrespective of whether they identify as "sex worker" or consider the activity to be "work". The internationally recognised definition of sex work excludes where a person is coerced into selling sex or is selling sex involuntarily.

Lokalisasi: is a term used to refer to sex work areas in Indonesian cities and towns.

4 The Relationship between Law and Access

Law may influence or impact on young people's access to SRH services in various ways. For the purpose of the analysis, identified laws impacting on young people's access have been divided into three categories: those that directly restrict young people's access to services, those that indirectly inhibit access, and those that facilitate access to services for young people.

Direct legal barriers constitute laws which explicitly and purposefully restrict either the delivery of, and/or access to, certain types of SRH services for certain groups of people and/or in particular circumstances. For example, laws that criminalise access to abortion (except in very limited circumstances) constitute direct legal barriers.

Indirect legal barriers are laws that do not directly impose restrictions on access to SRH services, but may function this way in practice. For example, laws that establish a minimum legal age for consent to sexual activity, may function to restrict young people under the age of sexual consent from accessing contraceptives: amongst other issues, providing such services to children under the age of sexual consent maybe regarded as tantamount to facilitating criminal activity (sexual abuse of a minor).

Facilitative laws are laws that help promote young people's access to SRH through providing young people with legal rights and protections that have the potential to empower them to make informed decisions about sexual health without discrimination. Confidentiality duties imposed on SRH services providers which mandate protection of young people's privacy, and laws which mandate the provision of sexuality education in schools, are examples of facilitative laws.

[1] United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf, accessed 14 June 2016.

5 Methodology

5.1 Research questions

Understanding the influence of law and legal rules on young people's access to SRH services in practice is a complex task. It involves understanding both what the law is, and how it is applied; what young people and service providers know and understand about the law, and if and how such perceptions shape their choices, expectations and practices accessing or providing SRH services. Finally, it involves understanding how the law interacts with other key social, political, personal and economic factors, which play a role in determining young people's access to services.

The following set of research questions were developed to gather information relevant to the areas set out above:

1. What are the direct and indirect legal barriers that influence young people's access to SRH services and how do they impact young people's access?
2. What do young people know about the law as it applies to SRH services?
3. What do young people know about the law as it applies to sexuality and sexual activity?
4. How do young people perceive or interpret such laws as applying to themselves or their peers?
5. How does this knowledge and perception influence their access to SRH services?
6. What are their experiences accessing SRH services and how do they expect this process to occur?
7. What are the gaps in their information and access?
8. How do legal barriers interact with social, cultural or other barriers to accessing SRH services?

5.2 Research methods

This study employed a number of methodological approaches to answer the above research questions. A desk-based review and analysis of existing laws and regulations was carried out in order to establish the content of legal provisions regulating young people's sexuality and access to SRH services in Indonesia.

Qualitative data were collected in Indonesia through individual interviews with SRH service providers (nurses, doctors, counsellors, etc.) as well as focus group discussions (FGDs) with groups of young people and parents. These qualitative interactions aimed to provide a more in-depth and contextual understanding of young people's and service providers' experiences of accessing/providing SRH services, and the relevance, role and influence of law: *whether, how* and *why law* has an influence in practice. In total, **88 respondents** were accessed during the qualitative field research in Indonesia, which took place between November 2015 and January 2016.

Finally, two quantitative surveys were distributed in-country – one to young people and one to service providers – to gather a limited amount of standardised and objective data concerning knowledge of relevant law, and SRH services seeking/provision practices. Overall, surveys were distributed to **604 young people** and **80 service providers**.

5.3 Sampling

5.3.1 Site selection

Locations for data collection in Indonesia were selected to capture some of the diversity within Indonesia, with particular regard to ethnicity, religion and economic development. However, selection of sites was also limited to those areas

	Jakarta City	Central Java (Semarang & Ungaran)
Geographic location	Urban, South-West	Urban & Rural, South-East
Socio-cultural characteristics	Multi-ethnic/religious	Predominantly Muslim
Socio-economic status[12]	Relatively wealthy	Relatively deprived

where the Indonesian Planned Parenthood Association (PKBI) was able to facilitate access to communities through their networks. Jakarta City and Central Java were selected as sites for primary data collection. Both locations comprised diverse, urban communities, although in Central Java researchers included one rural location (Ungaran) that was outside of the Semarang Municipality. As such, the data collected for this study should not be understood as being representative of the whole of Indonesia.

5.3.2 Interviews and focus groups

For the in-depth interviews with service providers, researchers aimed to capture to the greatest extent possible the diversity of SRH service provision in the two selected research sites. Services providers were accessed using purposive, stratified sampling. The final sample included health professionals working in both private and public clinics, and from a range of locations, including advantaged and disadvantaged areas, rural and urban areas, SRH centres in schools, as well as SRH centres focusing on so-called *lokalisasi* (sex work areas) or LGBTI communities.

For the FGDs with young people and parents, participants were purposively sampled to capture to the greatest extent possible the views and experiences of individuals from different age-groups, socio-economic, educational and religious backgrounds. Both parents and young people were separated according to gender due to the sensitive nature of the issues under discussion.

5.3.3 Surveys

Given time and resource constraints, it was not feasible to conduct a comprehensive, nationally representative survey. Nonetheless, two short survey tools were developed – one for young people and one for service providers – in order to collect some basic descriptive and standardised data that could be analysed objectively in relation to respondents' knowledge, understanding and perceptions of law, and experiences accessing or providing services. Survey respondents were sampled using a combination of purposive and probability sampling techniques, with the aim of reaching a diverse and representative group of respondents.

For a more detailed discussion of the study methodology, including sampling design and data analysis techniques, please see Annex A. The 'interview schedule' used during the in-depth interviews with service providers can be found in Annex B. The 'group discussion schedule' used during the FGDs with young people and parents can be found in Annex C. The survey questionnaires are included in Annex D (service providers) and Annex E (young people).

5.4 Ethical protocol

The research process was guided by Coram International's Ethical Guidelines for Research (see Annex H). Prior to data collection taking place, the research methodology as well as the data collection, collation and analysis tools went through Coram International's rigorous ethical review process (see Annex F) and were approved by the Director of International Policy and Programmes. Approval was also obtained from IPPF ESEAOR as well as the Indonesian Planned Parenthood Association (PKBI).

6 Youth and Sexuality

6.1 Youth, sexuality and culture

Sexual activity amongst young people is heavily stigmatized in Indonesia. In particular, sexual activity outside of marriage is widely considered to be unacceptable and a violation of cultural and/or religious norms. The few existing studies on adolescent sexuality in Indonesia highlight how dominant cultural/religious norms only permit sexuality within the context of marriage.[13] For example, Blackwood (2007) observes that:

> "The properness of marriage and the limitation of sexuality to marriage are concepts supported by both the state, through appeals to 'traditional values of Indonesia', and Islamic moral precepts. For Indonesia's majority Islamic population, these moral precepts in turn are often indistinguishable from community norms. The mechanisms that regulate sexuality are very much a product of the synthesis of customary practices *(adat)* and Islamic law."[14]

This strong link between marriage and 'legitimate' sexual activity was demonstrated by interviews and focus groups with young people, adults and health professionals in Jakarta and Central Java; many of whom used the derogatory term "free sex" to refer to sexual activity outside of marriage.

> *Is there such a thing as 'good' or 'bad' sex?*
> "Yes, free sex is bad. I think sex can only be a good thing when you are married."
> (other participants agree)
> *Why do you think this?*
> "This is what our religion says."
> *Now imagine you have a younger sister. She has a boyfriend, who keeps asking her to have sex. What advice would you give her?*
> "I would forbid her to have sex. I would also tell her boyfriend to be responsible."
> *What if she tells you that she is pregnant from her boyfriend?*
> "Then they would need to get married."
> **FGD with male students at Islamic university, Semarang**[15]

However, despite the strong social stigma attached to pre-marital sex, many informants interviewed for this study also admitted that young people in their communities often become sexually active before they are married.

> *At what age do young people in your community get married?*
> "Girls usually get married with around 21 years, sometimes younger; boys a bit later, with around 25 years."
> *And at what age do young people in your community start having sex?*
> "Mostly after marriage. But we have friends who already started having sex when they were 14 or 15."
> *Does this happen a lot in your community?*
> "Yes."
> **FGD with male school children aged 17, Semarang**[16]

> *At what age do young people in your community get married?*
> "Boys in our community usually get married in their mid-twenties, especially if they went to university. Girls often get married a bit earlier, with around 20 years."
> *And at what age do young people in your*

community start having sex?
"After marriage. But I know that some of my friends have had sex even though they are not married."
Does this happen a lot in your community?
"Yes; especially the boys often have sex before they are married." (other participants agree)
FGD with male university students aged 20-23, Jakarta[17]

These quotes indicate that, even though premarital sex is generally not accepted and heavily stigmatised, many unmarried young people in Indonesia are sexually active *before* they are married. According to the 2010 Greater Jakarta Transition to Adulthood Survey amongst young people aged 20-35, around 5% of unmarried females and 16% of unmarried males reported that they had sexual relationships. Indeed, it appears that young people in Indonesia are often forced to navigate conflicting norms and values around sexuality. As Utomo and McDonald (2009) explain, "on the one hand, liberal values [around sexuality] are promoted through [...] media marketing propaganda, and peer pressure; on the other hand, traditional Indonesian Islamic teaching and moral values are promoted by religious schools and groups, families, and the state." These conflicting influences leave young people in a 'normative limbo' in relation to their sexuality and appropriate sexual behaviour. They may also explain the apparent contradiction that emerged from qualitative interactions with young people, whereby respondents both expressed strong and uncompromising disapproval of pre-marital sex while acknowledging that, in practice, young people often have sex before marriage.

Understanding the disconnect between dominant social norms and young people's realities is crucial because, as this study will show, sexually active but unmarried young people face significant barriers to accessing SRH services based on their *marital status*. Importantly, the interactions between conservative social norms around sexuality; young people's engagement in sexual activity; and barriers to accessing SRH services, serve not only to undermine young people's sexual and reproductive health, but may also have broader consequences for young people's rights, in particular the rights of unmarried young girls. For example, young people interviewed for this study frequently suggested arranged marriages and the termination of young girls' schooling as the most appropriate responses to unplanned pregnancies.

Imagine you have a friend who is not married and still at school. She comes to you and tells you that she is pregnant from her boyfriend. What would you advise her to do?
"She would have to get married and drop out of school."
Does this happen a lot in your community?
"Yes, I would say it happens around three times per year in our school."
Are there any other options?
"Yes, if the boyfriend does not want the baby, then maybe her mother or aunt can adopt the baby."
FGD with female school children aged 16-18, Semarang[19]

This quote suggests that, in comparison to young men, young women face particularly harsh consequences when having premarital sex,

demonstrating how cultural norms around sexuality in Indonesia are not only 'aged' but also 'gendered'.

The views expressed by young people were affirmed by parents and care givers interviewed for this study, who expressed similar views: that people's sexuality is unacceptable outside of marriage, rooting these norms in religious tradition. Consider the following excerpt from a focus group with mothers in rural Central Java:

> *Imagine you have a daughter who is still at school. She has a boyfriend, who keeps asking her to have sex. What advice would you give her?*
> "I would advise her to be reasonable and abstain."
> (another participant added) "But I would still keep an eye on my daughter and pick her up from school every day."
> *Would you tell her about contraception?*
> "No, this would not be appropriate. I would reason with her only based on our religion."
> *What if she becomes pregnant?*
> "I would tell her that she has to get married."
> **FGD with mothers, rural Central Java**[20]

Not only do the mothers' responses demonstrate that sex and pregnancy are only acceptable within the context of marriage; they also illustrate how this norm serves to justify the denial of information about and access to contraception for young people; and, problematically, how unplanned pregnancy is likely to result in the arranged or forced marriage of girls. The operation of these norms, their relationship to the law, and their impact on young people's access to SRH services will be explored in greater depth in the following chapters.

Dominant cultural and/or religious norms around marriage and sexuality also have important implications for *married* women's reproductive choices, and by implication, for their access to sexual and reproductive health services (e.g. contraception). Most young people and adults interviewed for this study conceived of sexual activity and marriage primarily in relation to reproduction/having children. For example, many interviewees expressed views, according to which married men have a 'right' to have children with their wives, overriding the wives' preferences about when to have children.

> *Imagine a friend of yours has just got married. She confides in you that she is not ready to have a baby even though her husband wants one. What would you advise her to do?*
> "I would tell her to talk to her husband about this. But in general, married women should have children. Husbands have a right to have children with their wives."
> (other participants agree)
> *When would it be okay for her to say no?*
> "If she already has five or so children."
> **FGD with female university students aged 20-21, Jakarta**[21]

Young people and adults interviewed for this study often justified these narratives about marriage and reproduction by referring to religious norms or 'natural laws', which require married women to bear their husband's children. Consider the following excerpt from a focus group

with young men in Jakarta:

> *Imagine a female friend of yours has just got married. She confides in you that she is not ready to have a baby even though her husband wants one. What would you advise her to do?*
> "I would tell her that children are God's gift and that this is part of her body."
> *When would it be okay for her to say no?*
> "I think the only exception would be if she has a serious illness." (other participants agree)
> **FGD with young men aged 21-24, Jakarta**[22]

These quotes show that dominant cultural and/or religious norms have important implications for young women's access to contraception and family planning services, even when they are married. If a young married woman's primary duty is to bear her husband's children, then she should not be accessing contraceptives, as such behaviour would be socially unacceptable and deeply stigmatised. These quotes also provide further evidence of the gendered nature of norms around sexuality in Indonesia; and how they create gender-specific barriers to accessing services: If, according to dominant cultural and/or religious norms, married women should not decide independently on when and how often to reproduce, then they should also not be accessing family planning services independently. The following chapters will explore how these social norms reinforce and interact with specific legal provisions in restricting young people's access to SRH services.

The interviews with young people and health service providers also highlighted the extent to which cultural and/or religious norms have contributed to a 'culture of silence' around young people's sexuality, including the provision of SRH services.

> *Where do your children learn about sexual and reproductive health?*
> "At school; but not enough I think." (other participants agree)
> *Do you talk to your children about these things?*
> "No, not really. The children are very shy when it comes to these issues."
> *Why do you think this is the case?*
> "We do not talk about these things openly here. It is our culture."
> **Interview with mothers, rural central Java**[23]

The 'culture of silence' was particularly noticeable in relation to the topic of abortion. Indeed, many service providers interviewed for this study appeared to be reluctant (and sometimes even unwilling) to talk about abortion.

> *Do you provide abortion services?*
> "No. It's illegal to provide abortions."
> *In your experience, is there social stigma about getting an abortion?*
> "Yes, definitely. Here, we don't talk about abortion. It is against our beliefs."
> **Interview with private health worker, Semarang**[24]

Importantly, this 'culture of silence' extends well beyond the topic of abortion and permeates all layers of society, which may be explained in part by fundamentalist Islamic influences. For example, in their paper on the historical trajectory of adolescent SRH policy in Indonesia, Utomo and

McDonald (2009) observe that the rise of fundamentalist Islamic currents in the post-Suharto era has had a silencing effect on the Indonesian government in relation to adolescent SRH policy.

> "The rise of fundamentalist Islamic forces during the Reform Era of the past decade has reversed the progress that might have been made toward a détente between Western ideas and traditional Indonesian Islamic idealized morality with regard to adolescent reproductive health. Proponents of the fundamentalist perspective employ distorted images of Western-style sexuality to attack Western influence. For a government trying to balance many competing forces, including regional separatist movements, sexuality has become a topic that is best avoided."[25]

6.2 Youth, sexuality and the law

The gendered and aged construction of acceptable sexual behaviour in Indonesia is not just a matter regulated by culture; it is also a matter of law. In particular, laws on the age of sexual consent and the age of marriage may serve to restrict young people's access to services related to sexual behaviour. Indeed, in-country interviews with young people, adults and service providers indicated that these two areas of law act as important 'markers' of when (i.e. at what age and in which circumstances) young people may engage in sexual activity, and, as an extension of this, access services related to sexual activity. Importantly, these laws treat boys and girls differently, which reflects the above-mentioned gendered norms governing sexuality and marriage in Indonesia.

Before discussing specific legal provisions on sexual consent and marriage in more detail, it is important to make the following two qualifications: Firstly, laws on sexual consent and marriage can have both restrictive as well as protective functions. On the one hand, laws prohibiting early sex and marriage have the potential to protect young people from rights violations (such as forced marriage or child sexual abuse). On the other hand, they may function to deny young people's right to express their sexuality freely and serve to restrict their access to sexual and reproductive health. Secondly, it is important to underline that cultural/religious norms can both *influence* legal norms and be influenced by them. For example, the content of the law may reflect dominant cultural or religious norms, whilst simultaneously serving as a regulatory force that reinforces or influences cultural or religious beliefs about acceptable and unacceptable sexual behaviour and reproduction. From a methodological point of view, it is thus difficult to disentangle the impact of cultural/religious norms from the impact of legal norms, as they often reinforce and/or operate simultaneously with each other in restricting young people's access to services.

6.2.1 Law on the age of consent

The age of consent establishes when a person can independently consent to sexual activity. Sexual activity below this age generally constitutes statutory rape or child sexual abuse if it involves an adult.[26] Article 287 of the Indonesian Penal Code establishes that the age of sexual consent for unmarried girls is 15 years and provides that "carnal knowledge" with a woman under the age of 15 is punishable with 9 years of imprisonment. However, prosecution will only be instituted if a

complaint is filed with the police or if the girl is below 12 years of age.[27] The law does not contain any specific provisions in relation to the age of sexual consent for boys. However, given that dominant social and religious norms make sexual activity outside of marriage unacceptable, there is a strong link between the age of marriage and age of sexual consent in Indonesia. As a result of this link, the age of consent for boys has been interpreted to be 19 years, which is the legal age of marriage for boys with parental consent.[28]

The Penal Code further provides that committing any 'obscene act' with a minor of the same sex is punishable with up to 5 years imprisonment.[29] Although 'obscene acts' are not further explained by the legislation, this provision would generally be understood to establish the age of consent for same-sex sexual activity at 18 years, as a person under the age of 18 is a minor under the Child Protection Law.[30] There are thus different ages of consent for same sex sexual acts and different sex sexual acts in Indonesia.

A number of countries have a 'close-in-age' exception put in place, commonly known as 'Romeo and Juliet laws', to prevent the prosecution of individuals who engage in factually *consensual* sexual activity, but where one or both parties are under the age of sexual consent. In Indonesia, no such provision exists and thus two young people engaging in consensual sexual activity may both be prosecuted.[31] The lack of a 'close-in-age' provision can create indirect barriers for young people accessing SRH services, as they may fear disclosing that they are engaging in sexual activity to authorities, parents or legal guardians if they (or their partner) are under the age of sexual consent; a dynamic we discuss in further detail below (see Section 6.2.3).

Some of Indonesia's statutory laws in relation to sexual consent also draw directly on Islamic religious laws (Sharia) in regulating young people's sexuality. Aceh, a semi-autonomous province of Indonesia, has significantly stricter provisions in place in relation to young people's sexual activity than the rest of the country. Aceh's by-law No. 14 of 2003 on 'khalwat' prohibits two unmarried adults of the opposite sex, who are not close family members, from being together in 'close proximity' without the presence of others. In this respect, 'close proximity' would most certainly include consensual sexual activity.[32] Violations of the law on 'khalwat' are punishable by caning, which, according to Amnesty International, constitutes cruel, inhuman and degrading treatment and may amount to torture.[33] Furthermore, under the Islamic Criminal Code (Qanun Jinayat) in Aceh, same-sex sexual relations are criminalised, regardless of individuals' age.[34] Similar provisions based on Sharia law have since been passed in a number of other sub-national jurisdictions in Indonesia.[35]

Provisions on sexual consent may impact on young people's access in a number of ways. For example, for health service providers, misconceptions about the laws on sexual consent and their relationship to the laws on the age of marriage can create uncertainty when providing SRH services to sexually active young people below the (perceived) age of sexual consent. In addition, confusion around the age of consent can indirectly influence confidential access, as health professionals may be unsure whether they have any reporting obligations to child protection services and/or the police if they become aware

that a person under the age of sexual consent is engaging in sexual activity. These dynamics are explored in more detail below (see Section 6.2.3).

6.2.2 Law on the age of marriage

Legal provisions on the age of marriage in Indonesia are important in relation to young people's access to SRH services because, as will be shown in the next Chapter, the law restricts access to SRH services for *unmarried* couples. The legal age of marriage therefore represents a threshold at which many general SRH services become available to young people. In addition, the age of marriage is closely linked to the age of sexual consent, as sexual activity outside of marriage is considered unacceptable or even unthinkable according to the dominant cultural and religious norms mentioned earlier. In this context, the age of marriage in Indonesia may have a significant influence on young people's ideas about the age at which it is acceptable to seek services related to sexual activity and service providers' perceptions about when they can and should provide young people with services. As such, laws related to the age of marriage may operate as indirect legal barriers for young people accessing SRH services.

Under the Marriage Law (No. 1/1974) a person is able to independently consent to marriage at the age of 21. Below this age, consent of both parents is required.[37] Article 7 of the Marriage Law establishes that marriage is allowed for men who are 19 or older and women who are 16 and older only with parental consent. However, the Marriage Law also provides for a process whereby parents may petition a competent district-level religious court or marriage officer to authorise marriage below the above-mentioned minimum age of marriage under special circumstances.[38]

Through this provision, an absolute minimum age of marriage is effectively removed and it is left up to the judiciary to decide on the legal age of marriage in a case where the parents support the marriage. The provisions of the Marriage Law are in conflict with Article 26 of the Child Protection Law, according to which parents are responsible and accountable for preventing the marriage of children under the age of 18 years.[39] Furthermore, the provisions can be considered contrary to international standards, which usually classify marriage under the age of 18 as child marriage.[40] However, according to a 2011 report published by UNICEF Indonesia, the Marriage Law remains the key reference for Indonesian courts in practice, even though the Child Protection Law should take precedence over the Marriage Law.[41]

The laws on marriage also directly reflect and reinforce the above-mentioned cultural and religious norms, which understand sexual activity and marriage primarily in relation to reproduction and a husband's 'right' to have children with his wives. Articles 3 and 4 of the Marriage Law (No. 1/1974) permit polygamy, but only for men (i.e. polygyny).[42] According to the law, a man may seek to have more than one wife if his current wife is 1) unable to perform her duties as a wife (not further specified); or 2) she has an incurable disease; or 3) she is incapable of giving birth to a child.[43] These provisions related to polygamy highlight the strong link between marriage and reproduction in Indonesia. They also directly discriminate against women, reinforce discriminatory gender norms and stigmatise married women and girls who cannot have children, or who simply want to delay pregnancy.

6.2.3 Knowledge, perceptions and practice

Evidence from in-country field research suggests that while service providers and young people do perceive there to be a minimum age of marriage and sexual consent in law, they are generally misinformed about or not aware of the exact age threshold(s) established by the law. Furthermore, young people's and service provider's ideas about the legal age of sexual consent appear to be informed by their ideas about when it is legal and/or appropriate to marry, which suggests that the two concepts are in practice often treated synonymously.

Young people surveyed for this study expressed very ambiguous views about when it is 'appropriate' to get married. Amongst those survey respondents who chose a specific age rather than the 'no particular age' option (in response to the question "When is it appropriate to get married?"), answers ranged from 15 years to 32 years. The most frequently chosen option was 25 years, which is substantially higher than the legal age of marriage (with or without parental consent) enshrined in the Marriage Law (No. 1/1974).

Evidence from the qualitative interviews with young people suggests that there are widespread misperceptions about the *law* on marriage. While most informants rightly indicated that the legal threshold was lower for women than for men, they generally put the respective thresholds at a *higher* age than the ones prescribed by law (i.e. 16 for girls and 19 for boys, with parental consent). This misconception about the legal age of marriage may indirectly influence the service-seeking behaviour of young people, as they mistakenly believe that marriage (and thus sexual activity and access to SRH services) is illegal before reaching approximately 25 years of age.

Interestingly, many young people interviewed for this study indicated that in practice young people in their community often get married at an earlier age than the minimum age prescribed by the Marriage Law. This practice seems to be particularly prevalent in rural areas and largely pertains to young girls, which, as indicated by a number of informants in rural Central Java, may get married as early as 11 or 12 years of age.[44] This harmful practice is facilitated by the fact that the Marriage Law creates an exception for marriage of girls under the age of 16 years, whereby their parents or legal guardians can petition the relevant local religious court or marriage officers.

As with the legal age of marriage, young people and service providers also appear to have misconceptions about the legal age of sexual consent in Indonesia. Of the 604 young people surveyed in Central Java and Jakarta, 70% agreed that the law says that it is illegal to have sex if you are below a certain age, which suggests that many young people do perceive there to be a minimum age of sexual consent in law. Those who agreed that there was a legal age of sexual consent in Indonesia, were also ask to further specify the exact age at which boys and girls can legally have sex. Respondents (both boys and girls) most frequently chose 25 years (i.e. the mode) as the age threshold at which men could legally have sex in Indonesia. The figures were similar when respondents were asked about the age of sexual consent for women. Respondents (both boys and girls) also most frequently chose 25 years as the age threshold (i.e. the mode) at which women could legally have sex. These thresholds are

substantially *higher* than the minimum thresholds enshrined in the law (15 years for girls and, implicitly, 19 years for boys).

As was the case with the age of marriage, many young people interviewed for this study admitted that, in *practice*, young people start having sex at an earlier age (14 to 15 years) than the minimum age threshold prescribed by the law.[45] Sex workers interviewed for this study suggested an even earlier age (12 to 13 years) at which young people in their community usually start having sex.

Importantly, evidence from qualitative interactions demonstrates how service providers' and young people's ideas about the legal age of sexual consent (i.e. the 'age at which it is legal to have sex') are informed by understandings or perceptions about the legal age of marriage:

> *What is the legal age of marriage in Indonesia?*
> "I think it is 18 years for boys and 16 years for girls."
> *And at what age is it legal to have sex?*
> "After marriage!"
> **Interview with private doctor, Semarang**[46]

> *What is the legal age of marriage in Indonesia?*
> "Under 20 marriage is illegal." (other participants agree)
> *And at what age is it legal to have sex?*
> "The same; after marriage."
> **FGD with male school children, Semarang**[47]

This conceptual confusion between the age of marriage and the age of sexual consent was also confirmed by the quantitative data collected through the survey with young people in Central Java and Jakarta. Around 73% of the 604 young people surveyed for this study reported that it is only appropriate for a young person to become sexually active *when he or she is married*, rather than mentioning a specific age or answering 'no particular age'.[48] These misperceptions of the law support the argument that being sexually active is presumed to be the preserve of persons who are socially and legally adult and married, and conversely that being legally permitted to have sex is understood at least partially as demarcating the distinction between children and adults, as well as the distinction between unmarried and married individuals. In part, this is likely to be explained by the above-mentioned cultural and religious norms that stigmatise sexual activity outside of marriage. Indeed, many informants did not distinguish clearly between the requirements of the law and the requirements of cultural and/or religious norms. Furthermore, evidence from interviews with school children indicate that young people in Indonesia are often taught at school that sex outside of marriage is unacceptable or even illegal, which contributes to these conceptual confusions.[49] Importantly, these conceptual confusions have implications for young people's access to sexual and reproductive health services, as they establish age thresholds under which it is believed to be unacceptable or even illegal to engage in sexual activity and, consequently, access SRH services. As we show in the next Chapter, service providers in Indonesia usually make access to contraceptives and family planning services conditional on being married. Hence, the legal provisions (as well as misperceptions about legal provisions) related to marriage indirectly influence access to SRH

services for young people, as they implicitly determine the age(s) at which it is appropriate (and legal) to provide SRH services directly related to sexual activity.

The conceptual confusion between the age of sexual consent and marriage in turn influences the service-seeking behaviour of young girls and boys, given that sexual activity outside of marriage is mistakenly believed to be illegal in all cases. Consider the following excerpt from a focus group with female university students in Jakarta:

> *What is the legal age of marriage in Indonesia?*
> "It is 19 years for boys and 16 years for girls."
> And at what age is it legal to have sex?
> "It is only legal when you are married." (other participants agree)
> *Now imagine you have a younger sister. She is not married but has a boyfriend, who keeps asking her to have sex. What advice would you give her?*
> "I would tell them that sex before marriage is illegal. If he does not stop pressuring her, they would need to break up." (other participants agree)
> *What if she eventually gives in and they start having sex?*
> "This is not good. They would need to get married."
> *What about contraception?*
> "No, contraception is not an option."
> *Why? Would it be difficult for her to get contraception?*
> "Yes. For the pill, the doctor needs to write a prescription. He would find out that she is not married. This would be a bad situation."
> **Interview with female university students, Jakarta**[50]

In conclusion, we can say that, although young people and service providers accessed for this study were generally not knowledgeable about the laws on the age of marriage and sexual consent, they did report that the law sets a minimum age of marriage and sexual consent and tended to report this age to be relatively late (i.e. around 25 years). Young people and service providers also appeared to draw associations between the legal age of marriage and the legal age of sexual consent, which illustrates the power of cultural and/or religious norms that prohibit sex outside of marriage. In some cases, respondents even reported to believe that sexual activity is illegal outside of marriage. This misperception about the law in turn appears to have a restrictive impact on unmarried young people's SRH service-seeking behaviour, as young people prefer not to approach service providers for fear of being exposed.

Photo by UNFPA

7 Access to Services

This section explores young people's and service provider's knowledge, perceptions and reported experiences related to access to/provision of a range of sexual and reproductive health (SRH) services, including contraception, confidentiality, abortion and SRH education. It demonstrates how the law in Indonesia creates both direct and indirect barriers to access to SRH services for young people. It also explores the ways in which the law can sometimes be understood as a 'facilitative' factor, promoting and protecting children and young people's rights to access SRH services. However, this chapter also shows that these 'facilitative' laws are often not realized *in practice* due to misperceptions about the law, as well as the influence of other (cultural, social,economic) barriers.

7.1 Access to contraception and other general SRH services

7.1.1 Legal review

Indonesian law contains both 'facilitative' as well as 'restrictive' provisions in relation to young people's access to contraception and other general SRH services.[51] The review of the law identified a number of provisions that may serve to 'facilitate' young people's access to contraception and other general SRH services. The right to health is enshrined in the Indonesian constitution as a fundamental right[52] and in the 2009 Law on Health No 36[53] (henceforth referred to as the Health Law). The Health Law further specifically provides for the right of young people to obtain education, information, and services concerning adolescent health to be able to live healthy and responsible lives.[54] Furthermore, the Law on Child Protection (No. 23/2002) provides that every *child* shall have the right to health services and social security in accordance with their physical, mental, spiritual, and social needs.[55]

The Indonesian law does not explicitly restrict access to contraceptives and general SRH services for individuals *based on their age*. However, there are certain provisions that can be interpreted as indirectly establishing an age threshold for consent to medical treatment in Indonesia. The Child Protection Law of 2002 defines a child as everyone under 18 and it provides that 'parents and family members are responsible for maintaining the health of the child' (see Article 45(1)). This may suggest that health professionals need to consult both children *and parents* when a decision is being made about medical testing or treatment.[56] The Sexual Rights Initiative has interpreted Article 45(1) of the Child Protection Law as requiring parental consent for under-18 year olds when accessing HIV and STI testing services.[57] Yet, rather than explicitly establishing a parental consent requirement for HIV/STI testing (or any other SRH services for that matter), the law simply implies that a young person's health remains the concern of his or her parents until he or she turns 18.

Importantly, there are a number of provisions in Indonesian law that restrict access to contraceptives and family planning services based on individuals' marital status; excluding individuals who are not *legally married*. For example, Article 72 of the Health Law provides that persons have the right to a healthy and safe sexual and reproductive life (free from compulsion and/or violence) with *a legal partner*. Furthermore, Article 78 of the Health Law provides that family planning services are intended for productive couples.[58] In addition, the Population and Family Development Law (No.

52/2009) stipulates that the policy of family planning is aimed at *supporting husbands and wives* (or future husbands and wives) in making the right decision about their reproductive rights (Article 21.1), while Articles 24.1 and 25.2 provide that contraceptive services are aimed at legally married couples.[59]

By excluding *unmarried* people from the legal remit of contraceptives and other family planning services, these provisions create legal barriers that disproportionately affect young people, as these individuals are less likely to be married.[60] Furthermore, the legislation discriminates more generally against those individuals who may not wish to marry and/or have children as expected by dominant social norms. Importantly, these provisions do not explicitly prohibit the provision of contraceptives and other family planning services to unmarried young people, but rather imply that the provision of these services should be restricted to lawfully married couples. In practice, this usually leaves the provision of contraceptives and family planning services to unmarried couples at the discretion of individual service providers; a dynamic further discussed below.

In relation to *married* women, the 2009 Population and Family Development Law also contains a legal restriction on independent access to contraceptives. Article 26.1 states that when contraceptive use carries a health risk (which is only plausible in relation to female contraceptive methods), there needs to be a formal agreement between the husband and wife.[61] This spousal consent requirement directly restricts independent access to contraceptives and family planning services for married women.

Lastly, it is also important to consider the regulatory framework around the provision of permanent contraceptive services (i.e. sterilisation), even though this probably only pertains to very few young people in practice. In Indonesia, there are no statutory laws or governmental regulations that directly regulate access to sterilisation.[62] However, in 2014, several governmental agencies together with NGOs and practitioners groups jointly published a discussion paper, which includes a number of non-binding guidelines on access to sterilisation, which can be considered a type of 'soft law'.[63] The discussion paper recommends that service providers only provide female sterilisation (tubal ligation) if the patient is at least 26 years old, already has two children,and if the consent of the husband, another male family member, or a "responsible person" (not further specified) is obtained before the intervention.[64] These guidelines are not legally binding, of course, but they provide evidence of formal policy concerning provision of sterilisation services in Indonesia, which may have implications for young people's access to sterilisation services (see 'Restrictions on access to sterilisation' below).

7.1.2 Service providers: knowledge, perceptions and practice

Service providers interviewed in Jakarta and Central Java as part of the qualitative research expressed highly ambiguous ideas about whether, and in what circumstances, they may, according to the law, provide young people access to contraception and general SRH services. Generally speaking, service providers appear to believe that in all circumstances, and regardless of age or marital status, young people may have access to services that are not directly related to being sexually active, including counselling, advice, and

services related to menstruation. However, when it comes to SRH services that are directly related to being sexually active,[65] in particular contraception, service providers appear to generally believe that there are restrictions on their ability to provide these services.

Restrictions for unmarried young people

In line with provisions contained in the Health Law and in the Population and Family Development Law, outlined above, many service providers interviewed for this project stated that the provision of SRH services directly related to being sexually active is usually reserved for *married couples*. For example, the following response from a service provider interviewed in urban Semarang was the typical reaction amongst service providers, when asked about the provision of such services to unmarried, but sexually active young people:

> *If children come to you that are not married and they reveal that they are sexually active – how would you manage this?*
> "I would not give them contraceptives. Rather, I would tell them about the importance of abstention and the dangers of free sex. You need to get married first before you are allowed to have sex!"
> **Interview with private health worker, Semarang**[66]

Service providers interviewed during the qualitative research were somewhat ambiguous as to whether this norm of limiting access to SRH services directly related to being sexually active to married couples is a matter of law, or simply of good practice.

Do you provide services to young people?
"Yes, I give special consultation sessions for young people."
Do you provide contraceptives? For example, condoms or the pill?
"No, I do not provide contraceptives to young people. Young people will only get contraceptives here if they are married."
Is this the law?
"I don't really know about the law; this is just good practice. We do not encourage free sex."
Interview with private health worker, rural Semarang[67]

Do you provide services to young people?
"Yes, we have youth friendly services for young people aged 10 to 19."
Do you provide contraceptives? For example, condoms or the pill?
"No, we only provide education, from secondary school onwards. We focus on information. We do not provide condoms or the pill to unmarried people. In some exceptional cases I have referred youngsters to [a local NGO]."
Is this the law?
"Yes, there is a regulation not to provide contraceptives. Last year [i.e. 2014] I tried to give condoms to young people in our facility, but this was not accepted by my superiors."
Interview with public health worker, Jakarta[68]

Quantitative evidence collected through the survey also suggests that the practice of restricting access to contraceptives and family planning services is at least to some extent influenced by

service providers' interpretation of the law. Around 82% of the surveyed health professionals believed that, *according to the law*, they may only provide SRH services such as contraception and STI/HIV testing to minors if they are married.[69]

Importantly, interpretations and perceptions amongst service providers about the law on SRH services appear to be strongly influenced by cultural and/or religious ideas about when it is appropriate to have sex. When asked in the qualitative interviews why they refuse to provide SRH services such as contraception and STI/HIV testing to unmarried couples, service providers would not necessarily refer to the provisions in the law, but would also often refer to cultural and religious norms that make 'free sex' (sexual activity outside of marriage) unacceptable or even unthinkable.[70]

> *When are young people allowed to have sex?*
> "They have to be married first."
> *Is that the law?*
> "I don't know about the law, but this is what our religion says."
> **Interview with private doctor, rural Central Java**[71]

Other service providers did not draw a clear distinction between statutory and religious norms[72] suggesting that the practice of denying unmarried individuals access to SRH services is informed by a synergy of legal and social norms that dictate that it is inappropriate for young people to start having sexual relationships outside of the context of legal marriage and social reproduction.
Yet other service providers argued that it was primarily 'demand-side' barriers preventing unmarried young people from accessing contraceptive and STI/HIV services.

> *Do you provide services to young people?*
> "Yes, we do outreach work in schools, both public and private."
> *Do you provide contraceptives? For example, condoms or the pill?*
> "No, I do not provide contraception to young people, only information."
> *Is this the law?*
> "I do not know about the law. In any case, unmarried young people do not request contraception, because they feel ashamed or guilty."
> **Interview with private health worker, Jakarta** [73]

In contrast to the dominant practices described above, a few service providers accessed for this study indicated that they would indeed provide contraceptives to *unmarried* young people; however, only when parental consent was obtained beforehand.[74] These divergent practices amongst service providers suggest that the decision on when (at what age and to whom) to provide SRH services is often left at the discretion of individual health professionals, and that the restrictive provisions contained in the law are only partially implemented in practice. This is perhaps not surprising, given that the law only contains *implicit* restrictions based on marital status.

Restrictions on independent access

Amongst the few service providers who did in fact provide SRH services such as contraception and STI/HIV testing to unmarried young people, the research revealed a common misconception that *parental* consent is required for access. However,

as discussed above, there is no such provision in the law that explicitly requires *parental consent* for access to medical treatment below a certain age.

When service providers were asked in qualitative interviews under which age they would require girls and boys accessing SRH services to obtain the consent of their parents or legal guardians, they generally suggested an age threshold at around 16 or 17 years.[75] The age of majority in Indonesia is set at 16 under the Criminal Code and at 18 under the Juvenile Court Law. Indonesian Police statistics and identification documents in turn use 17 as a cut-off point for the age of majority. Lastly, the Child Protection Law of 2002 defines anyone under the age of 18 years as a child. Hence, there is no unified age of majority in Indonesian law. However, importantly, all these age of majority limits are subject to one condition: a child must not be or have been married. In cases of marriage, majority can be obtained earlier.[76] In light of this overlap between the laws on the age of majority and service provider's practice, it appears that the law *indirectly* influences service providers' perceptions about when (or until what age) it is appropriate to involve parents in decisions concerning their children's sexual and reproductive health.

When asked *why* they would require parental consent when providing SRH services to young people under this age threshold, service providers did not necessarily refer to any legal consent requirements, but rather suggested that young people under this age were not capable of making informed decisions about their health.[77] This indicates that service providers' practice in relation to parental consent is largely based on 'best practices' and opinions about when young people have reached 'maturity', rather than any legal requirements. However, these opinions about young people's maturity also appear to be influenced by legal provisions that establish a legal age for majority in Indonesia, which would explain why at least some service providers mistakenly believe that there are parental consent requirements in the law on SRH services.
It appears that, not knowing the exact content of the law on consent to medical treatment (which is mute on this point), service providers use the legal age of majority as a threshold for requiring parental consent, which, as a result, indirectly restricts access to unmarried individuals below this threshold. It is not clear exactly how much of this is due to misperceptions amongst service providers about the law on consent requirements for unmarried young people,and how much is due to service providers simply following 'best practices'. However, in practice, unmarried young people below the age of majority generally do not have independent access to SRH services such as contraceptives and STI testing.

The quantitative data also provided some evidence that the law on the age of majority influences service providers' perceptions of when it is legal to provide SRH services to minors, regardless of parental consent requirements. As mentioned earlier, legal marriage effectively removes the age threshold(s) established by the laws on the age of majority. Interestingly, around 82% (i.e. the vast majority) of the health professionals surveyed for this study stated that, according to the law, they may only provide a *minor* with SRH services directly related to being *sexually active if they are married*. Again, the questionnaire included condoms, the

contraceptive pill, injections, implants, STI testing and HIV testing under the category of SRH services directly related to being sexually active. This finding indicates that service providers are to some extent influenced by the law on the age of majority and the exception it creates for *married minors*, when restricting/providing access to SRH services. However, in this case it is important to keep in mind that the law on the age of majority is also likely to *reflect* dominant cultural norms that equate marriage with the attainment of majority/maturity.

Exceptions for 'highrisk' groups

There appears to be an important exception to the common practice of restricting provision of contraception to married couples. This exception applies to groups of individuals who are understood to have 'high risk'[78] SRH needs: defined as intensified STI, and in particular HIV, related vulnerabilities. Service providers who worked in *lokalisasi* (sex work areas) or who provided dedicated services to people who use drugs and individuals who engage in same-sex sexual activity noted that, whilst SRH services should generally be restricted to married couples, exceptions would be made for these 'high risk' groups.[79] For example, one government health professional working in a well-known *lokalisasi* in Semarang indicated that he would always provide contraception and STI/HIV testing services to local sex workers, regardless of their age or (perceived) parental consent requirements.

> *If children come to you that are not married and under the age of sexual consent, and they reveal that they are sexually active – how would you manage this?*
>
> "I would tell them that they need to abstain [from sex] and get married first. Bur for sex workers, it is okay to provide contraception, even when they are under-age. Contraception is not for normal youngsters."
>
> *Is that the law?*
>
> "No, we do this for medical reasons, not because of the law."
>
> **Interview with government health worker, Semarang**[80]

Statements like this indicate that service providers' practice of granting exceptions to restrictions on provisions of SRH services to unmarried youth from 'high risk' communities are justified on the bases of pragmatic considerations of medical necessity rather than on knowledge or interpretation of any law or legal provisions *per se*.

Restrictions for married women

Findings from the qualitative field research confirmed that, in practice,service providers nearly always require married women to obtain the consent of their husbands to access SRH services such as contraception, although they are not necessarily aware of the exact basis for this in the law.

As mentioned above, Article 26.1 of the 2009 Population and Family Development Law provides that married women must obtain consent from their husbands for legal access to contraceptives that carry a health risk.[81] Evidence from the field research, however, suggests that in practice service providers nearly always request the consent of the husband before providing contraceptive services to married women, even

when contraceptive use does not carry health risks. This may indicate confusion and misperceptions about the exact extent of spousal consent requirements in the law, but it may also reflect practices based on the dominant cultural norms around marriage and reproduction mentioned earlier.

On the one hand, service providers sometimes referred directly to government regulations when asked why they required the consent of the husband to provide contraceptives to married women, providing evidence of the influence of legal norms.[82]

> *Do you require the husband's consent when a married woman accesses contraceptives?*
> "Yes, if the woman is married, I will always ask for the husband's consent."
> *Is that the law?*
> "Yes, this is what the regulations say."
> *Do you know which law exactly?*
> "No."
> **Interview with private doctor, Semarang**[83]

On the other hand, many service providers would not necessarily express knowledge or awareness of the law. Rather, they would justify their practices on the grounds of social and cultural norms which suggest that married men are entitled to have children with their wife, and that matters of reproduction within marriage are both the husband's and wife's concern.

> *Do you require the husband's consent when a married woman accesses contraceptives?*
> "Yes, always."
> *Is that the law?*
> "I don't know about the law."
> *Why do you require the husband's consent?*
> "Because I think that it should not just be the wife's decision when to have children. This is a decision that should also involve the husband."
> **Interview with private doctor, Jakarta**[84]

Restrictions on access to sterilisation

Most service providers interviewed for this study seemed to think that the provision of sterilisation services is regulated by law. This pattern was confirmed by the quantitative data: of the 80 service providers included in the survey, only 16% agreed that there are *no* legal restrictions on the provision of sterilisation services in Indonesia. The remaining 84% disagreed with this statement. Service providers generally appeared to think of sterilisation services as a permanent contraception method *for women*, and not for men. Indeed, most services providers interviewed for this study would only talk about tubal ligation, when asked about the provision of sterilisation services in *general*.

Evidence from interviews with service providers in Jakarta and Central Java indicates that the above-mentioned governmental guidelines with regard to tubal ligation are quite closely followed in practice, even though service providers are not necessarily aware of the exact content of the guidelines. Importantly, when service providers did know about the guidelines, they were often not aware of its legal status and therefore preferred to follow them strictly for fear of violating governmental regulations.

Do you provide sterilisation services?
"No, not here. I only refer patients to the hospital."
When do you recommend sterilisation services?
"In general I don't recommend sterilisation. Only when the patient asks for it. She must also be older and have around 4 to 5 children."
Is this the law?
"I think there is a government regulation. It says that if the woman has no kids, it is illegal to provide sterilisation. Also, for women who are under 20 it is illegal to provide sterilisation. The woman also needs to be married and the husband needs to agree."
What would happen if you do not follow these rules?
"I am not sure what would happen, but I prefer to follow these rules so that I don't get into trouble."
Interview with private doctor, South-East Jakarta[85]

Whereas the majority of service providers interviewed for this study were unaware of the guidelines on sterilization, and only a few explicitly referred to their content,[86] most informants stated that they would only recommend and/or perform a tubal ligation with the consent of a male family member (usually the husband) and if the woman was married. These consent requirements for sterilisation services are the same as the restrictions on access to general contraceptive and family planning services identified earlier. However, the interviews also revealed that service providers applied *additional restrictions* on access to sterilisation services that go beyond the restrictions on general contraceptive services. In particular, service providers often stated that they would only recommend and/or perform a tubal ligation if the (married) woman had at least two children and was above a certain age; broadly in line with conditions provided for in the regulations. While there was no agreement on the exact age threshold for access to sterilisation offered by service providers in qualitative interviews, most service providers suggested an age-threshold above the one provided for in the discussion paper (i.e. 26 years).[87] This is likely to exclude young people, especially those who are not already mothers, from accessing sterilisation services should they wish to do so.

It is unclear whether service providers' practices with regard to provision of sterilisation services are influenced by the policy guidelines on provision of these services, or whether the guidelines themselves reflect pre-established 'best practices' in relation to the provision of sterilisation services (after all, the guidelines were co-authored by practitioners). These 'best practices' might in turn be informed by dominant social and/or religious norms amongst service providers concerning sterilisation. This is especially significant given the requirement that a woman has the consent of a 'responsible person', usually interpreted in qualitative interviews as being a *male* family member, before accessing sterilisation services, as well as the emphasis placed on her already having at least two children, and being of a 'sufficiently mature age' before getting sterilised.

In the case of male sterilisation, in contrast, the male patient's own consent is considered

sufficient, as is his own subjective judgement as to whether his family is of sufficient size (e.g. no suggestion that he should have at least two children). Furthermore, there is no recommendation that a man should have reached a particular age before being allowed access to sterilisation. These requirements in relation to sterilisation provide evidence of the highly discriminatory, gendered, and age-related norms that influence practices concerning the provision of SRH services in Indonesian communities, and restrict the ability of women, most particularly *young* women and girls, from making autonomous and independent choices about their own bodies and reproduction.

7.1.3 Young people: knowledge, perceptions and practice

Knowledge and Perceptions

Perhaps unsurprisingly, knowledge and perceptions concerning the law on access to SRH services appear to be even more ambiguous amongst young people than amongst service providers. In general, young people appear to believe that only married couples should access SRH services. This link between marital status and access to SRH services appears to be informed (or reinforced) by young peoples' opinions about when (i.e. at what age) a young girl should be able to access contraceptives, regardless of what they think the law says in this respect. Of all young people surveyed for this study (both male and female), more than half (52%) indicated that a young girl should only be able to access contraceptives when she is married (regardless of whether or not she has already had children). Similarly, around 16% indicated that a young girl should only be able to access contraceptives once she is married, but only after she has already had her first child. Taken together, these findings suggest that around 68% of young people surveyed for this study believe that a young girl should only be able to access contraceptives *after she is married*. Girls were significantly more likely than boys to believe that access was dependent on marriage. The more 'conservative' attitudes amongst surveyed girls may be the result of dominant social norms that stigmatise female sexual activity outside of marriage to a greater extent than male sexual activity outside of marriage.

There also appear to be some misperceptions amongst young people that the law creates a direct legal barrier to access contraceptives *based on age*, rather than marital status. Of the 604 young people surveyed in Central Java and Jakarta, around 30% agreed with the statement that 'the law sets an age at which young people are able to access any form of contraceptives/birth control' and 11% of respondents indicated that they did not know what the law says in this regard. Around 41% rightly indicated that the law does not contain a direct restriction on access to contraceptives based on age, and 18% rightly suggested that there was no direct legal age restriction, but wrongly suggested that 'legal access is at the discretion of the service provider'. These findings highlight the significant amount of confusion amongst young people in relation to the law on access to SRH services. We do not find evidence that there is a statistically significant relationship between the respondents' gender and their opinion about the law on access to SRH services.

Accessing services in practice

Only around 6% of all 604 young people surveyed

for this study admitted that they have had sex before. However, the strong social and religious stigma around young people's sexuality is likely to have prevented respondents from reporting truthfully on their sexual history. Indeed, the large proportion of respondents (80%) who *preferred not to answer the question* suggests that respondents were often too shy or afraid to openly report on their own sexual behaviour. Only 14% of respondents explicitly indicated that they had never had sex before.

Of all young people surveyed in Central Java and Jakarta, only 147 respondents (24%) indicated that they had ever tried to access any type of SRH service included in the survey.[88] Boys were significantly more likely to try accessing SRH services than girls. This gender-difference in relation to service-seeking behaviour was also confirmed by evidence collected through the qualitative interviews.

> *Would it be difficult for your friends to get contraception?*
> "No. Condoms are easy to get at the supermarket. You can get 10 condoms for around 50,000 Rupees." (some participants disagreed on the price)
> *Who is more likely to get contraception, boys or girls?*
> "Boys; definitely."
> **FGD with male university students, Jakarta**[89]

A simple correlation test reveals that age of the respondent is also significantly associated with service-seeking behaviour. Older respondents are more likely to report having tried to access any type of SRH service than younger respondents ($p < 0.01$). We find no evidence that the respondents' religion or place of residence (i.e. urban or rural) is associated with their reported service-seeking behaviour.

When looking specifically at access to contraceptives (i.e. condoms and pills), the quantitative data revealed significant differences between boys and girls (in line with the general pattern identified above). Of all 604 young people surveyed in Central Java and Jakarta, only 8% reported to having ever tried to access condoms and only 1.6% reporting to having ever tried to access contraceptive pills, keeping in mind that only 6% of the sample reported to be sexually active. Importantly, roughly 75% of the respondents who had tried to access condoms were male.[90] The gender-balance was reversed when examining those respondents who reported to having ever tried to access oral contraceptive pills (80% female, 10% male).

24% of the survey sample reported to have ever tried accessing any kind of SRH service.[91] When we look only at those respondents who indicated that they had tried accessing any SRH service, roughly 31% (or one in three)reported that they had been denied access to at least one of the SRH services included in the survey. Importantly, of all those respondents who reported that they were denied access to any SRH service, around 66% reported that they had been denied access to these services because of *their age*. This indicates that age maters when young people try to access SRH services.

The results are confirmed when we look at denial of access to condoms in particular.Of those respondents (both male and female) who indicated that they had ever been denied access

to *condoms*, roughly 56% reported that they were denied access *because of their age*.[92] Again, this finding indicates that age does indeed matter when young people try to access condoms.

Some boys interviewed for this study reported that, in order to buy condoms in drug stores or supermarkets, they or their friends were sometimes required to show identification cards (IDs), which are only issued upon reaching the age of 17 or upon marriage.[93]

> *Does it matter how old you are when buying condoms?*
> "Yes, at the supermarket they sometimes as for IDs if you look very young."
> *Is there a law about this?*
> "I don't know about the law. But sometimes the seller intimidates us when we want to get condoms, so we think it's not appropriate."
> **FGD with male university students, Jakarta**[94]

These findings may indicate that sellers of condoms implicitly apply the age threshold defined in the age of majority law, when determining whether to deny access to young people. However, this practice does not seem to represent a major barrier to accessing condoms for boys in Indonesia, because, as indicated by many young men interviewed in Jakarta and central Java, condoms can instead be easily purchased from street vendors, regardless of age.

In contrast, in order to access oral contraceptive pills, women in Indonesia usually require a prescription from health service providers, who, as was discussed earlier, often make access dependent on marital status or parental consent.

However, based on evidence gathered during interviews with young women in Jakarta and Semarang, it appears that oral contraceptive pills can also be purchased from some drug stores ("Apotek") *without* prescriptions from health professionals. However, young women interviewed for this study indicated that sellers would often intimidate them and frequently ask for IDs before providing oral contraceptive pills, as was the case with accessing condoms for boys.[95] These additional barriers to independent and safe access to oral contraceptive pills for unmarried girls were also confirmed through interviews with service providers. Consider the following quote from a health worker in Jakarta:

> *Do you require the husband's consent when a married woman accesses contraceptives?*
> "Yes, always. I provide the pill and injections to married women, but only with their husband's consent.
> *What about unmarried women?*
> "I do not provide the pill to unmarried women. Unmarried girls to not come here for the pill. I think this is because they feel ashamed. Instead, they will get unprescribed pills from the drug store. But there are often problems with side-effects if the pills are unprescribed."
> **Interview with private health worker, Jakarta**[96]

Financial barriers to access

The survey with young people also collected data on *where* respondents tried accessing SRH services. Interestingly, 'community members' were chosen as the most frequent category (30%) amongst all those young people that reported to

having ever tried accessing any of the SRH services included in the survey questionnaire.[97] Another 20% indicated that they had tried accessing services at a 'clinic specialising in SRH services' (which includes NGOs such as PKBI) and 18% indicated that they had tried accessing services at a 'public clinic'. The remaining categories ('pharmacy', 'school health centre' and 'private fee-paying clinic') were chosen much less frequently, with 9%, 4% and 5% respectively.[98] These findings suggest that young people frequently access SRH services through unregulated, unofficial channels (for example 'traditional healers' or street vendors), but rarely through fee-paying health clinics. Importantly, data from the survey of service providers indicated that private clinics are significantly more likely to provide oral contraceptive pills to young people, compared to public or school-based health centres.[99] Similar patterns were identified in relation to the provision of condoms, STI testing and HIV testing.[100]

Evidence collected through the qualitative fieldwork suggests that prices and fees of SRH services provided at private fee-paying health clinics can act as a significant barrier for young people's access to SRH services. This barrier was highlighted by a number of service providers; in particular health professionals working in relatively deprived areas.

> *What do you think is the biggest challenge in ensuring comprehensive access [to SRH services] for young people?*
> "Price is a big barrier! We provide HIV testing for 10 to 24 year olds for free; and counselling is for free. But even though I think this clinic is cheaper than other private clinics in the area, there are many young people that cannot afford our services."
> **Interview with private health worker, Jakarta**[101]

> *What do you think is the biggest challenge in ensuring comprehensive access for young people?*
> "I think the biggest problem in my area is that only young people with money can access quality services. For example, I can provide counselling to non-paying customers, but I cannot afford to provide any other services free of charge. Many young people come to my clinic directly from Puskesmas [the local government health centre] because they did not get the services they were looking for there. But when they come to me, very often, I also have to turn them away, because they cannot pay."
> **Interview with private doctor, Jakarta**[102]

The last quote highlights a pattern that was substantiated through other interviews with private and public service providers. Even though private clinics accessed for this study were generally more likely than public clinics to provide SRH services to young people without restrictions (e.g. based on marital status or parental consent), these private clinics nevertheless often remained inaccessible to young people from disadvantaged communities due to financial barriers.

7.2 Confidential access

7.2.1 Legal review

The Health Law provides that 'every person shall be entitled to the confidentiality of their personal health condition disclosed to the health service provider.'[103] Law No. 29/2004 on Medical Practice establishes that medical confidentiality shall always be treated as permanently classified, even after the death of the relevant patient. Limited disclosure of medical records, without the specific consent of the patient, is only allowed upon request by the relevant authority for the purposes of law enforcement. Full disclosure of medical records may only be made upon an order of court.[104] To our knowledge, there are also no child protection reporting obligations for health professionals in Indonesia.[105] The above provisions in the Health Law and the Medical Practice Law are supposed to provide privacy around SRH services and install confidence in young people that they are able to discuss SRH services confidentially with health service providers, and may therefore constitute 'facilitative laws'.

7.2.2 Knowledge, perceptions and practice

Evidence gathered through the surveys as well as in-depth interviews with service providers suggests that, even though health professionals are well aware of the confidentiality principle enshrined in the Health Law and the Medical Practice Law, this does not necessarily mean that young people can rely on confidential access to SRH services *in practice*. It appears that the parental consent requirement for unmarried individuals identified earlier represents a significant restriction on young people's confidential access to SRH services, as service providers seem to routinely break the confidentiality rule when it comes to members of the *immediate family*, which in turn undermines the potentially 'facilitative' impact of the confidentiality principle. In contrast, most service providers interviewed for this study indicated that only rape cases and drug abuse cases would justify informing someone *outside of the patient's immediate family.*

Most service providers interviewed for this study were aware of the confidentiality requirement and also indicated that they would ensure the confidentiality of their patients, regardless of age, once they have agreed to provide services. The quantitative data collected for this study provide further evidence that SRH service providers in Indonesia are generally well aware of the confidentiality requirements enshrined in the Health Law and the Medical Practice Law. Of the 80 health professionals surveyed for this study, around 72% agreed with the statement that, according to the law, they were required to protect a minor's confidential access to condoms, contraceptive pills and injections *under all circumstances*. In this respect it is interesting to note that, at the same time, 69% of the surveyed service providers agreed with the statement that, according to the law, they were required to inform a minor's parents (even against his or her will) if he or she accessed condoms, contraceptive pills or injections.[106] In fact, half of all respondents (i.e. 40 service providers) agreed with both statements. At face value, this might seem contradictory. However, we need to keep in mind that the questionnaire only asked respondents about what they thought the legal requirements in relation to parental consent and confidentiality were (no matter how contradictory they might be), and not what the respondents would do *in practice.*

Based on evidence collected through interviews with health professionals, it appears that *in practice* service providers routinely break the

confidentiality requirements set out in the Health Law and the Medical Practice Law, when providing contraception and STI/HIV testing to *unmarried* young people. As mentioned earlier, service providers would generally suggest an age threshold at around 16 or 17 years for requiring parental consent.[107] Again, it appears that, not knowing the exact content of the law on consent to treatment, service providers use the legal age of majority as a threshold for requiring parental consent, which, as a result, indirectly restricts access to unmarried individuals below this threshold.

Opinions about the law on confidentiality seem to be even more ambiguous amongst young people than amongst service providers. The quantitative data collected for this study provide some evidence that young people are aware of the confidentiality requirement in the law, even though disagreement seems to exist about its exact scope. Around 17% of surveyed young people were of the opinion that, according to the law, doctors could *under no circumstances* inform their parents when they access contraceptives, and 28% indicated that, according to the law, confidentiality could only be broken if the use of contraceptives carries a health risk. 10% were unsure about the law on confidentiality and 25% were of the opinion that, according to the law, it is up to the doctor to decide when to break the confidentiality requirement.

Only 18% of surveyed young people suggested that the law actually imposes a positive obligation on doctors to inform their parents when they access contraceptives. These findings indicate that a plurality (i.e. around 45%) of young people rightly believe that confidential access to contraceptives is (at least to some extent) legally guaranteed. The fact that 18% of respondents mistakenly believe that there is a positive obligation on doctors to inform parents may be explained by the *practice* identified during the qualitative interviews, whereby service providers require parental consent when unmarried young people access SRH services, even though the law is mute on this point. This misconception about the law may have a restrictive impact on young people's service-seeking behaviour, especially if they wish to have confidential access to services, but mistakenly believe that service providers are obliged to inform their parents or legal guardians.

Importantly, the quantitative data collected through the survey with young people also indicates that young people generally do not feel that their confidentiality will be guaranteed *in practice* when accessing SRH services (no matter what the law says in this respect). When asked whether they thought that doctors and midwives would keep their encounter confidential when approached for advice about contraception and STI testing, only 23% of surveyed young people responded with 'yes'. In contrast, more than half of all respondents (52%) were not sure and around 25% of young people responded with 'no'. This result suggests that young people generally do not believe (or are unsure) that access to SRH services will be kept confidential, which indicates that the 'facilitative law' on confidentiality has a relatively limited impact *in practice*. Unfortunately, the data do not allow us to say whether this is because of any misconceptions amongst young people about the law on confidentiality or because of their own previous experiences when trying to access SRH services. We did not find evidence that there is a statistically significant difference between girls and boys when it comes to confidence in confidential access to SRH services.[108] We also did not find evidence that age of the respondent is

significantly associated with confidence in confidential access.[109]

When asked whether it is ever appropriate to report a young person accessing their services to anyone *outside their immediate family*, health professionals interviewed for this study usually only mentioned cases of rape and drug abuse as exceptions to the confidentiality rule.[110] Of all 80 service providers surveyed for the quantitative component of this study, around 14% indicated that they had ever reported a minor to the police or child protection services because they learned that he or she was 'sexually active'. Unfortunately, the survey questionnaire did not distinguish between cases of forced and factually consensual sex, so it was not possible to determine how many of these cases were directly related to rape.[111]

7.3 Access to abortion

7.3.1 Legal review

The law in Indonesia creates significant direct legal barriers to access to abortion services, which affect all women in Indonesia, but are likely to have a disproportionate impact on young women and girls. A number of provisions in the Indonesian Penal Code directly criminalise both *accessing and providing* abortion services. Article 346 of the Penal Code provides that "any woman who deliberately intends, causes or lets another cause the drifting off to death of the fruit of her womb, shall be punished by a maximum imprisonment of 4 years."[112] Penalties for the *provision of abortion* services are even greater: article 348 of the Penal Code provides that any person 'who with deliberate intent causes the drifting off or the death of the fruit of the womb of a woman' *with her consent* shall receive a prison sentence of up to 5 years and 6 months. The penalty increases to a maximum of 7 years if the action results in her death.[113] In addition to the Penal Code, Article 21.3 of the Population and Family Development Law No 52 of 2009 criminalise the provision of abortion services in Indonesia,[114] and Article 194 of the Health Law states that any person who performs an abortion may be sentenced to 10 years of imprisonment or a fine of up to one billion Indonesian Rupees.[115] The legal review did not reveal any relevant case law that would indicate which of these laws and (at times contradictory) sentencing regimes take precedence in relation to abortion cases.
Despite these strict prohibitions on abortion, the Health Law of 2009 provides for a very limited number of circumstances in which a woman may legally access abortion services. The two exceptions are 1) if continued pregnancy would threaten the life of the pregnant woman and/or the foetus; and 2) if the pregnancy was caused by rape and continued pregnancy would cause psychological trauma to the survivor.[116]
Importantly, a woman may only legally access an abortion, if a number of further conditions are met, namely:

- if the woman has not reached 40 days of pregnancy, counted from the last day of menstruation, except in medical emergency situations;[117]
- if undertaken by a medical doctor/worker, with a certificate provided by the Ministry of Health;
- with the consent of the pregnant woman;
- with the consent of her husband (except in cases of rape);
- if the provider fulfils all the Ministry of Health's criteria.[118]

In addition to meeting the above-mentioned criteria, every woman seeking abortion in cases of rape and medical emergencies must also undergo counselling before and after the abortion.[119]

Furthermore, in cases of rape, women must report the incident to a doctor and a relevant person of authority and still be within the 40 days' time limit in order to legally access abortion services after rape.[121]

The restrictions on access to abortion are grave and render access to legal abortion highly rare in practice.[122] The provision requiring consent of a husband for legal access to abortion in cases of medical emergencies, denies women and girls access to legal abortion services even to save their own lives, should their husbands deny their consent. Furthermore, the law is mute on consent requirements related to *unmarried* women who seek abortion services in medical emergencies, which has been interpreted to deny unmarried women abortions even where pregnancy is life threatening because no spousal consent could be obtained.[123]

7.3.2 Knowledge, perceptions and practice

Qualitative evidence collected through interviews with service providers indicates that the almost absolute prohibition of abortion in Indonesia has a direct impact on the provision of abortion services: health professionals generally do not provide abortion services for fear of violating the law.

Do you provide abortion services here?
"No, we never provide or recommend abortion."
Why?
"Because abortion is illegal."
Do you know if there are any exceptions in the law?
"I don't know about exceptions. I think it is always illegal."
Interview with government health worker, Semarang[124]

Most medical practitioners accessed for this study were aware that there are some legal exceptions to the prohibition on abortion in Indonesia. Whilst the vast majority of service providers interviewed for this research project did not provide abortion services themselves,[125] some indicated that in the case of medical emergency they would be willing to refer a pregnant woman to specialised hospitals to undergo legal abortion. In keeping with provisions in the law related to spousal consent, a number of service providers indicated that they would only recommend abortions in cases of medical emergencies if the woman was legally married and if the husband's consent was obtained.[126] For example, the below quote suggests that service providers interpret the consent requirements in relation to abortion in a way that effectively prevents unmarried women from obtaining an abortion (even where pregnancy is life threatening), because no spousal consent can be obtained.

Do you provide abortion services?
"No, but I sometimes refer patients to the hospital in medical emergencies."
What does the law say about abortion?
"Abortion is illegal, except in cases of high health risk."
Are there any additional restrictions?
"Yes, the woman has to be married and I always ask for the husband's consent."
What about cases of rape?
"I don't know about rape victims."
Interview with private doctor, South-East Jakarta[127]

As illustrated by this quote, the second legal exception to the prohibition on abortion – the limited availability of abortion in the case of rape – was also much less known by service providers interviewed for this study. A number of service

providers suggested that lack of detailed knowledge about abortion law is the result of a lack of government newsletters that would provide health professionals with official information about the current law on abortion in Indonesia. In this respect, conservative cultural and religious norms appear to influence government policy. For example, one government health official interviewed for this study maintained that the Indonesian government was reluctant to provide official guidelines and informational material on abortion laws to service providers, for fear of being perceived as supportive of abortion by conservative and religious pressure groups.[128] Importantly, a lack of guidelines appears to cause uncertainty among health providers, resulting in a reluctance to recommend or undertake abortion procedures even in the limited cases in which it is in fact legal, for fear of overstepping the law.

> *"Many of my Puskesmas [public health centre] colleagues have asked me about when abortion is legal. They complain that they do not receive enough information about this issue.* ***I know that they prefer not to recommend abortions because they are unsure what is legal and what is illegal.*** *I think this is a problem."* [129]

Perhaps unsurprisingly, young people appear to be even less well informed about the law on abortion than service providers. In fact, most young people interviewed for this study seemed to think that abortion was illegal *in all circumstances*. This lack of knowledge about the law on abortion appears to have a direct impact on service-seeking behaviour, as most of the young women interviewed for this study indicated that they would never consider getting an abortion in the first place.

> *Have you heard about abortion?*
> "Yes, it's when you get rid of your baby before it is born."
> *What does the law say about abortion?*
> "Abortion is illegal."
> *Are there any exceptions?*
> "No, I don't think so. It is not an option.""
> (other participants agree)
> **FGD with female school children aged 16-18, Semarang**[130]

7.4 Access to Sexuality Education

7.4.1 Legal review

The Health Law specifically obliges the Indonesian government to ensure that young people can obtain education, information, and services concerning adolescent health to be able to live healthy and responsible lives.[131] In addition, Article 72(d) states that everyone is entitled to obtain information, education, and counselling concerning sexual and reproductive health.[132] Furthermore, Government Regulation No. 87/2014 on Population Development outlines seven elements of reproductive rights, including the right to information on sexual and reproductive matters.[133] Lastly, Presidential Decree No. 5/2015 states that reproductive health is to be incorporated into the official school curriculum.[134]

In contrast to these potentially 'facilitative' laws and regulations, there are also a number of provisions in Indonesian law that create direct legal barriers for young people's access to sexuality education. In relation to information about contraception, Article 534 of the Indonesian Penal Code makes the exhibition of means for *preventing* pregnancy, or the provision of information on where means or services for the prevention of services are available a criminal offense and punishable with up to two months.[135]

Article 283 of the Penal Code states that the provision or exhibition of materials to a minor under the age of 17, which include means to prevent or curb pregnancy are punishable with up to nine months of prison.[136] Lastly, the Indonesian Penal Code also contains a provision on 'offences against decency', which prescribes punishments for those who knowingly disseminate, openly demonstrate or put in writing, a portrait or an object 'offensive to decency.'[137] For those who make an occupation or habit of the commission of this crime, the prison sentence imposed can reach up to 2 years and 8 months.[138] It is not clear what the term 'offences against decency' entails and it is possible that the dissemination of sexuality education materials could fall within the legal remit of this provision. However, we have not been able to identify any cases where this provision has been applied in relation to sexuality education.

7.4.2 Knowledge, perceptions and practice

Sexuality education is not explicitly included in the national curriculum as a separate subject and basic SRH elements are instead taught under subjects such as biology, religion and physical education.[139] Although elements of SRH and HIV education are included in the national curriculum, in practice, it is up to the discretion of the teacher whether and how to apply it.[140] In addition to the internet and peer-to-peer education, focus group participants identified school classes as the most important source of information on SRH matters for young people. Indeed, the quantitative data collected through the surveys seem to confirm that the school is one of the most important sources of information on SRH matters for young people. Of the 604 young people surveyed in Jakarta and Central Java, around 77% reported that they had received some form of sexuality education in school. This stands in contrast with only 21% who reported to having received sexuality education from an NGO and only 14% who reported to having received sexuality education from a religious or community leader. Lastly, 8% of the sample reported that they had never received any sexuality education.[141]

Qualitative interviews with street children in Semarang confirmed that this marginalised group of young people is almost completely cut off from any sources of sexuality education, as they often dropped out of school early and do not have access to the internet. As a result, knowledge about SRH matters amongst street children appears to be very limited. For example, when asked what types of contraception exist, the street children interviewed for this study only mentioned condoms. This stands in contrast to most school children of comparable age interviewed for this study, who were generally aware of at least some types of female contraception (e.g. the contraceptive pill). When asked where they had heard about condoms, the street children interviewed in Semarang indicated that they had only heard about condoms from older friends, and that they were not sure how to use them properly.[142]

Importantly, even those young people who receive SRH information in school do not necessarily receive sufficient or adequate information recommended by international guidance on sexuality education.[143] In fact, interviews with service providers as well as young people suggest that the quality and scope of sexuality education provided in Indonesian schools is mostly limited to a discussion of the physiology of sexual organs and the risks associated with sex (e.g. HIV/STIs). For example, one private health worker interviewed in Semarang complained that school children in her neighbourhood only

'learned about the theory' and that they often did not know how to properly implement this theoretical knowledge about SRH matters in practice.[144] Many young people interviewed for this study also highlighted the lack of quality information provided in schools by teachers. Indeed, young people often used the focus groups to ask about specific issues that had apparently not been covered in school.[145] In order to compensate for this shortcoming in relation to sexuality education, a number of health workers and NGO staff interviewed for this research said that they conduct regular outreach sessions in schools and universities.[146]

There appear to be a number of factors (including legal barriers) that restrict the outreach work of health professionals and NGOs in schools and universities.Whilst this does not relate to the general provision of sexuality education, it is relevant for outreach workers providing information about and referrals for abortion. Some informants suggested that the prohibition on the dissemination of information about abortion contained in the Penal Code does have a 'silencing effect' on outreach workers, as they are afraid to discuss the issue of abortion during their outreach sessions.[147] This indicates that the provisions in the Penal Code may have a direct impact on restricting young people's access to sexuality education.

However, the most important factor restricting the outreach work of health professionals appears to be related to the lack of formal agreements between schools/universities and external SRH educators. Many interviewees stated that, in the absence of formal agreements, the success (and content) of the sexuality education sessions in schools depended to a large degree on the goodwill of the headmaster or the relevant teacher (e.g. the biology or religion teacher). For example, one service provider from Jakarta recounted an incident, where he was thrown out of a classroom simply because he started talking about contraception.[148] Some service providers also indicated that headmasters of religious schools were much less willing than headmasters of public schools to invite outreach workers to conduct SRH sessions, which may create additional barriers to accessing sexuality education for pupils enrolled in religious schools.[149] Lastly, a number of service providers criticised the fact that many facilities providing dedicated SRH counselling services were only open during school time (i.e. 8am until 2pm), which would effectively prevent many school children from coming to these facilities to receive additional information about sexuality education.

Photo by UNFPA

8 Law and Hetero-normativity

8.1 Same-sex sexual activity

8.1.1 Legal review

There are a number of potentially 'facilitative' laws and regulations in Indonesia that can be interpreted as prohibiting the discrimination on the basis of sexual orientation and/or gender identity. The Law on Human Rights (Law No. 39/1999) stipulates that every person in Indonesia should be treated equally and not be discriminated against on any grounds.[150] However, this provision has not yet been used in any court case to challenge discrimination against LGBTI people in Indonesia.[151] Furthermore, no anti-discrimination legislation on the basis of sexual orientation or gender identity exists in Indonesia to explicitly provide LGBTI individuals and individuals who engage in same sex sexual activity with protection. At this point, it is important to recognize that not all people who engage in same sex sexual activity necessarily identify as LGBTI. In relation to the provision of SRH services, the National Policy and Strategy on Adolescent Health (2004- 2009) provides that "the government and the community are obliged to support and create a conducive environment for adolescent reproductive health [and that] services must be provided without discrimination including to marginalized groups."[152] This policy directive could be interpreted as including young people who engage in same-sex activity as well as young people who identify as LGBTI.

Indonesia does not have any specific legislation regulating sexual orientation. None of the existing legislation mentions that same sex sexual activity is either prohibited or permitted.[153] However, as mentioned earlier, the Penal Code provides that committing any 'obscene act' with a minor of the same sex is punishable with up to 5 years imprisonment.[154] Furthermore, certain areas of Indonesia are permitted to pass specific bylaws and some of these bylaws directly or indirectly criminalise same-sex sexual activity. Overall, this study identified six bylaws that pertain to same-sex sexual activity. Importantly, only two Indonesian provinces (Aceh and South Sumatra) have passed laws that criminalise same sex sexual acts at the provincial level.[155]

1. Under the Provincial Ordinance on the Eradication of Immoral Behaviour (No. 13/2002) in South Sumatra, homosexual acts and anal sex performed by men (without specification whether insertive or receptive) is classified as "immoral behaviour".[156]
2. Under the City Ordinance on the Eradication of Prostitution (No. 2/2004) in Palembang, capital of South Sumatra Province, the provisions are similar to those in South Sumatra although the law refers to "prostitution" instead of "immoral behaviour."[157]
3. The District Ordinance on Social Order (No. 10/2007) in Banjar, South Kalimantan Province, mentions "abnormal" homosexual and heterosexual acts (in addition to "normal" acts) in its definition of "prostitution." The ordinance however provides no further explanation of what constitutes "abnormal" acts. The ordinance further prohibits the formation of organizations "leading to immoral acts" that are "unacceptable to the culture of [local] society" which are later explained through examples including lesbian and gay organizations "and the like".[158]
4. Under the City Ordinance on the Development

of a Value System in Social Life Based on the Teachings of Islam and Local Social Norms (No. 12/2009) in Tasik Malaya, West Java, adultery and sex work, both heterosexual and homosexual is prohibited.[159]

5. The City Ordinance on the Prevention, Eradication and Prosecution of Social Ills (No. 9/2010) in Padang Panjang, West Sumatra, explicitly mentions "homosexual and lesbian" relationships and later criminalises such relationships and prohibits persons from "offering themselves for homosexual and lesbian relationships either with or without payment."[160] The first of these four Ordinances is vague in relation to punishments of the outlined behaviours and generally refers to "existing laws" i.e. national laws. However, the final ordinance specifically outlines the punishment to be a maximum of 3 months imprisonment.[161]
6. Under the Islamic Criminal Code (Qanun Jinayat) in Aceh, which came in to force in October 2015 and applies to Muslims and non-Muslims alike, corporal punishment is introduced for same-sex relations.[162] This legislation violates international human rights standards, as corporal punishment constitutes cruel, inhuman and degrading treatment and may amount to torture.[163] Criminalizing consensual sexual activities between adults in private is a direct interference with the respect for private life and also constitutes discrimination.[164] Such direct criminalisation is also likely to deter homosexuals from accessing SRH services for fear of being arrested or disclosed to authorities.

8.1.2 Knowledge, perceptions and practice

Whilst there are no nation-wide laws in Indonesia that prohibit same-sex sexual activity, there seems to be a widespread belief amongst service providers, adults and young people that homosexuality is strictly illegal throughout the country. Furthermore, many interviewees assumed that national legislation on homosexuality was in line with dominant religious and social norms in prohibiting same sex sexual acts; a misperception which appears to be reinforced and perpetuated through the educational system.

> *Is it legal to be homosexual in Indonesia?*
> "No, homosexuality is illegal."
> *Where did you hear this?*
> "I learned that it is illegal in school; in the religion class. (other participants confirm) The teacher told us that it is against our religion to be gay."
> **FGD with sex workers, Jakarta**[165]

Importantly, this misconception about the legality of same-sex relationships in Indonesia appears to create barriers for homosexuals who want to access SRH services, as they may be too afraid or ashamed to approach service providers for fear of being exposed.

> *Is it legal to be homosexual in Indonesia?*
> "No, homosexuality is illegal here. But also according to Islam it is forbidden."
> *Who knows that you are homosexual?*
> "Only our close friends and some volunteers [at a local NGO]. We are afraid to tell our families, because they will not accept it." (one participant disagreed)

What do you do when you have problems related to sexual health?
"For testing, we go to the Puskesmas [the public health clinic].
But we have to hide that we are gay. The officer there doesn't know this."
What would you do if you have a problem that forces you to reveal your sexual orientation?
"That would be a big problem. I don't think I could go there. What if they tell my parents? I wouldn't know where to go."
FGD with homosexual young men, Jakarta[166]

Even though service providers interviewed for this study were generally of the opinion that homosexuality was illegal throughout Indonesia, they did not indicate that they would report homosexual patients to the authorities (except in anonymised form for the compilation of governmental statistics).[167] While the group of homosexual youth interviewed for this research seemed to be relatively knowledgeable about SRH compared to heterosexual interviewees of the same age, they also indicated that they received most of the relevant information via the internet, from NGOs or through peer-to-peer education, rather than at school.

While the largest barrier to access for young people who engage in same-sex sexual activity appears to be related to conservative cultural and religious norms, it is likely that the prohibitions of same-sex acts contained in the above-mentioned by-laws reinforce the common misconception amongst service providers and young people that homosexuality is illegal throughout Indonesia and in all circumstances. This in turn appears to influence the service-seeking behaviour of youths engaging in same-sex sexual activity, as they may fear being exposed when accessing SRH services.

8.2 Transgender individuals

8.2.1 Legal review

Similar to the legislation on same-sex sexual relations, there is no specific law or regulation either prohibiting or protecting gender diversity in Indonesia.[168] However, in practice, the law only recognises two genders: men and women. This is implied by the specific mention of men and women in the Marriage Law and by the Population Administration Law (No. 23/2006) regulating identity cards.[169] No third gender category exists in identification and citizenship documents and thus transgender individuals are confined to the female/male binary, limiting their ability to choose their legal identity.[170] Sex-reassignment surgery has been available in Indonesia since the early 1970s, but only through private services.[171] After sex-reassignment surgery, a transgender person may change their gender legally in a local court in the same manner as a change of name.[172] Marriage is legal after sex-reassignment surgery, but only with someone who identifies as the 'opposite gender' (i.e. not the newly assigned gender).

8.2.2 Knowledge, perceptions and practice

Whilst the evidence collected through the interviews and FGDs suggests that transgender people are socially more accepted in Indonesia than homosexuals, they nevertheless appear to face significant barriers when accessing SRH services. Transgender young people interviewed for this study indicated that they often faced open discrimination and harassment (e.g. shouting,

spitting, etc.) when visiting health centres. This is likely to prevent many transgender individuals from accessing SRH services in the first place. One transgender interviewee suggested that transgender individuals are even more reluctant to access health facilities than homosexuals, given that it is more difficult for them to 'hide' their sexual or gender identity from the service providers.[173] However, it was not possible to substantiate this claim through other sources. In general, the transgender community is much more visible than, for example, the gay and lesbian communities, given that *waria* often feature in popular theatre and television shows.[174]

Evidence collected through the quantitative component of this study also indicates that transgender individuals face discrimination by service providers due to their gender identity. Of those respondents who preferred not to be identified as male or female (i.e. the 'other' category), *all* reported to having been unable to access an SRH service (at least once) because of their gender identity. These findings are to some extent confirmed by the survey of service providers, around 20% of which indicated that they had (at least once) denied someone access to condoms, contraceptive pills and injections because of their gender or sexuality.

Unfortunately, the survey questionnaire did not distinguish between denials of access to homosexuals, to transgender individuals or to any other gender non-conforming individuals, so it is difficult to establish the exact extent of discrimination faced by transgender individuals when accessing SRH services.
In general, the discrimination faced by transgender individuals does not seem to be the result of any specific legal barrier, which is not surprising given that there are no specific laws or regulations either prohibiting or protecting gender diversity in Indonesia. Instead, the discrimination faced by transgender individuals when accessing SRH services appears to be largely the result of conservative attitudes and social norms amongst service providers and the general public.

When asked about sex-reassignment surgery, most service providers interviewed for this study were unsure of the legality of this procedure or believed that it was strictly prohibited. None of the service providers interviewed for this study ever provided or recommended sex-reassignment services, which may be because they believed that it is illegal in Indonesia, or simply because they did not have the technical expertise and equipment to carry out such a procedure.

9 Law and Sex Work

9.1 Legal review

Indonesia does not have a nation-wide law governing sex work. Instead, the legislation on sex work varies by province. However, Article 296 of the Penal Law makes "a person making an occupation or habit of intentionally causing or facilitating any obscene act by others with third parties" punishable with a maximum of one year and four months in prison, or a fine.[175] Furthermore, under Article 506 in the Penal Code, 'pimping' is punishable with a maximum imprisonment of one year. In many Indonesian provinces, sex work may be legally conducted in designated areas known as *lokalisasi*. Nevertheless, some provinces have passed regulations making all forms of sex work illegal, as for example Aceh.[176] The Government regulation of DKI Jakarta No 2007 on Public Order provides under Article 42 that it is illegal to facilitate, sell sex or force people to become sex workers.[177] To our knowledge, no similar local regulations on sex work exist in Central Java, the second research 'site' selected for this study.[178]

9.2 Knowledge, perceptions and practice

Interviews with male, female and transgender sex workers in Jakarta indicate that their knowledge about the law on sex work in Indonesia is relatively limited. Most sex workers were of the opinion that sex work is strictly prohibited *throughout the entire country.* This also appears to be a commonly held opinion amongst service providers interviewed for the study. As was the case for same-sex relationships, informants seemed to assume that legislation on sex work is in line with dominant cultural and religious norms, which strongly condemn any form of sex work. These misperceptions about the law appear to make sex workers reluctant to access SRH services, not so much because they fear being exposed (in contrast to individuals who engage in same-sex sexual activity), but rather because it creates an environment where abuse and discrimination against sex workers is perceived as legitimate and officially sanctioned.

> *Is sex work legal in Indonesia?*
> "No, sex work is illegal."
> *Are there any exceptions?*
> "I don't think so." (other participants agree)
> *What do you do when you have problems related to sexual health?*
> "We go to the Puskesmas [the public health clinic] and also to [a local NGO providing support to sex workers].
> *Do the health workers at Puskesmas know that you are sex workers?*
> "Yes, most of them know. So we are ashamed when we go there. Before we campaigned against discrimination together with [a local NGO providing support to sex workers] they would often hit us or shout at us because of what we do. Now it is much better."
> **FGD with sex workers, Jakarta**[179]

In relation to access to SRH services for sex workers, attitudes of individual service providers seem to be a much more important factor influencing access than any legal provisions on sex work. For example, a number of sex workers interviewed in South-East Jakarta indicated that they now felt comfortable with regularly accessing services at the local public health centre

("Puskesmas"), but only after they had campaigned against discrimination in the centre and the centre had put in place a dedicated service for sex workers.

As already discussed in the section on access to contraception, young sex workers appear to benefit from a so-called 'high risk exception'. While service providers interviewed for this study generally indicated that SRH services should be restricted to married couples, some also suggested that an exception would be made for individuals in so-called 'high risk' groups, including sex workers. A number of service providers who worked in *lokalisasi* (i.e. sex work areas) confirmed this practice.[180] As discussed earlier, service providers appear to make these exceptions for 'high risk' individuals not because of specific laws or regulations, but rather because of pragmatic medical considerations.

10 Law and Sexual Violence

10.1 Legal review

Limited legal definitions of sexual violence and rape, that fail to recognise sexual abuse in all contexts within which it can occur, can create indirect legal barriers to accessing SRH services. Individuals may be unable to access support services in contexts where their experiences are not recognised, or seen as lacking validity or importance. An example of this may be laws that guarantee impunity for rape perpetrated in the context of marriage.

Article 285 of the Penal Code states that "any person who by using force or threat of force forces a woman to have sexual intercourse with him out of marriage, shall be guilty of rape," which is punishable with up to 12 years of imprisonment.[181] The law thus defines victims and perpetrators of rape as gender-specific and only considers rape to occur in heterosexual, extra-marital interactions where the man is the perpetrator and the woman is the victim. Importantly, the provisions criminalising rape are expanded under the Child Protection Act and include 'children' as victims, thus extending the legal protection also to boys.[182] Furthermore, the Law Regarding Elimination of Violence in the Household (No. 23/2004) goes some way to address rape within the household by criminalising "forcing sexual intercourse [...] against an individual living within the scope of the household."[183]

There are important regional differences in relation to the law on sexual and gender-based violence (SGBV). For example, the region of Aceh is governed as a special territory, which provides it with an increased autonomy from the central government in Jakarta. The Sharia-based Criminal Code (QanunJinayat), which was introduced in Aceh in October 2015, introduces additional barriers for those who want to report rape, as well as punishments for anyone deemed to have made false allegations.[184] Under this Criminal Code, rape survivors must produce evidence of having been raped when filing a complaint.[185] If authorities deem the evidence to be 'insufficient' (not further specified), the suspect may walk free after taking an oath to assert their innocence. [186]

10.2 Knowledge, perceptions and practice

Most young people and service providers interviewed for the purpose of this study were aware of the general prohibition of rape in Indonesia, but also believed that it was not being enforced properly. Importantly, only very few service providers and young people confirmed that rape could occur between husband and wife and that this is a crime under Indonesian law. Similarly, only very few informants were aware of the fact that men and boys could also be victims of rape. This widespread misconception about spousal rape and rape of men and boys is likely to prevent a large number of married women, as well as men and boys, who are survivors of rape, from approaching health professionals and/or the police because they believe that they are not eligible to access services. To some extent this pattern was confirmed by the service providers interviewed for this study, given that only very few reported to have treated (or even heard of) male survivors of rape. Indeed, most cases mentioned by interviewees involved extra-marital rape of girls by older men (e.g. by neighbours and relatives). The interviews with young people and

service providers also confirmed that sexual violence carries a large stigma in Indonesia and that any consequences will usually be considered a 'family matter'. In such an environment, rape survivors will be reluctant to seek services for a number of reasons, including believing that the crime was their own fault or that service providers will judge them.

Misconceptions about the law on SGBV thus appear to have an indirect impact on access, as survivors of spousal rape and male survivors of rape may believe that they are not eligible to access services. These barriers appear to be reinforced by dominant cultural norms that stigmatise survivors of sexual violence, whether they are female or male.

In addition, laws on SGBV may have an indirect impact on young people's access to SRH services by influencing when and how access to SRH services is treated as confidential, or when and how confidentiality is broken. A number of service providers interviewed for this study maintained that they would only report cases of rape of under-aged[187] individuals, to the relevant local authorities (i.e. the Integrated Services Centre for Women and Children. Pusat Pelayanan Terpadu Perempuan dan Anak disingkat; often referred to as 'P2TP2A').

Importantly, rape cases would only be referred to the authorities *with the survivor's consent*. In addition, for unmarried female survivors of rape, the consent of the parents would usually be required, and for married female survivors, the consent of the husband would be required. Where consent for breaking confidentiality cannot be obtained from the survivors and their husbands/parents, the report will be anonymous.[188]

These practices related to consent requirements for reporting rape cases mirror the consent requirements for accessing general SRH services, and are likely to create additional barriers for female survivors of rape, who want to report the crime *without involving their families*. Importantly, obtaining an official report by a medical practitioner may be essential for proving that rape has occurred, for example when legally accessing abortion services after rape.[189] Similarly, under the Criminal Code in Aceh, rape survivors must produce evidence of having been raped when filing a complaint.[190] If authorities deem the evidence to be 'insufficient' (not further defined), the suspect may walk free after taking an oath to assert their innocence.[191]

Service providers interviewed for this study did not necessarily refer to a specific regulation or law to justify their reporting practice regarding rape cases of minors, which is not surprising, given that there appear to be none. However, some informants did mention a memorandum of understanding between P2TP2A, the police and health professionals, in which service providers agreed to report rape case to the authorities for the purpose of compiling incidence statistics. However, this memorandum does not impose a legal obligation on service providers to report rape cases and there seem to be no serious consequences for service providers that fail to report rape cases to the authorities. This is to

some extent supported by evidence collected through the survey with service providers, around 78% of which indicated that 'nothing at all' would happen if they failed to report.[192] On the one hand, this may serve to safeguard the confidentiality of rape survivors and provide a reasonable degree of discretion to service providers in order to distinguish between cases of child sexual abuse and cases involving minors engaging in factually consensual sexual activity.

However, on the other hand, the lack of official guidance on when (or at which age) to report child rape survivors, or 'sexually active' minors for that matter, may create uncertainty amongst rape survivors about what will happen when they approach service providers, which may in turn influence their service-seeking behaviour.

11 Conclusion and Recommendations

11.1 Conclusions

The law in Indonesia restricts young people's access to sexual and reproductive health services in both direct and indirect ways. The law in Indonesia also contains some 'facilitative' provisions in relation to young people's access to SRH services, which are not generally implemented in practice due to misperceptions about the law as well as other socio-cultural barriers. In the following paragraphs, we briefly summarise the main findings of this study, before moving on to specific recommendations for legal reform that would improve young people's access to sexual and reproductive health in Indonesia.

In terms of **direct legal barriers**, this study found that access to contraceptives and other family planning services, as well as access to abortion services are strictly regulated by national laws. Laws regulating the provision of contraceptives exclude unmarried young people from the remit of legal access. In practice, service providers appear to make some exceptions to this rule based on pragmatic medical considerations (e.g. for 'high risk' groups). However, in combination with dominant cultural and religious norms, these laws generally have a direct restrictive impact on access, especially for *unmarried* young women and individuals that do not conform to socially sanctioned sexual identities and behaviours.

Abortion is the most heavily regulated SRH service in Indonesia. The law permits abortion only in a few exceptional circumstances (i.e. in cases of rape and medical emergencies), which, in combination with additional legal barriers (e.g. spousal consent and reporting requirements), renders access to legal abortion highly rare in practice. The law requires the consent of a husband for legal access to abortion in cases of medical emergencies, which denies women and girls access to legal abortion services even to save their own lives, should their husbands deny consent. Furthermore, the law is mute on consent requirements related to *unmarried* women who seek abortion services in medical emergencies, which, in practice, appears to be interpreted to deny unmarried women abortions even where pregnancy is life threatening because no spousal consent can be obtained. The law also imposes significant barriers on rape survivors who want to legally access abortion services, such as the requirement to obtain a doctor's letter as well as an official statement from a police investigator, psychologist or other expert, and still be within the 40 days' time limit.

In terms of **indirect legal barriers,** the legal age of marriage and the legal age of sexual consent were identified as important areas of law that *indirectly* restrict access to SRH services for young people in Indonesia. Legal provisions on the age of marriage are important in relation to young people's access to SRH services because the law restricts access to SRH services for unmarried couples. The legal age of marriage thus represents a threshold at which many general SRH services become available to young people when they are married. Dominant cultural and religious norms heavily stigmatise sexual activity outside of marriage. It is therefore not surprising that many service providers and young people interviewed for this study mistakenly regarded the legal age of marriage to be *synonymous* with the legal age of consent. This confusion about the differences between the legal age of sexual consent and the legal age of marriage contributes to an

environment where service providers are reluctant to provide SRH services to unmarried but sexually active young people, or unmarried young people are too ashamed or afraid to ask for these services.

The additional hurdles faced by the LGBTI community and sex workers when accessing SRH services appear to be largely the result of conservative attitudes amongst service providers as well as misperceptions of the law amongst young people (e.g. that homosexuality and sex work is strictly illegal throughout the country), rather than any direct legal barriers. However, there are a number of laws regulating and restricting sex work, sexual orientation and gender identity, which appear to have an indirect impact on service-seeking behaviour, as they contribute to an environment where abuse and discrimination against LGBTI individuals and sex workers is perceived as legitimate and officially sanctioned.

Survivors of sexual and gender-based violence also face significant hurdles when accessing services. As mentioned earlier, the law creates direct legal barriers for rape survivors who want to legally access abortion services. In addition, it appears that misperceptions about the scope of the law on SGBV have an indirect impact on young people's access to services, as survivors of spousal rape and male survivors of rape believe that they are not eligible to benefit from services. The study also found that sexual violence carries a strong cultural stigma in Indonesia, which makes survivors of SGBV reluctant to seek services, for example because they believe that the crime was their own fault or that service providers will judge them.

Lastly, this study also identified a number of **facilitative laws**, which have the potential to empower young people to make informed decisions about their sexual health without discrimination and in confidentiality. In particular, the laws on confidential access to medical treatment and the laws on SRH education contain provisions that could potentially facilitate young people's access. However, our study also showed that these facilitative laws are generally not implemented in practice, due to misperceptions about the law and the influence of other socio-cultural barriers.

11.2 Recommendations for legal reform

The findings from this study reveal the power of the law in establishing both direct and indirect barriers to young people's access to SRH services. The findings also reveal how misperceptions and confusion about the law can influence young people's access. For example, where young people experience any doubt in relation to their right to confidential advice and medical services, they will be discouraged from attempting to access these services. Similarly, where service providers experience any doubt about the legal exceptions to the prohibition of abortion, they will refrain from providing or recommending abortion services in all circumstances for fear of overstepping the law. Given the widespread confusion about the law, it is of utmost importance to increase educational efforts aimed at improving young people's and service providers' understanding of the law in relation to SRH. Only this will ensure that the law is both interpreted and applied correctly. However, this research also has specific implications for legal reform, which are explored through the recommendations below.

11.2.1 Age of sexual consent

- The law on the age of sexual consent should treat all individuals equally, regardless of their gender and sexual orientation. The current law establishes the age of sexual consent for unmarried girls at 15, for persons engaging in same sex sexual relations at 18, and, implicitly, for boys at 19. We recommend the **adoption of a uniform age of sexual consent for boys and girls, as well as for same-sex sexual relations**, taking into account that many young people commence sexual activity during their early adolescence.
- Consensual sexual activity between adolescents who are 'close in age' should not be criminalized. Indonesia currently lacks of a 'close-in-age' provision in relation to factually consensual sex between young people. This can prevent young people from accessing SRH services, as they may fear disclosure to authorities, parents or legal guardians if they (or their partner) are under the age of sexual consent. We recommend a 'close-in-age' approach to sexual consent, which considers the age difference between parties, rather than criminalising all sexual activity below a specific age. In this respect, it is important to provide health professionals with a certain amount of discretionary power to distinguish between cases of consensual sexual activity and cases that raise child protection concerns.
- Aceh Province's by-law on 'khalwat' prohibits two unmarried adults of the opposite sex, who are not close family members, from being together in 'close proximity', which includes consensual sexual relations between unmarried individuals. This law should be removed as it discriminates against unmarried individuals. In addition, the punishments under 'khalwat' amount to cruel, inhuman and degrading treatment and may amount to torture.
- National laws should establish clear differences between the age of sexual consent, the age of marriage, and the age of consent to medical treatment, including consent to access SRH services. Official guidance should be developed for health service providers to clarify the implications of these provisions and how they should be interpreted together.

11.2.2 Age of marriage

- Marriage with parental consent is legal for men who are 19 or older and women who are 16 and older. The current law on the age of marriage contravenes international standards on child marriage. In addition, the Marriage Law is in conflict with the Child Protection Law, according to which parents are responsible and accountable for preventing the marriage of children under the age of 18 years. We recommend the **adoption of a uniform legal age of marriage at 18 years, without discrimination based on gender or sexual orientation**.
- The current provisions allowing polygyny should be removed, as they discriminate against women in general, and stigmatise married women and girls who cannot have children, or who simply want to delay pregnancy.

11.2.3 Access to contraceptives and general SRH services

- There are a number of provisions in the current law that restrict access to contraceptives and family planning services for individuals who are not legally married. These

include Article 72 of the Health Law and Articles 21.1, 24.1 and 25.2 of the Population and Family Development Law. These **provisions should be removed as they discriminate against unmarried individuals**, in particular unmarried young people.

- Spousal consent requirements contained in the Population and Family Development Law directly restrict independent access to contraceptives and family planning services for married women and should be removed.
- Official guidelines on the provision of permanent contraception (i.e. sterilisation) discriminate against women, especially young women, and should be revised accordingly.
- We recommend the adoption of a positive provision stating that young people should never be denied access to SRH services based on their age or lack of consent from a parent, guardian or spouse.

11.2.4 Confidential access

- Although the law in Indonesia protects young people's right to confidentiality when accessing services, more work needs to be done to support the implementation of this law in practice.
- In particular, advocacy efforts should focus on the development and **adoption of a legal rule that explicitly recognizes the capacity/competence of young people to consent to access** sexual and reproductive health services, without the need for parental or other third party consent.
- Clear child protection guidelines should be put in place to ensure that instances of child abuse are identified and addressed. We recommend that these guidelines do not include mandatory reporting requirements or a blanket minimum age threshold, but rather empower service providers to identify and distinguish child abuse from consensual sexual activity involving young people. There is a risk that child protection procedures will simultaneously fail in their attempt to address abuse, while creating barriers to confidential access to services for children and young people who need them. This is an area that requires further research and development.

11.2.5 Access to abortion

- Abortion in Indonesia is currently prohibited except in cases of rape and medical emergencies. Any criminalization of abortion creates direct legal barriers to access to sexual and reproductive services. Advocacy efforts should focus on realising the ultimate goal of unrestricted access to abortion services, and protection of this right under the law. **Abortion services should be made free, safe, accessible and confidential for all women and girls**.
- The law creates additional barriers for women seeking abortions in cases of rape and medical emergencies, which make legal access to abortion highly rare in practice. Rape survivors must obtain a report from a doctor as well as an official statement from a police investigator, psychologist or other expert, and still be within the 40 days of pregnancy time limit in order to legally access abortion services. Especially in light of the strong social stigma attached to sexual violence, this is an unrealistic timeframe, which should be **extended to allow enough time for rape survivors** to find out that they are pregnant, report the crime to the relevant authorities

and overcome socio-cultural barriers to accessing abortion services.

- The exhibition of means for the disturbance of pregnancy, or showing where such means or services are available, is punishable under the current law. These provisions in the Penal Code appear to have a 'silencing effect' on outreach workers, as they are afraid to discuss the issue of abortion during their outreach sessions. The **relevant provisions in the Penal Code on abortion should be removed** as they directly restrict young people's access to information about abortion.
- The provision requiring consent of a husband for legal access to abortion in cases of medical emergencies, denies women and girls access to legal abortion services even to save their own lives, should their husbands deny consent. Furthermore, the law is mute on consent requirements related to unmarried women who seek abortion services in medical emergencies, which appears to be interpreted to deny unmarried women abortions even where pregnancy is life threatening because no spousal consent could be obtained. The law should be reformed to explicitly guarantee independent access to legal abortion, regardless of spousal consent or marital status.
- Importantly, advocating for incremental changes to law is unlikely to have much impact on the availability of legal abortion in practice. Incorporating such efforts within a broader campaign towards full decriminalization of abortion, however, may have the potential to foster public engagement with the issue and help gain wider social and political support for the decriminalization of abortion and women's reproductive rights more broadly.

11.2.6 Access to comprehensive sexuality education

- Compulsory comprehensive sexuality education should be a mandatory part of school curricula in primary and secondary school. It should focus on skills in decision-making, communication, and respect for others, with a strong gender component, which avoids **propagating dominant stereotypes about sex and gender**, and go beyond a narrow focus on biological and reproductive aspects. This curriculum should also clearly explain the sexual and reproductive health services that are available for young people and the content and implications of relevant provisions in law.
- This research found that schools often rely on external SRH educators to provide sexuality education rather than trained teachers. One of the most important factors restricting the outreach work of health professionals is a lack of formal agreements between schools/universities and external health educators. There is a **need to institutionalise CSE in teacher training and a need to establish formal agreements and structures to facilitate SRH outreach work** in schools and universities.

11.2.7 Hetero-normativity

- **Strong legal provisions protecting LGBTI identified persons from discrimination should be developed**, and equality laws should be extended to apply specifically to LGBTI people.
- The Penal Code provision prohibiting 'obscene acts' with a minor of the same sex establishes a separate age of sexual consent for individuals engaging in same sex sexual activity, and

thereby discriminates against individuals based on their sexual orientation. Laws on the age of sexual consent should apply to all individuals equally, regardless of their gender or sexual orientation.

- **Provincial and local laws prohibiting same sex sexual relations should be removed**. In addition to directly discriminating against individuals based on their sexual orientation, these laws indirectly restrict the service-seeking behaviour of gay and lesbian youths, as they fear being exposed when accessing SRH services.
- Current laws regulating marriage and identity card laws confine individuals to the female/male binary. The relevant provisions should be amended, as they discriminate against transgender individuals and limit individuals' ability to choose their legal identity.

11.2.8 Sex work

- **All laws criminalising sex work in Indonesia should be removed**; regardless of whether they apply to the district-, provincial- or national-level. These laws contribute to an environment where abuse and discrimination against sex workers is perceived as legitimate and officially sanctioned, which in turn has a restrictive impact on the service-seeking behaviour of sex workers.

11.2.9 Sexual and gender-based violence

- **The law should recognize all forms of sexual and gender-based violence** (SGBV), regardless of the context (e.g. in the home, school community or within other institutions) or relationship (e.g. whether married or not) within which it occurs. In particular, Article 285 of the Penal Code should be amended to recognise that SGBV does not only occur in heterosexual, extra-marital interactions, where the man is the perpetrator and the woman is the victim.
- Sexual abuse should be defined in terms of absence of consent, rather than in terms of 'force' or violence.
- All acts of sexual violence, including physical and non-physical acts, as well as penetrative and non-penetrative acts of violence should be criminalized within law. In particular, the Law Regarding Elimination of Violence in the Household should be amended to cover all forms of sexual abuse, as it currently only recognises penetrative acts of sexual abuse.
- National as well as sub-national laws (e.g. the Sharia-based Criminal Code in Aceh Province) create significant legal barriers for survivors of SGBV who want to access accountability and SRH services. In particular, the 40 days limit placed on legal access to abortion after rape should be extended or removed so as to allow enough time for rape survivors to find out that they are pregnant, report the crime to the relevant authorities, and overcome socio-cultural barriers to accessing services.


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NIKE

Annex A: Methodology

1. Research strategies

This study utilised three distinct methodological approaches to examine the influence of the law on young people's access to SRH services in Indonesia. This included a desk-based review of existing laws, regulations and policies on SRH in Indonesia, as well as qualitative and quantitative methods of in-country primary data collection and analysis. The following tables summarises the most relevant research methods used to gather data in relation to each research question.

Research question	Data source
What are the direct and indirect legal barriers that influence young people's access to SRH services and how do they impact on young people's access?	Legal analysis; survey; FGDs; Interviews
What do young people know about the law as it applied to SRH services?	Survey; FGDs; Interviews
What do they know about the law as it applies to sexuality and sexual activity?	Survey; FGDs; Interviews
How do young people perceive or interpret such laws as applying to themselves or their peers?	Survey; FGDs; Interviews
How does this knowledge and perception impact on their access to SRH services?	FGDs; Interviews
What are their experiences accessing SRH services and how do they expect this process to occur?	FGDs; Interviews; Survey
What are the gaps in their information and access?	FGDs; Interviews; Survey
How do legal barriers interact with social, cultural or other barriers to accessing SRH services?	FGDs; Interviews

1.1. Desk review

The research began with a thorough desk review and analytic synthesis of laws, policies and other available data sources concerning legal provisions that regulate SRH and access to services for young people in Indonesia. Data sources were accessed through: 1) searching through relevant databases, including Open Grey, PubMed, ADOLEC, LexisNexis; 2) accessing information through IPPF and their contacts; and CCLC's institutional contacts, including UN agencies, universities and research centres.

The desk review enabled the team to make preliminary findings about law and practice related to young people's access to SRH services, and to identify gaps in current information. The desk review informed the development of the research tools that guided the primary data collection.

1.2. Qualitative interactions

Qualitative data was collected by a researcher from Coram International, with assistance and interpretation provided by local PKBI staff. Field research in Indonesia was carried out over a period of two weeks, between 28th November and 12th December 2015. A Coram International researcher spent one week conducting field research in

Semarang and surrounding villages in Central Java, and one week in Indonesia's capital city, Jakarta DKI. In total, **88 respondents** were accessed during the qualitative field research in Indonesia.

1.2.1. Individual interviews with service providers

The Coram International researcher conducted **14 in-depth individual interviews** with SRH service providers. Of these, 6 were conducted in Jakarta, and 8 in Semarang and surrounding villages. Services providers based at both private and public clinics were included, and from a range of locations, including advantaged and disadvantaged areas, rural and urban areas, SRH centres in schools, as well as SRH centres who work primarily in so-called lokalisasi (prostitution areas) or with LGBTI communities. Overall, the Coram International researcher interviewed nine service providers from private, fee-paying health clinics, four service providers from public health clinics (Puskesmas), and one service school-based service provider. Amongst all fourteen health professionals accessed for this study, three focused primarily on the provision of SRH services. Two were located in rural areas, and the remaining service providers were located either in urban or sub-urban areas.

Interviews provided a private setting in which participants were able to share their personal ideas and experiences in a confidential setting, without being impacted by their peers and colleagues. Interviews were qualitative and semi-structured in nature. An 'interview schedule' (see Annex B) was developed to facilitate a level of standardisation (and comparability) in the data collected. However, the tools were used as guides, rather than being followed strictly; instead the researcher was guided by the respondents' answers within the broader frame of the research questions. Questions were asked based on the respondents' experiences and with a view to encouraging the most authentic and responsive data.

The interviews with service providers primarily aimed to collect data on:

1) Respondents' knowledge, understandings and attitudes towards relevant law relating to gender, sexuality and health;
2) How these perceptions are linked to individual's practices, choices and experiences concerning the provision of SRH services to young people

1.2.2. Focus group discussions with young people and parents

Overall, **74 respondents were accessed through focus groups discussions (FGDs)**, with 2 to 6 individuals per FGD. The Coram International researcher conducted a total of 18 FGDs with young people aged 13 to 24 years. Of these, 7 FGDs were held in Semarang and surrounding villages and 11 FGDs were held in Jakarta DKI.

Due to the sensitive nature of the issues under discussion, both parents and young people were separated according to gender for focus group discussions, unless researchers were accessing an established mixed-gender group of young people (e.g. sex workers, LGBT youths). Of the 18 FGDs conducted in total, 8 were female-only, 9 were male-only, and 1 was not separated by gender, given that the researcher was accessing an established mixed-gender group of young people (i.e. LGBT sex workers).

Lastly, the Coram International researcher conducted 2 FGDs with parents and care givers of children and young people(aged 1 year to 23 years): 1 FGD was held in a rural site outside of Semarang (Ungaran), and the other in an urban site in East Jakarta. In both cases the FGDs were female-only and the age of the adult respondents varied from 38 to 48 years. Most adult respondents accessed for this research had more than one child in the above-mentioned age range.

A 'group discussion schedule' (see Annex C) was developed to orient FGDs, but they were used flexibly, enabling researchers to explore issues according to the organic direction of the conversation. The discussion schedule was designed such that respondents were encouraged to discuss issues in a general, hypothetical, or scenario-based format, so that they did not feel the need to reveal personal experiences in order to share their ideas. Respondents were presented with a series of 'scenarios' and asked to discuss/debate how they viewed the situation, as well as their perceptions of the law related to the situation (e.g. different circumstances in which an individual may seek contraception or abortion services, what the law says about this and what their opinions are about relevant laws). Exploring these issues through FGDs was useful as it provided participants with the opportunity to respond to each other's' stories and opinions; stimulating ideas and debate.

1.3. Surveys

Given time and resource constraints it was not feasible to conduct a comprehensive, nationally representative survey. Nonetheless, two short survey tools were developed – one for young people and one for service providers – to collect some basic descriptive and standardised data that could be analysed objectively, in relation to respondents' knowledge, understanding and perceptions of law, and experiences accessing or providing services. The survey tools can be found in Annex D (Service Providers) & Annex E (Young People) and comprise a series of closed and multiple choice questions.

Researchers used a mixed sampling method, combining both purposive and probability techniques, in order to access a range of different groups of young people and health professionals, with diverse SRH needs/services, and from a wide variety of socio-economic, ethnic, religious and geographical contexts. In addition, local PKBI chapters in Jakarta and Semarang were able to mobilise their contacts on the ground to enable access to particularly marginalised and vulnerable groups, such as young people engaged in sex work, MSM groups, transgender communities, and street children.

Enumerators were instructed to distribute the survey to groups of young people and service providers who had not participated in PKBI activities, or received unusual levels of sensitisation or education about the law, in order to avoid obtaining heavily biased results. After surveys had been completed, responses were entered into data entry sheets by local PKBI volunteers, who received training on data entry from the international researcher during the in-country visit.

1.3.1. Young people's survey

Surveys for young people were distributed manually by PKBI staff within educational institutions and community centres in each research location. In total, the young people survey included **604 respondents**, with 300 young people in Central Java (Semarang and surrounding rural areas) and 304 young people in Jakarta. Of the 604 young people surveyed in Central Java and Jakarta, 416 were girls (68.8%), 186 were boys (30.7%), and 2 individuals (0.3%) did not identify as either male or female and instead chose the "other" category.The mean age of the Central Java sample was 17 years, with the minimum reported age of respondents being 12 and the maximum 26 years. As in Central Java, the mean age of the Jakarta sample was 17 years. However, the minimum age of respondents was 13 years in this case, and the maximum age was 25 years. Of all 604 respondents included in the survey, around 46% indicated that they lived in an urban neighbourhood, 31% reported that they lived in suburban areas, and 15% reported that they lived in rural areas. The remaining young people included in the survey either lived in urban slums (3%) or refugee camps (4%).

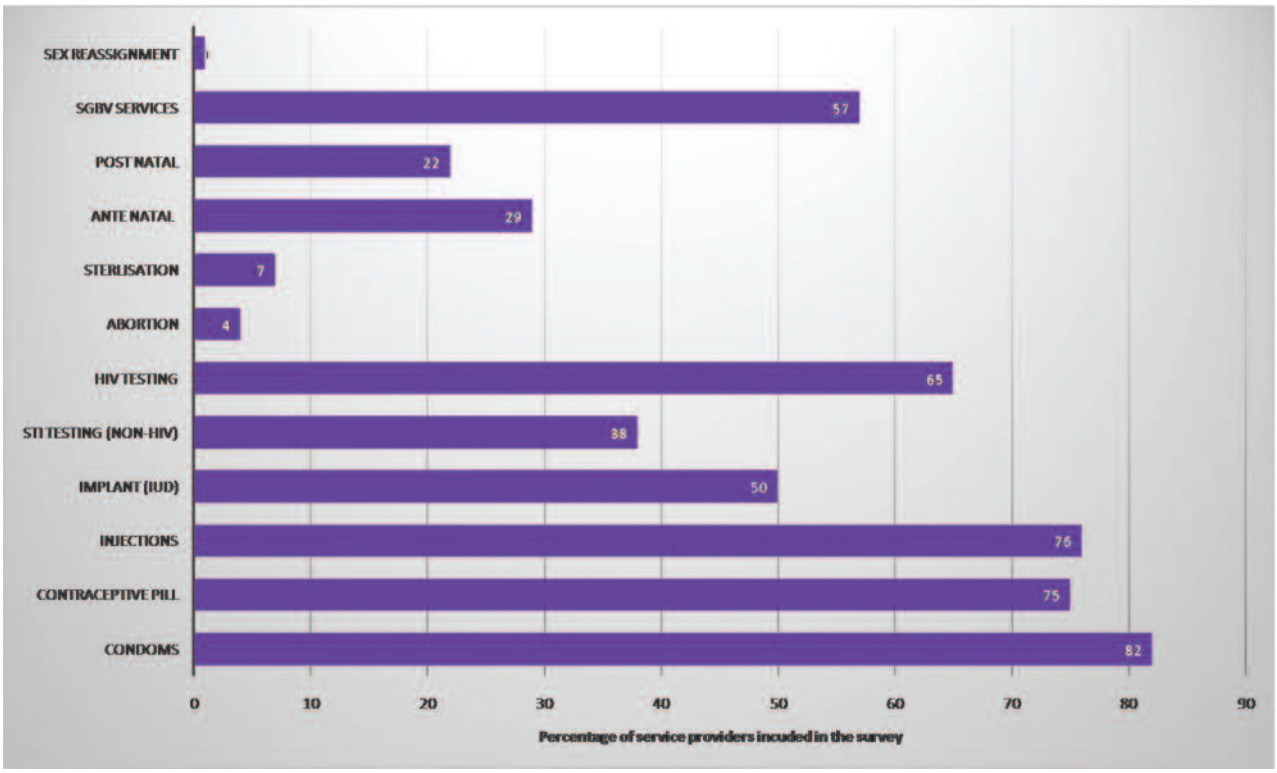
1.3.2. Service providers survey

Surveys for service providers were distributed manually by PKBI staff in hospitals, health centres and other facilities providing SRH services. Institutions were purposively selected to represent some of the diversity amongst SRH service providing facilities in Indonesia, including both public and fee-paying clinics; specialised youth-based clinics, including school clinics as well as services for the general population and clinics focusing on the provision of specialist services to at risk groups (such as LGBT groups).

Researchers collected responses from a total of **80 service providers** (40 in Jakarta and 40 in Central Java). Of the total 80 service providers surveyed for this study, 60 were female (75%) and 20 were male (25%). Around 56% of service providers worked in public health centres, 7% worked in private fee-paying clinics, 15% worked in school-based health centres and the remaining service providers worked in facilities specialising in SRH services.

Figure 1 below shows the types of SRH services provided by the health professionals included in the survey. It is noticeable that only a very small percentage of health professionals included in the survey indicated that they provide abortion services, which is likely to be the result of the almost complete prohibition of abortion in Indonesia. Sterilisation and sex reassignment services are also not very frequently provided by the health professionals included in this survey. This is probably due to the fact that these particular SRH services usually entail relatively complex medical procedures, which can only be undertaken in specialised clinics or hospitals. Services related to contraception (i.e. condoms, contraceptive pills, injections) seem to be the most frequently provided services amongst the health professionals included in the.

Figure 1: Types of SRH services provided by service providers



2. Data analysis techniques

After the data collection was completed, the Coram International research team embarked on a comprehensive analysis of findings. The analysis was multi-disciplinary, and drew upon ethnographic, social science, and legal research methods.

Qualitative data collected through interviews and FGDs was analysed manually through a detailed examination of interview transcripts and recordings to identify key themes, patterns, discourses, relationships and explanations relevant to the research questions. The qualitative analysis drew on a range of techniques including ethnography, case study analysis and discourse analysis, which included an analysis of the language used by respondents to communicate about law, childhood, adolescence, gender, sexuality, consent, violence, and other topics relevant to the research questions.

Quantitative data collected via the surveys was collated and analysed using of the statistical software package STATA as well as Microsoft Excel. The analysis provides a basic descriptive profile of the sample, in terms of demographics, knowledge and perceptions of law, and experiences seeking SRH services. The data was also disaggregated to identify trends among specific groups. Subsequently, the team embarked on inferential analysis of the data, through the use of statistical tests to search for associations and relationships between different variables.

Whenever possible, the results from the quantitative component of the analysis were triangulated with the qualitative data analysis.

Whilst quantitative analysis is particularly useful in establishing objectively young people's knowledge and perceptions of the law, and their experiences accessing different services, qualitative analysis allows the researchers to understand and draw conclusions about the direct and indirect impact of law on young people's choices, behaviours and experiences related to access.

Annex B: Interview Schedule – Service Providers

Purpose of study/consent:

Interview details Interviewer's name (if agreed):

Date:

Location (please give details):

Information about interviewee

Position in the organisation:

Number of years in position:

Previous work?

Have you received any training or education which helps you in your work?

Any other information:

Information about the service Name of the service:

Introductory questions

1. Could you tell me a little about your organisation? What is your role at the organisation? What SRH services do you provide (contraception, sexual testing, abortion, etc), and to whom?

2. Do you provide services to young people? Do many young people access your services? Is it easy or difficult for young people to access your services? Why? Are there any difference in services you provide to young people and those you provide to adults? Do you do outreach services? What kinds/where (i.e. in schools?)

SRE

3. In your experience, how well informed are young people about SRH? Where do they learn about these issues?

4. Are there any laws/ policies that regulate SRH for young people? Are they implemented in practice? What do you think of these?

Law and Consent

5. Are there any legal restrictions on access to your services based on age? (probe on access to particular types of services, e.g. contraception, STI testing etc.)

6. Do you require consent from parents/ legal guardians for young people/ children to access your services below a certain age?

7. What is the age of sexual consent in Indonesia? What is the legal age of marriage? Does this have any impact on accessing services? How/why?

8. If a child comes to you under the legal age of sexual consent, and reveals they are sexually active – how would you manage this? Would you take any action/ what? What does the law say about this? Are there any obligations on you as a service provider to take any action under the law? Do you agree with this? Why/ why not?

Law and confidentiality

9. If a young person comes to access your service is it ever appropriate to tell anyone about this? When and who? What, if anything, does the law have to say about this? Is confidentiality important for young people's access to services? Why/why not?

Law and abortion

10. Do you provide any abortion services? Who is legally able to access abortion services and under what conditions? What are the legal restrictions on access to abortion? Do you think this creates any barriers to access to services? For whom? What are the reasons that the law is this way? What are your views on this?

11. At what age can you have a legal abortion? Are there any age restrictions? If a young girl needs to access an abortion, does she require consent from anyone? Who? Does a married woman need the consent of her husband? What are the reasons that the law is this way? What are your views on this?

12. In your experience, is there social stigma about getting an abortion? Who/where does this come from? Do you think this currently affects how girls use SRH services?

Law and sterilisation

13. Do you provide sterilisation services? Are these services common? Who are these services generally provided to?
14. Are there any government policies (or laws) that provide for/regulate/restrict sterilisation services? Can you tell me about these? What do they say? What do you think of these?

15. What are your views on sterilisation? Would you ever recommend/ encourage someone to get sterilised? Who? Why/why not?

16. Are there any age restrictions on access to sterilisation? Whose consent is required for sterilisation? (e.g. person being sterilised/parent/guardian/partner etc.)

17. Would you ever consider providing sterilisation services to someone without their consent? Who? (probe: e.g. people with disabilities, mental health problems etc.)

Law, gender and sexuality

18. Do you provide any services for trans-gender/third sex individuals? Do you provide any sex reassignment services? If not, why not? Where would a person go to access these services?

19. Do you know about any laws or policies that regulate these services/ access to services for these groups? What are they? What do you think of them?

20. Are there any additional hurdles/challenges, do you think, for third sex/ trans people to access mainstream SRH services (e.g. family planning services, STI testing/ treatment, general health care services etc.)

21. Does the law say anything about same-sex relationships/ sexual activity? What? Is this law implemented? What is the impact of this law in practice?

22. Does this create any barriers to access to services for homosexual people? Why/why not?

23. Is there any obligation on you as a service provider to report children engaged in homosexual relationships/ sex?

Law and sexual violence

24. Do you ever find that your patients / people accessing your services have been victims of sexual violence

25. Do you provide any services for victims of sexual violence? What are these?
26. What are the main forms of violence related to sex and gender that predominantly affect young people in your experience?

27. Do you think the law effectively protects young people against violence? In your experience are young people reporting incidents of violence believed?

28. Do you think laws in relation to sexual violence have any impact on access to SRH services, especially for young people? If so, how/ why?

Conclusion

29. Do you think that young people in this have access to the SRH services they want and need?

30. What do you think are the biggest challenges in ensuring comprehensive and equitable access to SRH services for young people?

31. Are there any problems specifically with the law? Is there anything that should be different?

32. What are your recommendations for improving young people's access to SRH?

Annex C: Group Discussion Schedule – Young People

Introduction:

Briefly explain research/confirm consent.

Introduce researcher: name, age, where from, religion, gender/sexual identity.

Ask the participants if they would like to introduce themselves. Say they can give as little or as much information about themselves as they like, depending on what they think is most relevant.

General Questions:

At what age do young people in your community get married?

Is there a law about this? What does it say?

At what age do young people in your community start having sex?

Is there a law about this? What does it say?

Where do you learn about SRH? Who do you speak with about it? *(Probe to determine what kind of SRH education is available and what it does and doesn't include)*

Scenarios:

Your friend/sister /daughter r is 15 years old. She has a boyfriend. He keeps asking her to have sex with him.

- What do you think she should do? What advice would you give her?
- Would your feelings/advice be different if your friend was a boy/your brother?

What if she says no, but he won't stop pressuring her and eventually she gives in:

- Does this happen in your community?
- How do you feel about this situation? What advice would you give your friend/sister?

Is there such a thing as "good" and "bad" behavior when having sex? Where do these ideas come from? Do you agree? How do you think these ideas affect young people when they try to access sexual and reproductive health services?

See if they bring up contraception. If not, prompt them.

- Do you think they would use contraception? What kind/type?

- Where would they get contraception from?(If respondents bring up more than one type of contraception, probe to get details about each type).
- Would it be difficult for them to get contraception? Yes, No, Why?
- Does it matter how old they are?
- How much would it cost?
- Would they need anyone's permission (e.g. parents)?
- Who would be more likely to seek contraception? The boy or the girl? Why?
- Is there a law about this? What does it say?

A couple of months later your friend/sister/ daughter comes to you and tells you she is pregnant…

- What advice would you give to her?
- Would she tell her family or anyone else? Who would she tell? Why?
- What would her options be? Can she have an abortion? What factors would influence her choice?
- Would there any costs?
- Does her age matter?
- Does it matter if she's married?
- Is there a law about this? What does it say?

Now imagine your friend/ sister has the baby…

- Is she likely to seek any other medical services? What type?
- Are there laws that restrict the tests and scans she could request to get information about her baby? What are the benefits of this? What are the problems it could cause (if any)?
- If she's in school, how might her school react? Would she be able to continue studying?
- Is there a law about this? What does it say?

Another good friend of yours has just gotten married. She confides in you that she is not ready to have a baby (even though her husband wants one) just yet because she is still young…

- How do you feel about this situation?
- What advice would you give her?
- Could she access contraception if she wanted to?
- Would she need her husband's permission? Why/ why not?
- Is there a law about this? What does it say?

Your friend decides that the best thing to do to avoid pregnancy is to abstain from sex during certain times of the month. On one of these days that she refuses, her husband forces her to have sex with him anyway…

- How do you feel about this situation?
- What advice would you give your friend?

- Your friend says she was raped by her husband and she wants to seek medical advice/go to the police. Is this an option?
- Does it matter whether her husband was physically violent?
- If your friend did seek help, how do you think she would be treated by health workers/ police?
- Is there a law about this? What does it say?

Your friend goes to talk to her health provider and her health provider recommends sterilization?

- Is this service often recommended? What types of people would a service provider recommend it for?
- What do you think about sterilization? Is it a method you could imagine using one day?
- Do you think it is ever for a service provider to encourage someone to be sterilized? Why or why not?

Questions about gender and identity:

I now have a few strange questions. They are not "trick questions". Just say what you think…

How many genders do you think there are? Are there any people of different genders that you know (at school / in your community)? Have you ever heard of being transgendered? Do you have these groups in Indonesia? What about men who like men or women who like women? Are there people you know who identify as 'gay and lesbian'?

What problems (if any) do these groups of people face? Do they face problems in the community? Are there any laws related to these things? What does the law say? Is it legal to be homosexual in Indonesia? Is it legal to change your sex?

Final Questions:

Do you think that young people in Indonesia have access to the SRH services they want and need?

What do you think are the biggest problems (if any) that young people face with SRH?

Are the any problems specifically with the law?

Is there anything that should be different?

Annex D: Survey – Service Providers

Location of survey (where respondent was accessed):

(IPPF MA to fill out):

Please number the survey and fill in your initials here:

Instructions: Our organisation [fill in name of MA] is conducting some research about children and young people's access to sexual and reproductive health services, and the way that access is regulated by law.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: we want to learn from your knowledge and experiences. We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. Would you like to take the survey?

Yes ❑ No ❑

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ❑ No ❑

PART 1: Basic personal and household information		
1.1	Gender (circle one)	Female / Male / Other _____
1.2	Age (fill in):	_____ (number)
1.3	Which of the following best describes your place of work? (circle one)	1 Public clinic 2 Private (fee-paying) clinic 3 School health centre 4 Clinic specialising in SRH 5 Pharmacy 6 Hospital
1.4	Where is your place of work located?	_____ (village)/ _____ (district)

1.5	How would you describe this area? (circle the best answer)	1 Rural area 2 Town (semi-urban) 3 Urban neighbourhood 4 Urban slum 5 Suburban area 6 Refugee camp
1.6	Which of the following services do you provide? (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant / IUD treatment 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Sterilisation 9 Ante natal service 10 Post natal services 11 SGBV related 12 Gender reassignment

PART 2: Laws regulating sexual activity

2.1	Does the law say that it is illegal to have sex if you are below a certain age? (select your best guess)	Yes / No
2.2	If so, what is the age ¬¬? (fill in or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.3	Is it legal to provide contraceptives to young people under this age?	Yes / No / It depends
2.4	Does the law say that it is illegal to have sex with someone else who is below a certain age? (circle your best guess)	Yes / No
2.5	If so, what is the age ¬? (fill in or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.6	Is it legal to provide contraceptives to young people under this age?	Yes / No / It depends

PART 3: Laws regulating provision of services to young people

This section lists a number of sexual and reproductive health services (in the columns) and possible ways in which young people's access to the services is regulated by the law (in the rows). Circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether or not the statement about the law is true in relation to that particular service.

	Condom, oral contracep-tive pill, injection	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassign-ment)	Gender reassign-ment surgery	Sterilisa-tion
It is only legal to provide this service to young people 18 years and above:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to young people 15 years and above:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
It is only legal to provide this service to a minor with their parent's consent:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I may only provide this service to a minor based on my assessment of their competence:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I may only provide this service to a minor if he or she is married:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
There are no legal restrictions on the provision of this service:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 4: Laws regarding confidentiality of young people's access to services

This section is about the confidentiality and reporting requirements that apply to the provision of services to young people. Again, circle the best answer – 'yes' or 'no' – in the box below each service to indicate whether the statement about the law applies to that service.

	Condom, oral contracep-tive pill, injection	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassign-ment)	Gender reassign-ment surgery	Sterilisa-tion
According to the law, if a minor (under the age of 18) accesses this service I am required to inform his or her parents (even if he or she does not consent to my doing so):	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, if a minor accesses this service I am not required to inform her parents, but I may do so at my discretion:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am only permitted to inform a minor's parents (without her consent) if there is a risk to her health:	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
According to the law, I am required to protect a minor's confidential access under all circumstances	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

PART 5: Service provision in practice *(circle the best answer to each question in relation to each service listed below)*								
	Condom, oral contracep-tive pill, injection	Implant/ IUD	STI testing (non HIV)	HIV testing	Abortion	Hormonal treatment (gender reassign-ment)	Gender reassign-ment surgery	Sterilisa-tion
Have you ever denied someone access to the following services because of their age?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Have you ever denied someone access to the following services because of their gender/sexuality?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
In your capacity as a service provider, have you ever reported a case to the police/child protection services because you learned a minor was sexually active under the age of 18?	Yes / No							
What happens if you fail to do so?	1 I risk going to jail 2 I risk losing my job 3 Nothing at all							
Is it ever your responsibility to encourage someone to be sterilised? (circle all that apply)	1 Yes, if they have a severe disability 2 Yes, if they already have too many children 3 Yes, if they have (or are planning to) change their gender ever under any circumstances 4 In none of these circumstances							

Annex E: Survey – Young People

Location of survey (where respondent was accessed):

(IPPF MA to fill out):

Please number the survey and fill in your initials here:

Instructions: Our organisation [fill in name of MA:_____] is conducting some research about children and young people's access to sexual and reproductive health services, and we're interested to hear about your ideas and experiences.

We would like to ask you some questions. It should only take 10 - 15 minutes. Please be as honest as you can in your answers: there are not right or wrong answers to most of the questions and we want to learn from you! We promise that we will never tell anyone how you have answered these questions. All of the information you give us will be kept strictly anonymous, and we will not ask you your name.

The purpose of the research is to identify any barriers, which make it difficult for young people to access sexual and reproductive health services, such as contraceptives or other health services they need. Based on what we learn through the survey, we will make recommendations on how service providers can improve young people's access.

You do not have to fill out this survey form if you don't want to, and you can choose not to answer any or all of the questions. We don't mind if you prefer not to take the survey, and it won't affect your interactions with [fill in name of MA] in the future. Would you like to take the survey?

Yes ❑ No ❑

We would like to use some of what you tell us in our report but we will never use your name. Is that ok?

Yes ❑ No ❑

PART 1: Basic personal and household information	
1.1 **Gender** (circle one)	Female / Male / Other _____
1.2 **Age** (fill in):	_____ (number)
1.3 **Where do you live?** (fill in)	_____ (village)/ _____ (district)
1.4 **How would you describe the area where you live?** (circle the best response)	1 Rural area 2 Suburban area 3 Urban neighbourhood 4 Urban slum 5 Refugee camp

1.5 **Total size of household** (fill in):	_____ (# females)/ _____ (# males)
1.6 **Who do you live with / who looks after you?** (circle the best answer)	1 I live with both my parent 2 I live with a single parent 3 I live with relatives (not a parent) 4 I live with other adults (not relations) 5 I live with my partner
1.7 **How many siblings do you have in total? How many of these siblings are older than you?** (fill in)	Number of siblings_____ (number) Number of older siblings_____ (number)
1.8 **Level of education** (select the best answer):	1 no formal education 2 elementary 3 primary 4 secondary 5 college / university 6 other
1.9 **Do you do any work for a wage?** (circle the best answer)	1 Yes, full time 2 Yes, part time 3 No
1.10 **Religion** (select the best answer):	1 Muslim 2 Protestant 3 Catholic 4 Hindu 5 Buddhist 6 Confucian 7 Other
1.11 **Do you identify as an individual belonging to a social/racial/ ethnic minority group?** (circle the best answer)	Yes / No
1.12 **Do you believe that you have any form of partial or permanent disability?** (circle the best answer)	Yes / No
1.13 **Which of the following is present in your household?** (circle all that apply)	1 a refrigerator 2 a mattress 3 a television 4 a computer 5 a mobile telephone 6 piped water 7 a flush toilet 8 a gas cooker 9 a car 10 internet

1.14 **What is the occupation of the head of your household?**	1 Farmer 2 Casual labourer 3 Government employee 4 Factory worker 5 Shopkeeper 6 Employee of private company 7 NGO 8 Hospitality 9 Household help 10 The head of my household does not engage in any income earning activities 11 Other
1.15 **Marital status of respondent** (select the best answer):	1 never married 4 widowed 2 married now (living together) 3 separated/divorced 5 other
PART 2: Knowledge and perceptions of norms and law	
2.1 **In your view, at what age is it appropriate for young people to become sexually active?** (select the best answer)	1 At the age of : _____ (fill in age) 2 When he or she is married 3 It depends (no particular age)
2.2 **In your view, at what age is it appropriate to get married?** (select the best answer)	1 At the age of : _____ (fill in age) 2 It depends (no particular age)
2.3 **Does the law say that it is illegal to have sex if you are below a certain age?** (select your best guess)	Yes / No
2.4 **If so, what is the age?** (fill in with your best guess or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.5 **Does the law say that it is illegal to have sex with someone else who is below a certain age?** (circle your best guess)	Yes / No

2.6 **If so, what is the age?** (fill in with your best guess or circle 'no age')	____ (for boys) ____ (for girls)/ No age
2.7 **In your view, at what age should a young girl be able to access contraceptives?** (circle the best answer)	1 At the age of: _____ 2 When she is married (regardless of whether or not she has already had a child) 3 Once she is married (but only after she has already had her first child) 4 At any age
2.8 **Does the law set an age at which young people are able to access any forms of contraceptives / birth control?** (circle the best answer)	1 Yes 2 No 3 No age, but legal access is at the discretion of the service provider
2.9 **If yes, what is that age?** (fill in with your best guess)	_____
2.10 **According to the law, can the doctor tell your parents without your permission if you go to access contraceptives?** (circle the best answer)	1 Yes; the law requires her to tell my parents when I access a service 2 Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3 Only if there is a risk to my health 4 Never under any circumstances
2.11 **According to the law, can the doctor tell your parents without your permission if you go to access STI testing?** (circle the best answer)	1 Yes; the law requires her to tell my parents when I access a service 2 Yes; she is not required to tell my parents, but the law says she can do so at her discretion 3 Only if there is a risk to my health 4 Never under any circumstances
2.12 **According to the law, can a 17 year old girl access an abortion?** (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1 Yes, always 2 Only with her parent's permission 3 Only if she was raped 4 Only if her life is in danger 5 Never under any circumstances
2.13 **According to the law, can a 14 year old girl access an abortion?** (circle 1 OR 5 OR any combination of 2, 3 and/or 4)	1 Yes, always 2 Only with her parent's permission 3 Only if she was raped 4 Only if her life is in danger 5 Never under any circumstances

PART 3: Experiences accessing services	
3.1 **At what age did you first have sex?** (fill in your age OR circle 55 OR 99)	Age_____ 99 Never had sex 55 I don't want to answer
3.2 **If you ask a doctor or midwife for advice about contraception or STI testing, do you feel confident that they will they keep this information confidential?** (circle the best answer)	Yes / No / Maybe
3.3 **Have you ever tried to access any of the following services?** (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant/IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services
3.4 **Where have you tried to access the services you just mentioned?** (circle all that apply)	1 Public clinic 2 Private (fee-paying) clinic 3 School health centre 4 Clinic specialising in SRH 5 Pharmacy 6 Community member 7 Other (please specify)
3.5 **Have you ever been denied access to any of the following services?** (circle all that apply)	1 Condom 2 Birth control pill 3 Injections 4 Implant/IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services

3.6	**Have you been denied access to a service because of your age?** (circle all that apply)	1 Condom 2 Oral contraceptive pill 3 Injections 4 Implant/IUD 5 STI testing (non HIV) 6 HIV testing 7 Abortion 8 Emergency contraception 9 Sterilisation 10 Ante natal services 11 Post natal services 12 SGBV related services
3.7	**If you have ever been denied access to a service because of your age, please specify the age at which this occurred** (fill in, or circle 99)	Age _____ 99 I have never been denied access because of my age
3.8	**Have you been unable to access an SRH service because of your sexual/gender identity?** (circle the best answer)	Yes / No
3.9	**Has anyone ever had sex with you or committed sexual acts with you through force or against your will? For example through pressure, coercion, physical force, or because you were unable to say no?** (circle the best answer)	Yes / No / I prefer not to say
3.10	**Have you received any education about sexual and reproductive health services?** (circle all that apply)	1 Yes, at school 2 Yes, from a religious/community leader 3 Yes, from an NGO 4 No, never

Annex F: Ethical Protocol

Coram Children's Legal Centre
Ethical Guidelines for Field Research with Children

Each research project carried out by Coram Children's Legal Centre should be ethically reviewed and Guidelines should be developed that are tailored and relevant to each piece of research. The reason for this is that different types of research will raise unique, context-specific ethical issues and it will be necessary to identify and address these issues on a project-specific basis. However, these Guidelines should be applied when carrying out all project-specific ethical reviews.

1. Application of Ethical Guidelines

The Ethical Guidelines will apply to all field research carried out by Coram Children's Legal Centre and organisations and individuals carrying out research on behalf of Coram Children's Legal Centre. The Guidelines will not apply to the consideration and selection of research projects. They will apply to: methodology selection and design; the design of data collection tools; the collection, storage, collation and analysis of data; and the publication of research.

2. Ethics review

All research project methodologies and data collection, collation and analysis tools must be approved by the Director, International and Research or the Legal Research and Policy Manager, before they are deployed. The Professional Director or Legal Research and Policy Manager will review the methodologies and tools in light of these Guidelines and best practice, and make revisions accordingly, which will then be incorporated into revised methodologies and tools.

3. Selecting researchers

Coram Children's Legal Centre will ensure that all external researchers have the necessary experience to carry out the research required. Where necessary, training will be provided to external researchers by Coram Children's Legal Centre staff on these guidelines and best practice issues for carrying out the relevant research.

4. Guiding principles

All research projects will be subject to the following ethical principles.

4.1 Do no harm and best interests of the child

It is of paramount importance that Researchers protect the physical, social and psychological wellbeing, and the rights, interests and privacy of research participants. The welfare and best interests of the participants will be the primary consideration in methodology design and data collection. All research will be guided by the UN Convention on the Rights of the Child, in particular Article 3.1 which states: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts or legislative bodies, the best interests of the child shall be a primary consideration."
It is the obligation of the Researcher to identify and avoid harmful effects. If Researchers identify that they are causing harm to a participant/s, the research must be stopped.

Particular care will be taken to ensure that questions are asked sensitively and in a child-friendly, manner that is appropriate to the age, gender, ethnicity and social background of the participants. Clear language

will be used which avoids victimisation, blame and judgement. Where it is clear that the interview is having a negative effect on a participant, the interview will be stopped. Any child protection concerns will be identified and dealt with appropriately (see 4.8, below).

Children will be provided with the opportunity to participate in data collection with a trusted adult or friend if this would make them feel more at ease. Researchers should identify staff at institutions (e.g. schools, community groups, detention centre staff) that are available to accompany participants, if requested.

Interviews may cover particularly sensitive or traumatic material, and it is important to ensure that participants feel empowered and not solely like victims. Interviews should finish on a 'positive or empowering note' (e.g. through asking questions about what would improve the situation of children in the relevant study sample). This will help to ensure that children do not leave the interview focusing on past experiences of abuse. Where children reveal past experiences of violence or abuse, researchers will convey empathy, but will not show shock or anger, as this can be harmful to children who have experienced violence.

4.2 Data collection must be necessary

It is important to ensure that unnecessary intrusion into the lives of participants is avoided. Researchers must ensure that the data being collected is necessary to address the research questions specific to each project. Data collection for extraneous purposes must be avoided.

Where possible and appropriate, participants may be provided with material incentives to compensate them for time spent contributing to the research.

4.3 Researchers must not raise participants' expectations

Researchers must carefully explain the nature and purpose of the study to participants, and the role that the data will play in the research project. Participants should also be informed that the purpose of the Researcher's visit is not to offer any direct assistance. This is necessary to avoid raising expectations of participants that the Researcher will be unable to meet.

4.4 Ensuring cultural appropriateness

Researchers must ensure that data collection methods and tools are culturally appropriate to the particular country, ethnic, gender and religious context in which they are used. Researchers should ensure, where possible, that data collection tools are reviewed by a researcher living in the country context in which research is taking place. Where possible, data collection tools should be piloted on a small sample of participants to identify content that lacks cultural appropriateness and adjustments should be made accordingly.

4.5 Voluntary participation

Researchers must ensure that participation in research is on a voluntary basis. Researchers will explain to participants in clear, age-appropriate language that participants are not required to participate in the study, and that they may stop participating in the research at any time. Researchers will carefully explain

that refusal to participate will not result in any negative consequences. Incentives may be provided; however, researchers must ensure that these would not induce participants to participate where doing so may cause harm.

4.6 Informed consent

At the start of all data collection, research participants will be informed of the purpose and nature of the study, their contribution, and how the data collected from them will be used in the study, through an information and consent form, where possible and where this would be appropriate and not intimidating for young people. The information and consent form should explain, in clear, age appropriate language, the nature of the study, the participant's expected contribution and the fact that participation is entirely voluntary. Researchers should talk participants though the consent form and ensure that they understand it. Where possible and appropriate, parents / carers should also sign an 'information and consent form'. The needs for this will depend on the age and capacity of participants. Where possible, parental consent should be obtained for all children aged under 13 years. For children aged over 13, the decision on whether consent from parents / carers is needed will be made on a case-by-case basis, depending on the nature and context of the research and the age and capacity of participants.

Where it is not possible for the participant to sign an information and consent form (e.g. due to illiteracy), researchers will explain the nature and purpose of the study, the participant's expected contribution, and the way the data they contribute will be used, and request the verbal consent of the participants to conduct research and then record that permission has been granted. Special effort must be made to explain the nature and purpose of the study and the participant's contribution in clear, age-appropriate language. Researchers will request the participant to relay the key information back to them to ensure that they have understood it. Participants will also be advised that the information they provide will be held in strict confidence (see below, 4.6).

Special care must be taken to ensure that especially vulnerable children give informed consent. In this context, vulnerable children may include children with disabilities or children with learning difficulties or mental health issues. Informed consent could be obtained through the use of alternative, tailored communication tools and / or with the help of adults that work with the participants.

4.7 Anonymity and confidentiality

Ensuring confidentiality and anonymity is of the upmost importance. The identity of all research participants will be kept confidential throughout the process of data collection as well as in the analysis and writing up study findings. The following measures will be used to ensure anonymity:

- Interviews will take place in a secure, private location (such as a separate room or corner or outside space) which ensures that the participant's answers are not overheard;
- Research ers will not record the name of participants and will ensure that names are not recorded on any documents containing collected data, including on transcripts of interviews and focus group discussions;
- Researchers will delete electronic records of data from personal, unprotected computers;
- CCLC will store all data on a secure, locked server, to which persons who are not employed by the

Centre cannot gain access. All employees of the CCLC, including volunteers and interns, receive a criminal record check before employment commences; and

- Research findings will be presented in such a way so as to ensure that individuals are not able to be identified.

All participants will be informed of their rights to anonymity and confidentiality throughout the research process. Participants should be informed where it is possible that their confidentiality will be compromised. This may occur where, in a particular, named setting, the background information relating to a participant may make it possible for them to be identified even where they are not named.

4.8 Addressing child protection concerns

During the data collection process (e.g. in individual interviews and also possibly group interviews), participants may disclose information that raises child protections concerns (i.e. information indicating that they are currently at risk of or are experiencing violence, exploitation or abuse). Prior to the data collection taking place, researchers should be provided with copies of the child protection policies and procedures of each institution from which participants are recruited (i.e. schools, community groups, detention facilities) and should familiarise themselves with child protection referral mechanisms and child protection focal points.

In the event that the child interviewee reveals that they are at high risk of ongoing or immediate harm, or discloses that other children are at high risk of ongoing or immediate harm, the researcher will prioritise obtaining the child's informed consent to report this information to the appropriate professional as set out in the child protection policy, or, in the absence of such a policy, the person with authority and professional capacity to respond. If the child declines, the researcher should consult with an appropriate designated focal point, as well as the lead researcher and other key persons in the research team (on a need to know basis), concerning the appropriate course of action in line with the child's best interests. If a decision is made to report this information to the designated professional, the child interviewee is carefully informed of this decision and kept informed of any other key stages in the reporting and response process.

In some cases, it will be more likely that child protection concerns may arise. Where this is the case, Researchers should ensure that research is carried out with a social or support worker who is able to give assistance and advice to the participant where necessary.

4.9 Ensuring the physical safety and well-being of researchers and participants

Researchers must ensure that data collection takes place in a safe environment. Participants will always be interviewed with at least two persons present (two researchers; one researcher and one translator; one researcher and a social worker; or one researcher and a note taker).

Researchers are provided with a Code of Conduct, attached to each contract of employment.

Endnotes

[1] See page 2, UNPFA http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf [accessed 27.04.2016]

[2] See UNESCO http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/ [accessed 27.04.2016] and WHO http://www.who.int/topics/adolescent_health/en/ [accessed 27.04.2016].

[3] See Youth Law of Indonesia, Pasal 1.1. Available at http://www.youthpolicy.org/wp-content/uploads/library/Indonesia_2009_Youth_Law.pdf [accessed 29.01.2016]

[4] UNCRC, "Convention on the Rights of the Child",1990, retrieved on 26 January 2016 from http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

[5] World Health Organisation, "Defining Sexual Health", retrieved on 30 September 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

[6] World Health Organisation, "Reproductive Health", retrieved on 30 September 2015 from http://www.who.int/topics/reproductive_health/en/

[7] The University of Western Australia, retrieved 18 December, 2015, from http://www.student.uwa.edu.au/life/health/fit/share/sexuality/definitions

[8] See Zwaan, Lily, "Waria of Yogyakarta: Islam, Gender, and National Identity", 2012. Independent Study Project (ISP) Collection. Paper 1440.

[9] See Evelyn Blackwood, 2005. Gender Transgression in Colonial and Postcolonial Indonesia. The Journal of Asian Studies, 64, pp 849-879.

[10] United Nations Population Fund, Global Forum on MSM & HIV, United Nations Development Programme, World Health Organization, United States Agency for International Development, World Bank. Implementing comprehensive HIV and STI programmes with men who have sex with men: practical guidance for collaborative interventions. New York (NY): United Nations Population Fund; 2015. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf, accessed 14 June 2016

[11] UNHCR, "Sexual and Gender Based Violence: Guidelines for Prevention and Response" Retrieved on Retrieved on 25 July 2015 from http://www.unicef.org/emerg/files/gl_sgbv03.pdf

[12] We recognise that this classification is an oversimplification and that there is likely to be considerable diversity within each research location. However, to the greatest extent possible, we have included respondents that represent this diversity in each research location.

[13] See e.g. Bennett, L. R. (2005). Women, Islam and modernity: Single women, sexuality and reproductive health in contemporary Indonesia. London: Routledge; Utomo, I. & McDonald, P. (2009). Adolescent Reproductive Health in Indonesia: Contested Values and Policy Inaction. Studies in Family Planning. Volume 40, Number 2. P.133-146

[14] Blackwood, E. (2007) Regulation of sexuality in Indonesian discourse: Normative gender, criminal law and shifting strategies of control, Culture, Health & Sexuality, 9:3, page 296, DOI: 10.1080/13691050601120589.

[15] FGD 3, male students at Muslim university aged 22-23, Semarang, 30th November 2015.

[16] FGD 5, male pupils aged 17 at Islamic school, Semarang, 4th December 2015.

[17] FGD 17, male university students aged 20-23, Jakarta, 9th December 2015.

[18] See Utomo et al (2012). Premarital Sex, Conception and Birth among Young Adults in Jakarta, Bekasi and Tanggerang, Indonesia. Working paper. Available at: http://paa2012.princeton.edu/papers/120248 [accessed 27.04.16].

[19] FGD 2, female school children aged 16-18, Semarang, 30th November 2015.

[20] FGD 7, mothers of children aged 16-23, rural Central Java, 3rd December 2015.

[21] FGD 11, female university students aged 20-21, Jakarta, 6th December 2015.

[22] FGD 10, young men aged 21 to 24 years, Jakarta, 6th December 2015..

[23] FGD 7, mothers of children aged 16-23, rural Central Java, 3rd December 2015.

[24] Interview 1, private health centre, Semarang, 29th November 2015.

[25] Utomo, I. & McDonald, P. (2009). Adolescent Reproductive Health in Indonesia: Contested Values and Policy Inaction. Studies in Family Planning. Volume 40, Number 2. Page 143.

[26] See for example http://www.fpa.org.uk/factsheets/law-on-sex#age-consent [accessed 16.01.16].

[27] Penal Code, Article 287. There are two more exceptions: If 'carnal knowledge' falls under the remit of Article 291 (serious physical injury) or Article 294 (where sexual activity involves the own child, stepchild or foster-child, pupil, a minor entrusted to care, education or vigilance or an under-age servant or subordinate).

[28] See e.g. Age of Consent in Indonesia. Accessed 10th November 2015 https://www.ageofconsent.net/world/indonesia

[29] Penal Code, Article 292.

[30] Law on Child Protection (No 23/2002) Art. 1(1).

[31] Age of Consent in Indonesia. Accessed 10th November 2015 https://www.ageofconsent.net/world/indonesia

[32] Amnesty International, Indonesia -Briefing to the UN Committee on the Elimination of Discrimination Against Women, 52nd Session, July 2012, p. 10

[33] Ibid.

[34] Amnesty International, "Indonesia: Repeal abhorrent bylaw that imposes flogging for consensual sex", 23rd October 2015, accessed 11th November 2015 https://www.amnesty.org/en/press-releases/2015/10/indonesia-repeal-abhorrent-bylaw-that-imposes-flogging-for-consensual-sex

[35] See e.g. Utomo, I. & McDonald, P. (2009). Adolescent Reproductive Health in Indonesia: Contested Values and Policy Inaction. Studies in Family Planning. Volume 40, Number 2. Page 136; Sexual Rights Initiative (forthcoming). National Sexual Rights Law and Policy Database: Indonesia.

[36] Law on Marriage (No .1/1974) Art. 6. Available at: http://www.scribd.com/doc/53066173/Undang-undang-Republik-Indonesia-No-1-Tahun-1974-Tentang-an#scribd [accessed 05.02.16].

[37] Law on Marriage (No .1/1974) Art. 6.

[38] PLAN. 2014. Just married, just a child. Child marriage in the Indo-Pacific region. Plan Australia. p.26. Available at: https://www.plan.org.au/~/media/plan/documents/resources/plan_child_marriage_report_july_2014.pdf?la=en [accessed 05.02.16].

[39] Article 1 of the 2002 Law on Child Protection defines a 'child' as any person under eighteen years of age, including a child still in the womb.

[40] See e.g. Committee on the Elimination of Discrimination against Women, General Recommendation 21, Equality in marriage and family relations, 1994.

[41] Centre for Population and Policy Studies, Gajah Mada University, The Situation of Children and Women in Indonesia 2000-2010: Working towards progress with equity under decentralisation, p. 138, (Jakarta: UNICEF, 2011) Available at: http://www.unicef.org/sitan/files/Indonesia_SitAn_2010.pdf

[42] Law on Marriage (No .1/1974) Articles 3-4. Available at: http://www.scribd.com/doc/53066173/Undang-undang-Republik-Indonesia-No-1-Tahun-1974-Tentang-an#scribd [accessed 05.02.16]. See also Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), accessed 1st November 2015 http://www.refworld.org/docid/4cd251d92.html p.16; IPPF. 2012. Advocacy For Adolescent Access: Indonesia - A framework for identifying legal restrictions on young people's access to sexual and reproductive health services, information and education. Unpublished manuscript.

[43] Ibid. Note that these provisions are qualified for government employees. Government Regulation No. 45/1990 stipulates that a male state official can marry more than one woman only after receiving permission from his superiors. See Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), p. 61, endnote 31.

[44] FGD 6, female school children aged 17 in Ungaran, rural Central Java, 4th December 2015; FGD 7, female parents aged 38 to 47 in Ungaran, rural Central Java, 4th December 2015.

[45] FGD 5, male pupils aged 17, Islamic school, Semarang, 4th December 2015.

[46] Interview 1, private health centre in Semarang, 29th November 2015.

[47] FGD 5, male pupils aged 17, Islamic school, Semarang, 4th December 2015.

[48] See Question 2.1 of the young people survey (Annex E).

[49] e.g. FGD 12, male university students aged 19 to 21. 9th December 2015; FGD 5, male pupils aged 17, Islamic school, Semarang, 4th December 2015.

[50] FGD 11, female university students aged 20-21, Jakarta, 6th December 2015.

[51] The term 'general SRH services' is used to refer to all services that are not discussed in separate chapters (i.e. abortion, confidentiality and SRH education). Such general SRH services include counselling, STI and HIV testing, services related to menstruation, as well as the provision of male and female contraception.

[52] Constitution of Indonesia 1945 Art. 28(h). 9.The 1945 Constitution of the Republic of Indonesia As amended by the First Amendment of 1999, the Second Amendment of 2000, the Third Amendment of 2001 and the Fourth Amendment of 2002. Unofficial translation available at: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_174556.pdf [accessed 07.02.16].

[53] Law on Health No. 36 of 2009. Available at: http://apiycna.org/wp-content/uploads/2014/01/Indonesia_Health-Law-no-36.pdf [accessed 07.02.16].

[54] Law on Health (No. 36/2009) Art. 137.

[55] Law on Child Protection (No 23/2002) Art. 8. Available at: www.hukumonline.com/pusatdata/downloadfile/fl44432/parent/17453 [accessed 07.02.16].

[56] See UNESCO http://unesdoc.unesco.org/images/0022/002247/224782E.pdf [accessed 29.01.16]. The only provision that directly regulates consent to medical treatment was found in the Mental Health Law of 2014. According to secondary sources, this law allows 'other people' to approve the medical treatment of a person with a psychosocial disability, if the person is deemed 'incompetent.' Furthermore, it allows medical personnel to force treatment on a person whom they deem 'may endanger' themselves or others. See HRW https://www.hrw.org/news/2014/09/16/break-shackles-stigma-mental-health-care-indonesia [accessed 29.01.16]

[57] Sexual Rights Initiative (forthcoming). National Sexual Rights Law and Policy Database: Indonesia.

[58] Law on Health (No. 36/2009).

[59] Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), pp 23-24, accessed 1st November 2015 http://www.refworld.org/docid/4cd251d92.html

[60] See the discussion of the legal age of marriage in Indonesia in the previous chapter.

[61] Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), p. 28.

[62] In fact, while the Indonesian government does not actively promote sterilisation, the government allocates funds to support voluntary sterilisation through non-governmental organisations. See EngederHealthhttps://www.engenderhealth.org/files/pubs/family-planning/factbook_chapter_4.pdf p.95-96.

[63] MoH et al. (2014). BukuPanduanPraktisPelayananKontrasepsi. Jakarta, 2014. Translated from Bahasa Indonesia by IPPF Indonesia (PKBI).

[64] The discussion paper also provides guidelines on when practitioners should recommend male sterilization/vasectomy. However, the criteria are much less stringent than those for female sterilisation: male patients do not need to obtain the consent of anyone (including their wives) and the guidelines also do not mention a specific lower age limit.

[65] The phrase' SRH services that are directly related to being sexually active' includes condoms, the contraceptive pill, injections, implants, STI testing and HIV testing. Of course, HIV transmission (and testing) is not always directly related to sexual activity.

[66] Interview 1, private health centre in Semarang, 29th November 2015.

[67] Interview 7, private health centre in rural Semarang, 3rd December 2015.

[68] Interview 11, public health centre, Jakarta, 10th December 2015.

[69] The questionnaire included condoms, the contraceptive pill, injections, implants, STI testing and HIV testing under the category. If service providers agreed that,according to the law, any of these services may only be provided to minors if they are married, respondents were coded as believing that the law restricts access.

[70] e.g. Interview 11, public clinic in central Jakarta, 10th December 2015.

[71] Interview 7, private clinic in Ungaran, Central Java. 3rd December 2015.

[72] e.g. Interview 2, public health centre in central Semarang, 29th November 2015.

[73] Interview 12, private clinic in Jakarta focused on SRH services, 11th December 2015.

[74] e.g. Interview 2, government health clinic (Puskesmas), 29th November 2015; Interview 10, private clinic in Jakarta, 10th December 2015; Interview 14, public health centre in Ciracas, South East Jakarta, 11th December 2015.

[75] e.g. Interview 2, government health clinic (Puskesmas), 29th November 2015. Interview 14, public health centre in Ciracas, South East Jakarta, 11th December 2015.

[76] See Youth Policy http://www.youthpolicy.org/factsheets/country/indonesia/; UNICEF http://www.youthpolicy.org/wp-content/uploads/library/Indonesia_2007_UNICEF_CRC_Report_Contribution.pdf [accessed 29.01.16] and See Pasal 63, Undang-Undang Republik Indonesia Nomor 23 Tahun 2006. Available at: http://disdukcapil.depok.go.id/wp-content/uploads/2014/04/UU-NO-23-TH-2006.pdf [accessed 01.02.16]

[77] e.g. Interview 10, private clinic in Jakarta, 10th December 2015.

[78] Service providers used the term 'high risk' groups to refer to communities of sex workers, people who use drugs and individuals engaging in same-sex sexual activity, who are understood to be particularly vulnerable to contracting STIs and HIV/AIDS. The term is used in this report without making a judgement as to its validity. Nor is it used to imply that all individuals that fall within these categories are at an equal risk of contracting STIs and HIV/AIDS.

[79] Interview 2, public health centre in central Semarang, 29th November; Interview 8, public health centre (Puskesmas) in suburban Semarang, 5th December 2015, Interview 9, private health clinic focusing on the provision of SRH services in a poor area of Jakarta, 6th December 2015.

[80] Interview 8, public health centre (Puskesmas) in suburban Semarang. 5th December 2015.

[81] Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), p. 28.

[82] Interview 8, public health centre (Puskesmas) in suburban Semarang. 5th December 2015; Interview 10, private clinic in Jakarta, 10th December 2015.

[83] Interview 5, private clinic in suburban Semarang, 3rd December 2015.

[84] Interview 13, private clinic in Ciracas, South-East Jakarta, 11th December 2015.

[85] Interview 13, private clinic in Ciracas, South East Jakarta, 11th December 2015.

[86] e.g. Interview 13, private health clinic in Ciracas, South East Jakarta. 11th December 2015; Interview 11, public health clinic in Jakarta, 10th December 2015.

[87] See e.g. Interview 7, private clinic in Ungaran, Central Java. 3rd December 2015; Interview 14, public health centre (Puskesmas), South-East Jakarta, 11th December 2015.

[88] Specific SRH services included in the survey (e.g. condoms, oral contraceptive pills, injections, etc.) can be found in Annex E, Question 3.3.

[89] FGD 12, male university students aged 19 to 21. 9th December 2015.

[90] This is particularly noteworthy given that the sample included 69% female respondents, 30% male respondents and 1% 'other' respondents.

[91] Specific SRH services included in the survey (e.g. condoms, oral contraceptive pills, injections, etc.) can be found in Annex E, Question 3.5.

[92] We also examined respondents who indicated that they had ever been denied access to oral contraceptive pills. However, given that only 6 respondents (0.9% of the sample) reported to having ever been denied access this service, the statistics are likely to be unreliable and were therefore not reported here.

[93] See Pasal 63, Undang-Undang Republik Indonesia Nomor 23 Tahun 2006. Available at: http://disdukcapil.depok.go.id/wp-content/uploads/2014/04/UU-NO-23-TH-2006.pdf [accessed 01.02.16]

[94] FGD 12, male university students aged 19 to 21. 9th December 2015.

[95] FGD 2, female school children aged 16-18, Semarang, 30th November 2015.

[96] Interview 12, private clinic in Jakarta focused on SRH services, 11th December 2015.

[97] Overall, 147 respondents (i.e. 24% of the overall sample) reported to having ever tried to access any SRH service. Specific SRH services included in the survey (e.g. condoms, oral contraceptive pills, injections, etc.) can be found in Annex E, Question 3.3.

[98] Note that the different categories were not mutually exclusive (i.e. respondents could choose more than one category). The unspecified 'other' category was chosen by 20% of the sample, which may indicate that that the survey did not adequately capture all the possible locations where young people in Indonesia access SRH services.

[99] The category of 'private clinics' also included clinics specialising in SRH services (see Question 1.3., Annex D). A chi-square test revealed that differences between categories are statistically significant ($p < 0.01$).

[100] Again, differences between categories are statistically significant ($p < 0.01$).

[101] Interview 12, private clinic in Jakarta focused on SRH services, 11th December 2015.

[102] Interview 13, private health clinic in Ciracas, South East Jakarta. 11th December 2015.

[103] Law on Health (No. 36/2009) Art. 57.

[104] It was not possible to locate an English-language version of the Medical Practice Law of 2004. This information is based on the following secondary source: /UNFPA. 2014 (unpublished manuscript). Adolescent Sexual and Reproductive Health Law Survey - Indonesia, 2014.

[105] IPPF/UNFPA. 2014 (unpublished manuscript). Adolescent Sexual and Reproductive Health Law Survey - Indonesia, 2014.

[106] In this respect, we need to keep in mind that, to our knowledge, there are no provisions in the Indonesian law that establish a specific age threshold in relation to consent to medical treatment or SRH services, and that the link between the age of majority and parental consent is largely based on service provider's understanding of best practice.

[107] e.g. Interview 2, government health clinic (Puskesmas), 29th November 2015. Interview14, public health centre in Ciracas, South East Jakarta, 11th December 2015.

[108] Chi-square test ($p = 0.387$)

[109] ANOVA test ($p = 0.171$)

[110] See also Section 7.1 on "consent requirements" in relation to immediate family members and confidentiality.

[111] Jewkes, R., & Abrahams, N. 2002. The epidemiology of rape and sexual coercion in South Africa: An overview. Social Science and Medicine, 55, 7, p.1232.

[112] Penal Code 1982 Art 346. Available at: http://www.unodc.org/res/cld/document/idn/indonesian_penal_code_html/I.1_Criminal_Code.pdf [accessed 08.02.16].

[113] Penalties are increased even more (to 12 years maximum) in the case that the termination of pregnancy is done without the consent of the woman and 15 years maximum in the case this is done without her consent and causes her death (Article 347).

[114] We were not able to obtain an English-language version of the Population and Family Development Law of 2009. Secondary sources on this provision do not contain information on sentencing. See Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), p. 36.

[115] Health Law 2009, Article 194.

[116] See Law on Health (No. 36/2009) Art. 75-76.

[117] See Section IV, Article 31(2) of Government Regulation No. 61/2014 "PeraturanPemerintahRepublik Indonesia Nomor 61 Tahun 2014 TentangKesehatanReproduksi" (unofficial translation).

[118] See Law on Health (No. 36/2009) Art. 75.

[119] Law on Health (No. 36/2009) Art. 75.

[120] According to Section IV, Article 34 of Government Regulation No. 61/2014 rape victims must obtain a doctor's letter as well as an official statement from a police investigator, psychologist or other expert (not further specified) in order to prove rape and legally access abortion services. See "Peraturan Pemerintah Republik Indonesia Nomor 61 Tahun 2014 Tentang Kesehatan Reproduksi" (unofficial translation).

[121] Amnesty International, Left without a choice, barriers to reproductive health in Indonesia, (London: Amnesty International, 2010), p. 20, accessed 1st November 2015 http://www.refworld.org/docid/4cd251d92.html p.35.

[122] Only 4% of the 80 service providers surveyed for this study indicated that they provide abortion services in their facilities. It is of course possible that service providers included in the survey simply did not have the necessary technical expertise and/or medical equipment to perform abortions. We did not implement a nationally representative survey of SRH service providers.

[123] Centre for Reproductive Rights, Supplementary information on Indonesia, scheduled for review by the CEDAW Committee during its 52nd session, 21 June 2012, Geneva, accessed 3rd November 2015 http://www2.ohchr.org/english/bodies/cedaw/docs/ngos/CenterForReproductiveRightsIndonesia_for_the_session_CEDAW52.pdf

[124] Interview 2, public health centre, Semarang, 29th November 2015.

[125] See Annex A, Figure 1 for a breakdown of services provided by health professionals included in the survey.

[126] e.g. Interview 11, public health centre, Jakarta, 10th December 2015; Interview 12, private clinic in Jakarta focused on SRH services, 11th December 2015; Interview 13, private health clinic in Ciracas, South East Jakarta. 11th December 2015.

[127] Interview 13, private health clinic in Ciracas, South East Jakarta. 11th December 2015.

[128] Interview 11, public health centre, Jakarta, 10th December 2015.

[129] Interview 11, public health centre, Jakarta, 10th December 2015.

[130] FGD 2, female school children aged 16-18, Semarang, 30th November 2015.

[131] Law on Health (No. 36/2009) Art. 137.

[132] Law on Health (No. 36/2009) Art. 72(d).

[133] We have not been able to locate an English-language version of this regulation. The relevant information was obtained from Sexual Rights Initiative (forthcoming). National Sexual Rights Law and Policy Database: Indonesia.

[134] We have not been able to locate an English-language version of this decree. The relevant information was obtained from Sexual Rights Initiative (forthcoming). National Sexual Rights Law and Policy Database: Indonesia.

[135] Penal Code Article 534

[136] Penal Code Article 283

[137] Kajal Bhardwaj and Vivek Divan, Sexual health and human rights: A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand, p. 159, (Geneva: World Health Organisation, 2011) accessed 3rd November 2015 http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf

[138] Penal Code, Article 282(3).

[139] Rebecca Gibian and Diana Crandall "Indonesia's secret abortion problem" The Week, 26 June 2015, accessed 1st November 2015 http://theweek.com/articles/561517/indonesias-secret-abortion-problem

[140] UNESCO Asia and Pacific Regional Bureau for Education (2012). Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific. Page 35. Available at: http://unesdoc.unesco.org/images/0021/002150/215091e.pdf [accessed 01.02.16].

[141] Note that, except for the 'never' response, the different categories were not mutually exclusive. Unfortunately, the survey questionnaire did not include the internet and peer-to-peer education as categories.

[142] FGD 4, street children in urban Semarang, 3rd December 2015.

[143] International Technical Guidance on Sexuality Education http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

[144] Interview 4, private health clinic focusing on SRH services, Semarang, 30th November 2015.

[145] See e.g. FGD 5, male pupils aged 17, Islamic school, Semarang, 4th December 2015.

[146] e.g. Interview 4, private health clinic focusing on SRH services, Semarang, 30th November 2015.

[147] e.g. Interview 1, private health centre in Semarang, 29th November 2015; Interview 4, private health clinic focusing on SRH services, Semarang, 30th November 2015.

148 Interview 8, public health centre (Puskesmas) in suburban Semarang, 5th December 2015.

149 Interview 11, public health clinic in Jakarta, 10th December 2015.

150 Zumrotin K. Susilo, Herna Lestari & Nanda Dwinta Sari Universal access to sexual and reproductive rights: Profile on Indonesia, p. 10. (Jakarta: YayasanKesehatanPerempuan, 2014) accessed 1st November 2015, http://arrow.org.my/publication/country-profile-universal-access-to-sexual-and-reproductive-rights-profile-on-indonesia

151 UNDP & USAID, Being LGBT in Asia: Indonesia Country Report, (Bangkok: UNDP, 2014), p. 24, accessed 3rd November 2015 http://www.id.undp.org/content/indonesia/en/home/library/democratic_governance/being-lgbt-in-asia--indonesia-country-report.html

152 Cited in Conner B, Mago A, Middleton-Lee S. 2014. Sexual and reproductive health needs and access to health services for adolescents under 18 engaged in selling sex in Asia Pacific. HIV Young Leaders Fund. Amsterdam. p.67.

153 Importantly, and as mentioned earlier, Article 292 of the Penal Code establishes that committing any 'obscene act' with a minor of the same sex is punishable with up to 5 years imprisonment.

154 Penal Code, Article 292. This provision may indicate that same-sex sexual relations are legal if both individuals are above 18.

155 ILGA. 2015. A World Survey of Laws: criminalisation, protection and recognition of same-sex love. p.73. Available at: http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2015.pdf [accessed 08.02.16].

156 UNDP & USAID, Being LGBT in Asia: Indonesia Country Report, (Bangkok: UNDP, 2014), pp 22-23, accessed 3rd November 2015 http://www.id.undp.org/content/indonesia/en/home/library/democratic_governance/being-lgbt-in-asia--indonesia-country-report.html

157 Ibid.

158 Ibid.

159 Ibid.

160 Ibid.

161 Ibid.

162 Amnesty International, "Indonesia: Repeal abhorrent bylaw that imposes flogging for consensual sex", 23rd October 2015, accessed 11th November 2015 https://www.amnesty.org/en/press-releases/2015/10/indonesia-repeal-abhorrent-bylaw-that-imposes-flogging-for-consensual-sex

163 Ibid.

164 Kajal Bhardwaj and Vivek Divan, Sexual health and human rights: A legal and jurisprudential review of select countries in the SEARO region: Bangladesh, India, Indonesia, Nepal, Sri Lanka and Thailand, p. 46, (Geneva: World Health Organisation, 2011) accessed 3rd November 2015 http://www.ichrp.org/files/papers/182/140_searo_divan_bhardwaj_2011.pdf

165 FGD 19, transgender, homosexual and heterosexual sex workers aged 19 to 24, Ciracas in South East Jakarta, 10th December 2015.

166 FGD 10, homosexual young men aged 21 to 24 years, Jakarta, 6th December 2015.

167 Interview 8, public health centre (Puskesmas) in suburban Semarang, 5th December 2015.

168 Zumrotin K. Susilo, Herna Lestari & Nanda Dwinta Sari, Universal access to sexual and reproductive rights: Profile on Indonesia, p. 11. (Jakarta: Yayasan Kesehatan Perempuan, 2014) accessed 1st November 2015, http://arrow.org.my/publication/country-profile-universal-access-to-sexual-and-reproductive-rights-profile-on-indonesia

169 UNDP & USAID, Being LGBT in Asia: Indonesia Country Report, (Bangkok: UNDP, 2014), p. 21, accessed 3rd November 2015 http://www.id.undp.org/content/indonesia/en/home/library/democratic_governance/being-lgbt-in-asia--indonesia-country-report.html

170 NehaSood, Transgender People's Access to Sexual Health and Rights: A Study of Law and Policy in 12 Asian Countries. (Kuala Lumpur: ARROW, 2009), p. 13, accessed 11th November 2015 http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/bangkok_transgender.pdf

171 "A home for transgender elderly in Indonesia" Phuket News, 12th March 2016 accessed 10th November 2015 http://www.thephuketnews.com/phuket-news-a-home-for-transgender-elderly-in-indonesia-37727.php

172 NehaSood, Transgender People's Access to Sexual Health and Rights: A Study of Law and Policy in 12 Asian Countries. (Kuala Lumpur: ARROW, 2009), p. 13, accessed 11th November 2015. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/bangkok_transgender.pdf

[173] FGD 19, transgender, homosexual and heterosexual sex workers aged 19 to 24, Ciracas in South East Jakarta, 10th December 2015.

[174] See e.g. Evelyn Blackwood, 2005. Gender Transgression in Colonial and Postcolonial Indonesia. The Journal of Asian Studies, 64, pp 849-879.

[175] Penal Code Article 296

[176] UNESCO, Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services (Bangkok: UNESCO, 2013), p. 46, accessed 5th October 2015 http://unesdoc.unesco.org/images/0022/002247/224782E.pdf

[177] Information provided by IPPF Indonesia via email.

[178] Information provided by IPPF Indonesia via email.

[179] FGD 19, transgender, homosexual and heterosexual sex workers aged 19 to 24, Ciracas in South East Jakarta, 10th December 2015.

[180] Interview 2, public health centre in central Semarang, 29th November; Interview 8, public health centre (Puskesmas) in suburban Semarang, 5th December 2015, Interview 9, private health clinic focusing on the provision of SRH services in a poor area of Jakarta, 6th December 2015.

[181] Penal Code 1982 Art. 285.

[182] See Articles 81 and 82, Indonesia Law Number 23 Of 2002 On Child Protection.

[183] Law Regarding Elimination of Violence in the Household (No. 23/2004) Art. 8(a).

[184] Amnesty International, "Indonesia: Repeal abhorrent bylaw that imposes flogging for consensual sex", 23rd October 2015, accessed 11th November 2015 https://www.amnesty.org/en/press-releases/2015/10/indonesia-repeal-abhorrent-bylaw-that-imposes-flogging-for-consensual-sex/

[185] Ibid.

[186] Ibid.

[187] In this case, 19 years was often mentioned as the relevant age limit. e.g. Interview 11, Jakarta, 10th December 2015.

[188] For the report, IPPF Indonesia will be approached to provide further information on the legal status and exact content this memorandum.

[189] According to Section IV, Article 34 of Government Regulation No. 61/2014 rape victims must obtain a doctor's letter as well as an official statement from a police investigator, psychologist or other expert (not further specified) in order to prove rape and legally access abortion services. See "PeraturanPemerintahRepublik Indonesia Nomor 61 Tahun 2014 TentangKesehatanReproduksi" (unofficial translation).

[190] Amnesty International, "Indonesia: Repeal abhorrent bylaw that imposes flogging for consensual sex", 23rd October 2015, accessed 11th November 2015 https://www.amnesty.org/en/press-releases/2015/10/indonesia-repeal-abhorrent-bylaw-that-imposes-flogging-for-consensual-sex/

[191] Amnesty International, "Indonesia: Repeal abhorrent bylaw that imposes flogging for consensual sex", 23rd October 2015, accessed 11th November 2015 https://www.amnesty.org/en/press-releases/2015/10/indonesia-repeal-abhorrent-bylaw-that-imposes-flogging-for-consensual-sex/

[192] The other two options on the questionnaire were: 1) "I risk going to jail", and 2) "I risk losing my job." (see Annex E, Part 5).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International Planned Parenthood Federation
East & South East Asia and Oceania Region
246, Jalan Ampang
50450 Kuala Lumpur
Malaysia
Tel : +60 (3) 425 66 122
+60 (3) 425 66 246
+60 (3) 425 66 308
Fax : +60 (3) 425 66 386
Email : office@ippfseaor.org
Website : www.ippfseaor.org

Sub-Regional Office for the Pacific
BSP Life Centre, Level 4
Thomson Street
Suva, Fiji
Tel : +679 3315 624 / 625
Fax : +679 3315 656
Email : ippf@ippf-srop.org.fj

IPPF Central Office
4, Newhams Row, London SE1 3UZ
United Kingdom
Tel : +44 020 7939 8200
Fax : +44 020 7939 8300
Email : info@ippf.org
Website : www.ippf.org