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ADOLESCENT REPRODUCTIVE HEALTH IN INDONESIAN CONTEXT: A DEVELOPMENT OF COMMUNITY HEALTH PROGRAM BASED ON ROADMAP OF SUSTAINABLE DEVELOPMENT GOALS

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Topic:

1. Adolescents and their development
2. Adolescent reproductive health in Indonesian context
3. Adolescent, family, school, and community related to adolescent reproductive health
4. Sustainable development goals (SDGs) for adolescent reproductive health

Adolescents and Their Development

In the phase of pubertal development, adolescent is a transition time from childhood to adulthood, which in this phase, adolescents have accelerated signs of growth and sexual maturation, physical and psychological development dimensions (Tu et al., 2015). The dimension of development, including physical, emotional, cognitive, social, and spiritual which the maturation of development was vary depending factors of physical (genetic, nutrition, and socio-economic status and ethnicity) and also psychological (family, mass media and peer experiences, and environment) (Perry & Pauletti, 2011), (Schubert et al., 2005), (Deardorff et al., 2011), (Belsky, 2011), (Brown, Halpern, & L'Engle, 2005), (Fisher & Eugster, 2014).

A time of change during puberty that influnced internal and external factors simultans accelarated their primary and secondary characteristics of sexual development which differenced between boys and girls of their consequences of development. This situations brings the adolescents to take their emotional changes that influences on their attitute on reproductive health. Therefore, changes that occur require special attention and interaction between parents and children, as well as health workers, to promote positive growth and development and positive attitudes to future RH (Alosaimi, 2014), (Baams, Dubas, Overbeek,

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& van Aken, 2015), (Blumenthal, Leen-Feldner, Trainor, Babson, & Bunaciu, 2009), (Peskin et al., 2015), (Kaljee et al., 2011).

Adolescent Reproductive Health in Indonesian Context

The hormonal changes during developing person from childhood to adolescents will caused growth spurt, primary sex and secondary sex characteristics and the long term affected on attitude and behaviors regarding psychologic and social influences (Tsai, Strong, & Lin, 2015), (Negriff, Brensilver, & Trickett, 2015), (Koo, Rose, Bhaskar, & Walker, 2012).

Our research reported that there are differences of presence of secondary pubertal development by gender. The differenced including, on Adam's apple development, hair growth in the armpit, face, and genitalia, oily armpits and a deepened voice for boys; whereas nipple changes, widened hips, hair growth in the genitalia and armpit, and oily skin for girls. Meanwhile, there were differences of presences of emotional changes by gender, which showed that adolescents were becoming more sensitive and enjoying looking at the mirror. Girls adolescents were more immature of secondary pubertal development than boys, while boys adolescent were more immature on emotional changes than girls. Our research showed that there were differences of indicators of attitudes toward ARH by gender, which girls adolescents were more negative attitudes toward ARH compared to boys (Tantut Susanto et al., 2016).

Based on our research, Immature pubertal development were higher in boys [22.7%] than girls (18.4%). However, negative attitudes were higher in girls (40.6%) than boys (37.1%). Factors associated with negative attitudes toward RH in both boys and girls were age, RH communication with parents, and pubertal development. Smoking was an additional factor in boys, whereas living in an urban area was an additional factor in girls. High knowledge about RH was associated with less negative attitudes toward RH in both boys and girls. Therefore, immaturity and factors that influence negative attitudes toward RH should be explored during puberty. Improving knowledge about RH may help to prevent negative attitudes toward RH, especially for girls in urban areas and boys with smoking habits (Tantut Susanto et al., 2016).

Adolescent, Family, School, and Community Related to Adolescent Reproductive Health

Adolescent aged 10 – 19 years in Indonesia is about 43.5 millions or 18% from total populations (Ministry of Health Indonesia, 2013), (Central Bureau of Statistics Indonesia, 2012). Based on National health research for adolescent reproductive health (ARH) aged 10 –

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24 years and un-marriage reported that 3% of boys and 1.1% of girls were engaged in sexual intercourse, which majority of them not using contraceptive and not received of health education about ARH. This situation illustrated risk for ARH in Indonesia, including Early the onset of sexual relationship among un-marriage adolescent, unprotected of sexual intercourse using contraceptive, and low of health education for ARH (Ministry of Health Indonesia, 2013).

Meanwhile, regarding Population and health survey for Indonesian ARH for Age 15 – 24 years and un-marriage reported that 52.8% of girls were discusses first menstruation time with their fried and 49.8% of boys were just kept silent when they got first time of noctural emission or wet dream. On the other hand, to early aged from adolescent aged 15 – 19 years were experienced negative of life style, like smoking, drinking alcohol, and using drug. Surprisingly, about 0.7% of girls and 4.5% of boys were experienced sexual intercourse in the age 15 – 19 years, which they perceived to protection of HIV/AIDs just using condom (Central Bureau of Statistics Indonesia, 2012). These indicated that vulnerable of children and youth population in Indonesia that must be concerned by parent and the others of healthcare services.

In puberty phase, adolescents have a great experienced to change their growth and development, including physical, psychological, social, and spiritual. During this phase, adolescents have tried to develop their behavior, as well as new behavior because very challenging, regarding peer pressure, as adolescent sexual and reproductive health (Diarsvitri, Utomo, Neeman, & Oktavian, 2011; Utomo, 2003). Therefore, they need a sex education which the content is appropriated with their basic health need. On the other hand, based on Indonesian context, there were a sensitivity and taboo for discussing adolescent reproductive health. In schools and community (Mcdonald, 2013). Therefore, it is essential to provide adolescent reproductive health based on family approached.

Figure 1 showed ARH in Indonesian context. Several factors (including socio-demographic, sexual development, communication and information, social culture and spirituality) were identified that influenced on the competency of ARH and associated for practice of ARH behavior among Indonesian adolescent (Susanto, Rahmawati, Wuryaningsih, et al., 2016).

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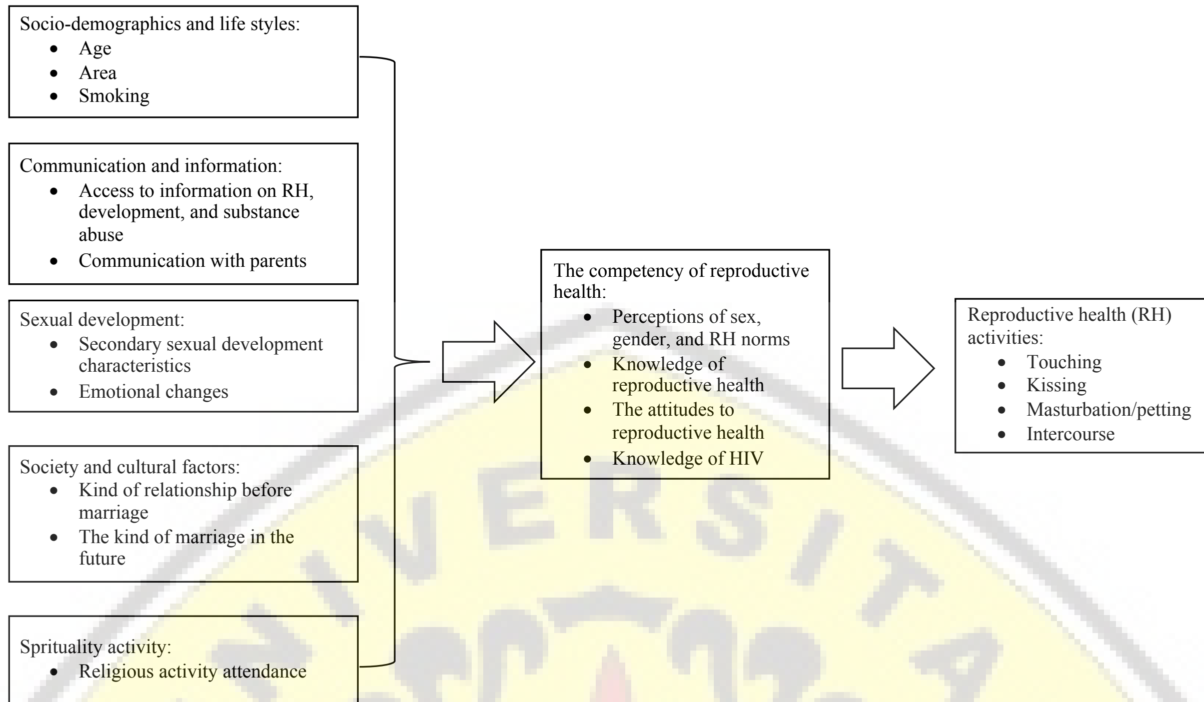

Figure 1 Conceptual schemes of activity reproductive health (RH) among Indonesian adolescents

Regarding our research, we tried to develop how adolescent discussing about reproductive health with family, peer, teacher and society. We assess the characteristic of adolescent and the topic discussion of ARH between children, parent, teachers, and their peers. Based on our community research on risk factors of ARH behavior Indonesian adolescent (Susanto, Rahmawati, Wuryaningsih, et al., 2016). We identified that sexual risk behavior was practiced among 43.3% of boys and 56.3% of girls. Results revealed that boys adolescents who have bad attention of ASRH attitude was reported more higher 5.60 times for risk ASRH behaviour (95% CI:3.56-8.81). Therefore, boys adolescent was developed some of kind relationship before married, such as *pacaran*, engaged, and *nikah siri*. Meanwhile, girl adolescents who have bad attention of ASRH attitude was reported more higher 3.45 times for risk ASRH behaviour (95% CI:2.30-5.18). Therefore, girls adolescent was percepted unregistered of kind marriage in the future. The results indicated some specific factors influences its pattern in an Islamic culture among adolescent. This study affirmed that the importance of ASRH program in Indonesia that created for relevan with religious, cultural, and etnicities (Susanto, Rahmawati, Wuryaningsih, et al., 2016).

Figure 2 showed the interaction between adolescent-Family-Peer-Teacher for discussion ARH. The systems will develop to maintain the ARH needs.

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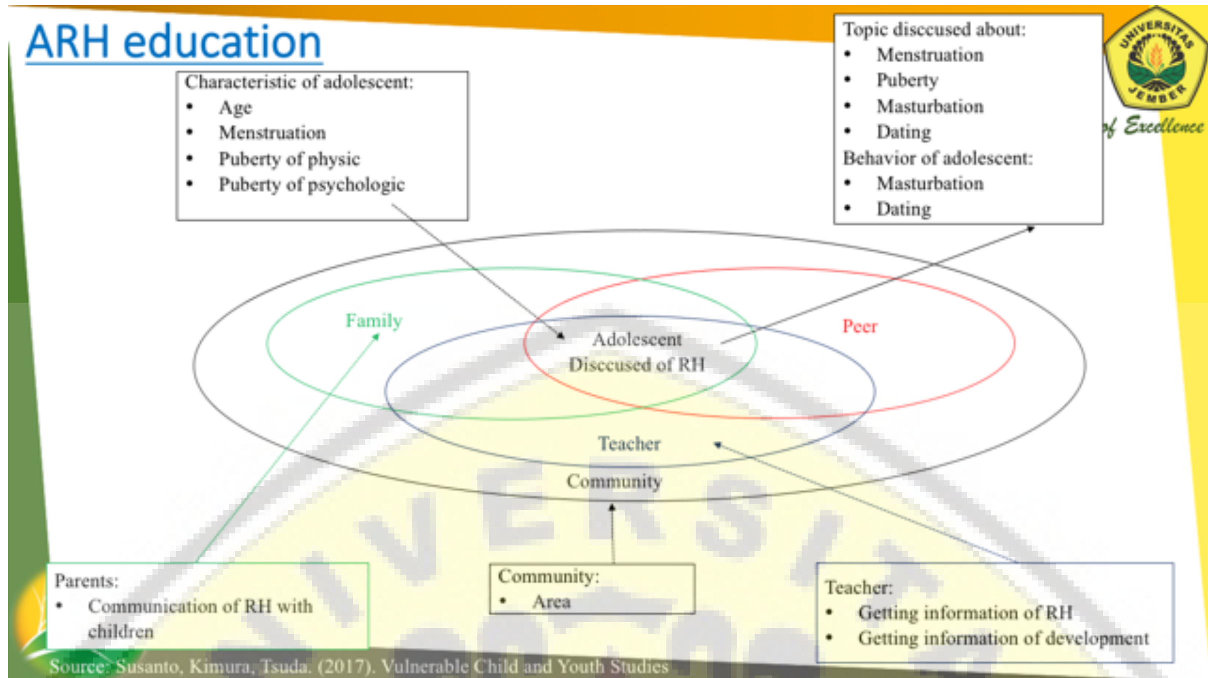

Sexuality banned and reproductive health is one of the hardest issues for family, school and community discussion to children in an Indonesian context based on social, culture, and religion. This study was to examine the presence of dating and masturbation and its factors associated among girls adolescent in Indonesia. The results showed that the presence of dating and masturbation behavior are 56.5% (95% CI: 51.1%–61.8%) and 6.6% (95% CI: -1.3%–14.5%), respectively. Age, the absence of information about development, menstruation, the absence of discussion puberty and dating with teacher are associated with dating. Meanwhile, areas, the absence of discussion puberty with teacher, and the absence of discussion masturbation with parents are associated with masturbation. The characteristics of adolescents and communication patterns of discussion between children and parents and teachers influenced dating and masturbation of girls. The results indicated that integrated sex education program based on school that involved parenting class was needed to plan in Indonesia context.

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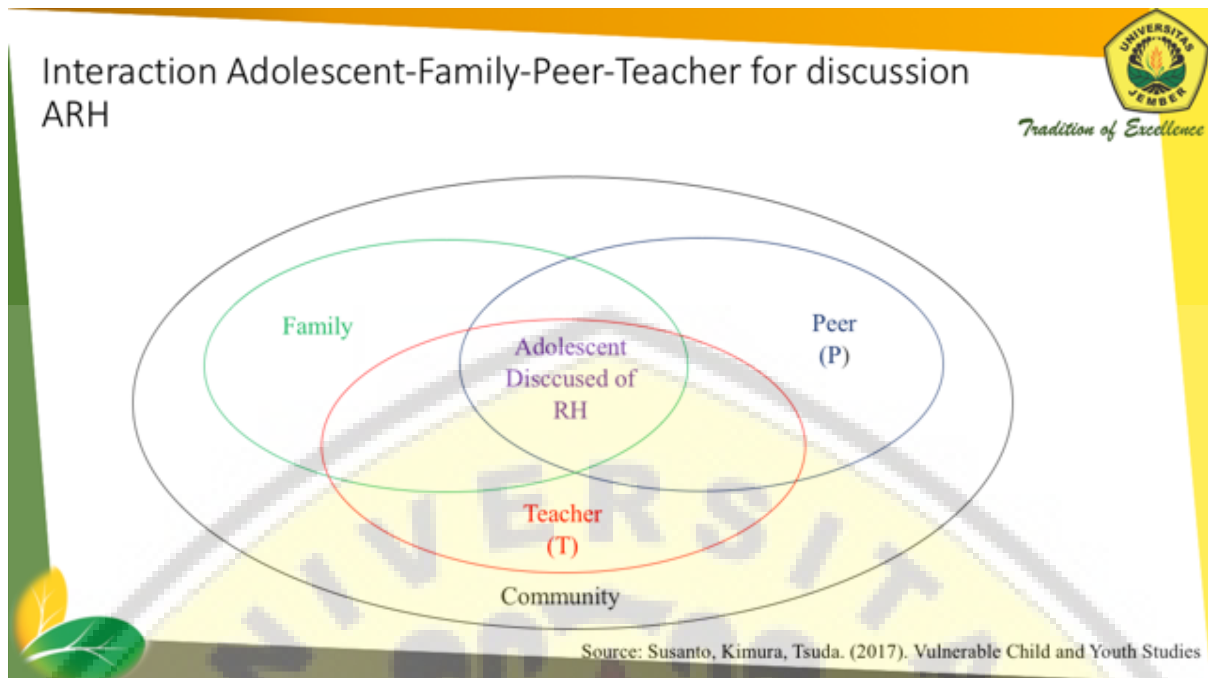

Figure 3 show an ecologic framework for adolescent health. An ecologic is process of a life cycle development phase of human. During their development from preconception to the old age, human learns of life course to fulfill their needs of life. Regarding this framework, the stage of early adolescent is golden period to learn life course to maintain their healthy life. During adolescents' life course, adolescent should achieve five goals for healthy adolescence. Four component of system in the community, including school, family, neighbourhood, and macro-level factors influence to achieve goals for healthy adolescence. The basic of goals for healthy adolescent which is very important is physically and mentally healthy. This goal is comprehensive aspect, such as physical, psychological, social, and spiritual need. Ones needs of aspect in this goal which is important for adolescents is to meet adolescent reproductive health needs. While, family is key point of important factor to support adolescent to meet adolescent reproductive health need for success promoting adolescent health.

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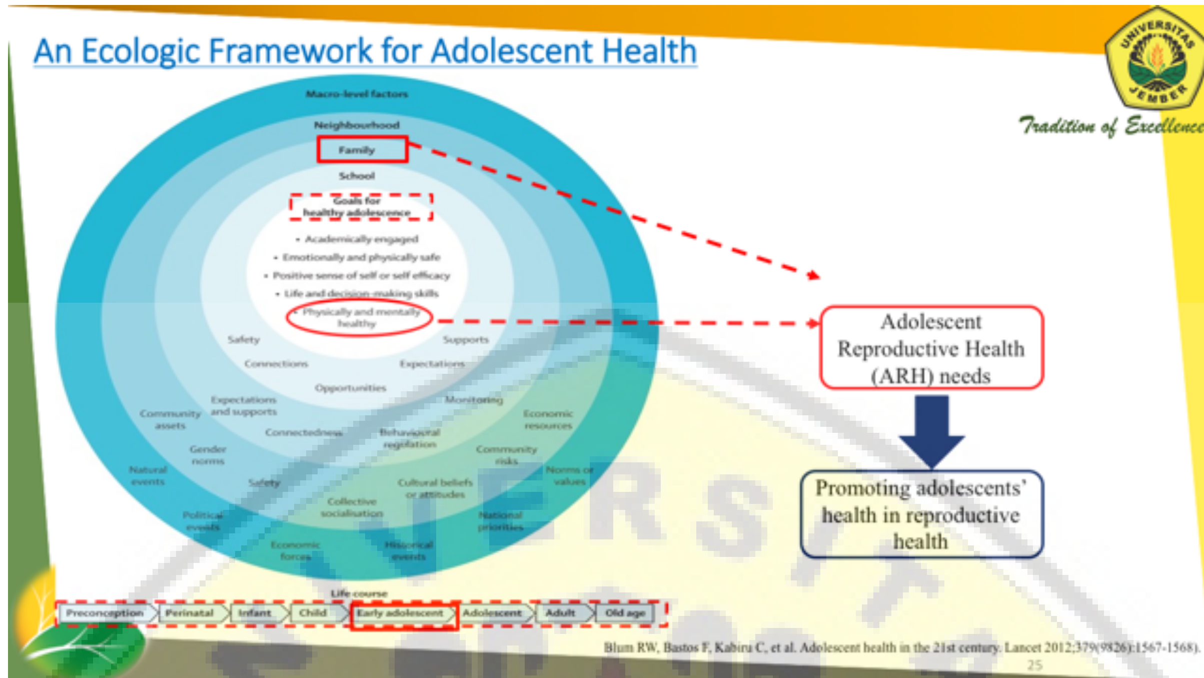

During their life cycle life, family follows 8 stages nuclear family life cycle. Stage 5nd with ARH need big concern of family environment. Therefore, all of family members should be involve as family as systems. Adolescent reproductive health needs in Indonesia. United Nation Population Fund (UNPF) reported adolescents face barriers to acquiring reproductive health information and care. Regarding our previous studies in adolescent reproductive health areas in Indonesia, limited access information of reproductive health influenced on low knowledge of adolescent reproductive health, never communicated of reproductive health with parents, negative attitude and active behavior of adolescent reproductive health (Kholifah, Yumni, Minarti, & Susanto, 2017; Susanto, Rahmawati, & Wantiyah, 2016), (Tantut Susanto et al., 2016). During puberty, family environment is important factor to support adolescent reproductive health needs. While, evidence based showed that family structure, family communication, family microsystem and family connectedness were protective and control factors to facilitate adolescent reproductive health needs. On the other hand, regarding social, culture and religion context in Indonesia, discussing about adolescent reproductive health was sensitivity and taboos in family context (Susanto, Kimura, Rumiko, & Tsuda, 2016). Therefore, parents are uncomfortable or afraid to talk in sex education. Furthermore, the protective and control factors in family nursing areas can identify using friedman family assessment model.

Friedman family assessment model (FFAM) as theoretical framework. FFAM is described family as component of society for unit of analysis (Friedman, Bowden, & Jones, 2003). As

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component of society, family is interacted with the other system in their life cycle. For example, in their activities, all of family members accesses medical center for health system, used bank to fulfill economic system, going to schools to access education system, and to church to access religion system. Furthermore, this figure show conceptual scheme of family as legal systems in community, in which the family is viewed as one of many institutions in society, similar to health, educational, religious, or economic institutions (Joanna Rowe Kaakinen, Coehlo, Steele, Tabacco, & Hanson, 2015). FFAM consists six broad categories of interview questions, including identification data, developmental stage and history of the family, environmental data, family structure, family functions, and family stress and coping. This model is used family assessment guide in all of population setting of care using open questions. Therefore, variable of family structure and family function would be use to develop a scale in this study.

Development conceptual family framework using FFAM. Family structure in FFAM have four variable, including family communication, family power and decision making, family value, and family role structure. Meanwhile, family functions in FFAM have five variable, including family affection function, family socialization, family health care function, family economic function, and family reproductive function (Joanna Rowe Kaakinen et al., 2015). However, FFAM is tools assessment with open questions which each item have some sub items. Therefore, strengthening of family structure and functionalization of family functions for developing tools assessment needed to facilitate parents for fulfillment and promoting adolescent health, particularly in adolescent reproductive health needs. As systems, family needs each sub system to operate their unity system, including input, process, and output to change their family life cycle.

This study was to explore factors related to Indonesian parents to implement family function on adolescent reproductive health (ARH), regarding the Family System Framework (FSF) and the Friedman Family assessment Model (FFAM). The results showed that factors related with implementation of family function on ARH in both boys and girls children were changes role and regulation system, family communication pattern and processes, family role structure, and family power and decision-making. Family values was an additional factor in boys, whereas age of child was an additional factor in girls. The FFAM can used to explain parents to implement family function on ARH as system context based on FSF. Family coaching and guidance should be implemented to improve family function on ARH with specific attention

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to family values for boys and child of age for girls based on the society, culture, and religion of Indonesian families.

Sustainable Development Goals (SDGs) For Adolescent Reproductive Health

Then, how SDGs as roadmap to develop program to facilitate ARH? We knew that on 2015 new regulation was released as know as SDGs with 17 goals. The SDGs focus on 5P, people, planet, peace, prosperity, and partnership.

Sexual and reproductive health and rights are critical to many of the Sustainable Development Goal (SDG) target, and these recommended indicators correspond specifically to three SDG targets: health (target 3.7), education (target 4.7), and gender equality (target 5.6) (Sneha Barot , Susan A. Cohen , Jacqueline E. Darroch , Alanna J. Galati , Chelsea Polis, 2015). Gender equality based on gender norms varies in time and between cultures (Rolleri, 2013b). The United Nations Development Programme (UNDP) is promoting the UNDP gender equality strategy 2014–2017 to achieve gender equality (United Nations Development Programme, 2014).

Issues relating to gender norms on equality in reproductive health (RH) vary in Indonesia, with dispparities based on society, culture (Khairani, 2013), and religion (Pakasi, 2013). Indonesian women still suffer from dicriminication and marginalization based on culture, gender, and religion, as well as issues related to siri marriages (Gadis Arivia, 2015), age of marriage, abortion, and sexual, and reproductive health (Mary Huang Soo Lee, 2012). This has led to inequalities in gender roles and norms in Indonesia and has resulted in the emergence of social problems and conflicts in society, including physical, psychological, or sexual violence against women and children (M. Anwar Fuad, 2011; Ratih Probosiwi, 2015).

Evidance has revealed that puberty is a key event in life for shaping adolescent gender norms and health trajectories into adulthood (Kågesten et al., 2016). In addition, the pattern of morbidity and mortality rates in adolescents differ on the basis of the differentiation between sexes (Blum, Astone, Decker, & Mouli, 2014), with a key determinant being gender inequality. Gender attitudes are complex in cases where certain individuals may indulge in harmful gender discriminatory practices (Sneha Barot , Susan A. Cohen , Jacqueline E. Darroch , Alanna J. Galati , Chelsea Polis, 2015). Adolescent girls are willing to challenge the gender norms that disadvantage them; however, they require support in exercising agency and building their self-

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esteem and confidence, whereas adolescent boys require support to recognize and challenge gender norms that reinforce their privilege, rather than being punished when such gender norms are challenged (Kågesten et al., 2016).

Indonesian national surveys have shown that from 2012 to 2013, there was an increase of approximately 30% in the number of cases of sexual violence, which is the equivalent of 35 people per day being victims of sexual violence (Trimaya, 2015). Meanwhile, based on the Annual Notes National Commission for Women in Indonesia up to March 2016, reported sexual violence occured within the family (30%) or community (61%) (KomNas Anak & Perempuan, 2016). The forms of sexual violence included rape (72%), sexual abuse (18%), and sexual harassment (5%); the cases of sexual violence based in the community included rape (1,657), sexual abuse (1,064), sexual harassment (268), sexual violence (130), kidnapping and runaway girls (49), and attempted rape (6) (KomNas Anak & Perempuan, 2016). This figures show that there is currently an urgent issue of violence against women and children in the family and the community in Indonesia.

For adolescents in Indonesia, living by idealized morality codes means that sexual behavior is influenced by social norms, religious restrictions, and moral taboos (Benedicta, 2010). There is evidance showing that gender is an important determinant in sexual risk-taking behavior, based on gender attitudes and behaviors, especially on adolescents (Rolleri, 2013a). The trends in the society and the family of Indonesia that causes differences in gender roles is to position the role of boys and girls are different, both in status, the role of which is attached or actual rights are universal rights (KomNas Anak & Perempuan, 2016). The process of inheritance this value will ultimately make the child continue to hold the doctrine of what should be done by boys and what not to do, as well as for girls there is a set of rules that should not be infringed upon because culture forbid (Trimaya, 2015). The reproductive and sexual health of adolescents changes as a result of changes in gender norms, and rigid gender norms can have a harmful impact on sexuality and RH (Rolleri, 2013), such as dating behavior. A previous study reported differences in gender and sexual orientation, with males engaging in more sexting than females; moderate and high levels of sexting could be a risk factor for certain problematic behaviors, including dating violence (Morelli, Bianchi, Baiocco, Pezzuti, & Chirumbolo, 2016). In addition, girls reported more dating violence than boys, including perpetrating verbal/emotional abuse, physical abuse, sexual abuse, relational abuse, threatening behavior and stalking (Niolon et al., 2015). In contrast, boys who endorsed gender role

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discrepancy and associated discrepancy stress were generally more likely to engage in acts of sexual violence, although not necessarily physical violence (Reidy, Smith-Darden, Cortina, Kernsmith, & Kernsmith, 2015).

Parents, peers, and schools also play key roles in shaping gender norms among adolescents (Kågesten et al., 2016). Islamic culture regards sexuality as a taboo and a sensitive subject (Sarnan, 2012), and sexuality and the ban on premarital sex have been reported to be the most difficult issues for discussion in families, schools, and the community (Utomo, McDonald, Reimondos, Utomo, & Hull, 2013). Previous studies in Indonesia have shown about 44.8% of parents feel a sense of taboo, or are uncomfortable or afraid when discussing sexual education with their adolescents (Suwarni, Ismail, Prabandari, & Adiyanti, 2015). In Indonesia, the role of gender norm attitudes among children on their sexual behavior, based on society, culture, and religion remains unclear.

This research examined perception of adolescent for family planning based on analyzed adolesent sexual and reproductive health (ASRH) behaviour (Susanto, Kimura, Tsuda, Wuri Wuryaningsih, & Rahmawati, 2016). The results showed that 89.4% of adolescents were more than 20 aged of married and 92% of adolescents were registered marriage of family planning. The strongest of predictors that perception of gander and norm ASRH (OR: 1.53; 95% CI: 1.02-2.29) and behavior of ASRH (OR: 2.69; 95% CI: 1.57-4.58) were reported aged married of adolescent and perception kind of marriage of adolescent perception. The results indicated of family planning of adolescent perception based on aged and kind of marriage influenced by customary norms and values ancestral cultures for maturation in the adolescent age marital in the future (Susanto, Kimura, Tsuda, et al., 2016).

Inequality of gender roles and norms results in the emergence of social problems and conflicts in society, such as sexual violence against children, especially in context of Indonesian society and culture. This study examined the determinant factors associated with attitudes about gender norms, sexuality, and reproductive health (GNSRH) of adolescents regarding the combined of adolescent reproductive health (ARH) and family system development (FSD) in Indonesian context. Results showed that determinant factors of the attitudes about GNSRH in both boys and girls were religiosity and family stress, coping, and adaptation. Parent’s gender, area of residence, and family communication patterns and processes were additional factors in boys, whereas access to information on reproductive health, knowledge of HIV, and family health

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care were additional factors in girls. Therefore, determinant factors that influence attitudes to GNSRH regarding ARH and FAD should be explored during puberty. Furthermore, the comprehensive education of gender norm attitudes of the family-adolescent framework to promote gender equality and tackle harmful stereotypical attitudes needs to be tailored on the basis of the Indonesian context to specific needs and influences of family communication in boys and family healthcare in girls.

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