

Contraceptive Services Available to Unmarried Sexually Active Adolescents

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Abstract

Background: Low contraceptive use amongst unmarried sexually active young men and women presents an ethical dilemma in Indonesia, particularly in realising reproductive rights as a fundamental human right. This study aims to address the difficulties in extending access to family planning for unmarried sexually active youths. **Methods:** A review of the laws relating to the provision of family planning was combined with a secondary data analysis of the 2012 Indonesian Demographic Health Survey throughout 6 provinces on the island of Java. The sample population included 5,150 unmarried adolescents, aged 15 to 24 years. The 2012 Indonesian Demographic Health Survey was the first and only survey that included unmarried young women in Indonesia. The association between subjects who had 'ever had sex' and three groups of predictors (demographic characteristics, peer influences, and knowledge of contraceptive methods) were examined using multivariate logistic regressions. **Results:** Results of the study found that subjects who were unmarried but had engaged in sexual activity were more likely to be those aged 19 to 21 years (OR = 2.36) and 22 to 24 years (OR = 6.81), of low education status (OR = 2.1), with a boyfriend or girlfriend (OR = 2.38), and those who approved of pre-marital sex (OR = 8.5). **Conclusions:** Results from this research suggest that new interpretations of the Law 52/2009 regarding family planning and Law 36/2009 that prohibits health services to unmarried sexually active youths are required in order to address the issues faced by Indonesia's youth.

Keywords: adolescent, contraceptive, contraception, family planning, sexual behaviour, Indonesia

Introduction

Indonesia attended both the 1994 International Conference for Population and Development (ICPD) in Cairo and the 2012 London Summit on Family Planning. Both of these meetings emphasised the recognition of reproductive rights as a fundamental human right, and the importance of ensuring that governments make family planning available to everyone who seeks it. Indonesia was one of one hundred and seventy nine governments that attended those meetings and agreed that population and development are closely linked. Indonesia made and confirmed its commitments to empower women and meet family planning and reproductive health needs for the advancement of both individual and national development.

In 2014, twenty years after the 1994 ICPD, Indonesia launched a National Health Insurance Scheme that intends to cover the health needs of the entire population, including family planning, by 2019. However, the Indonesian Government is yet to present a concrete policy that will guarantee access to quality contraceptive information and services for adolescents and unmarried women. The government continues to adhere to traditional norms, whereby family planning services only cater for married

women and men. Prior to the 2012 Indonesian Demographic and Health Survey (IDHS), there was no data on the number of unmarried sexually active young people in Indonesia, as previous IDHSs included married women only. The Government's reluctance to allow the availability of modern family planning methods to everyone, or at least to those who need it, may lead to an increase in teenage pregnancy, clandestine abortions, and the transmission of HIV and other sexually transmitted infections.¹⁻⁵

The National Population and Family Planning Board (BKKBN) contraceptive program achieved less progress between 2002 and 2012 than it did in previous decades. The contraceptive prevalence rate, in married women increased marginally from 50% in the 1991 IDHS to 62% in the 2012 IDHS. However, the largest growth period was between 1991 and 2002-2003, with an increase of less than 2% between 2002 and 2012. During the same decade of 2002 to 2012, the recalculated estimates of those with unmet needs declined only slightly from 13% to 11%.⁶ The BKKBNs policy that contraceptives should only be provided to married couples has resulted in no data about the need of contraceptives among unmarried young people.

At the 2012 London Summit on Family Planning, Indonesia reaffirmed its commitment to increase access to family planning and reproductive health services to ultimately achieve a fertility rate of 2.1 children per woman by 2025.⁷ There were four strategies identified: Strengthening the program at a local provincial and district level to improve access; Providing services and supplies free of charge, as a part of the country's universal health coverage program launched in January 2014; Enhancing the training of health workers on long-acting reversible contraceptive methods; Improving the capacity of the existing 23,500 family planning clinics across the country.

The announcement of these strategies gave the impression that the Indonesian Government would make family planning available to all however this has not been the case.⁸ The BKKBN has cited that a lack of data on the need for contraceptives among unmarried sexually active adolescents correlates to little need for family planning services to young people, and as such no need to alter the interpretation of Indonesian law to make family planning available to them. The present research aims to present data from the 2012 IDHS as evidence of young people's need for contraceptives when they are already sexually active. Contraceptives may not delay the onset of their sexual activity, however it can prevent unplanned pregnancy and other undesirable consequences.

The perceived challenges in extending access to unmarried sexually active young people. The 1994 ICPD Programme of Action and the 2012 London Summit on Family Planning participants stated “*access to contraceptives is both a right and a transformational health and development priority.*” Despite the promises declared and signed in these international meetings, the rights of unmarried sexually active young people are not guaranteed in Indonesia.⁹ Over the past two decades, the BKKBN has not succeeded in providing quality family planning services as a basic human right when it comes to supplies and information needed, particularly in cases of unmarried women, men, and adolescents. Consequently, Indonesia has not delivered a human rights based approach to integrated family planning and antenatal care, safe delivery, post-natal care, and management of the repercussions of unsafe abortion, or the treatment of reproductive tract infections, prevention and treatment of sexually transmitted infections and HIV/AIDS that may be experienced by unmarried young people.

The challenges facing the BKKBN are apparent in two national laws, numbered 52/2009 and 36/2009. Both laws outline the legal basis for the provision of access to and quality of family planning information, education, counselling, and contraceptive services. These laws do not promote a human rights based approach to unmarried sexually active young people.

Law 52/2009 on Population Development and Family Planning defines the boundaries of what can and cannot be delivered by the BKKBN, which clearly states that family planning should be provided to married couples only. Article 23, paragraph 1, states that central and local governments are required to improve access to and quality of information, education, counselling, and contraceptive services by providing contraceptive methods in accordance with the choices made by a husband and wife, taking into account age, parity, number of children, health condition, and religious norms.¹⁰ Noticeably, most BKKBN policies are defined with an additional statement that concludes they “...*must be in accordance with religious norms*”. Many non-government organisations or civil society organisations identify this closing clause as a barrier to a rights based approach to family planning as it discriminates against unmarried sexually active people.

The Health Law 36/2009, Article 73, mandated that the government “*shall ensure the availability of information and resources for safe, quality, and affordable reproductive health services, inclusive of family planning*”. Article 78, paragraph (2) states that “*the government is responsible to ensure the availability of human resources, service facilities, equipment, and medicine in providing safe, quality, and affordable family planning services for the community*”.¹¹ However, Article 72 specifically states that entitlements for “everyone” is limited to those who are: (1) entitled to undergo a healthy and safe reproductive and sexual life [but must be] with a legally married partner; (2) entitled to be free of discrimination, coercion, and/or violence in making decisions about her/his reproductive life [but must] respect the moral values of not degrading human dignity, as in agreement with religious norms; (3) entitled to self-determine when and how often to reproduce as medically appropriate, [but must] not in conflict with religious norms; (3) entitled to receive information, education and counselling on reproductive health that is true and verifiable.

The BKKBN should question whether it is right to continue taking a conservative position in interpreting the three most used clauses in its operational day-to-day policies:

“...*with a legally married partner;*
“...*respect the moral values;* and
“...*not in conflict with religious norms.*”

By taking such a position the BKKBN is in fact at odds with the principles of the 1994 ICPD Programme of Action that stated, “*reproductive rights rest not only on the recognition of the right of couples and individuals to plan their family*”, but on “*the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction - free*

*of discrimination, coercion, and violence, in accordance to the human rights documents”.*⁸

Evidence of unmet needs. As a result, the sexual and reproductive health needs of adolescents and unmarried young people have continued to be ignored and unmet.¹² Nation-wide, the proportion of unmarried women and men aged 15 to 24 years is high, about 29.4 million or 12% of the total 237.6 million population of Indonesia.¹³ The 2012 IDHS reported that among women aged \leq 20 years, 12.8% are already in a union (sexually active) and by the time they reach 20 to 24 years, 59.5% women of this age group are already married or living with their partner.⁶ The Ministry of Health (MoH) and BKKBN should jointly monitor the magnitude of unmet needs for contraception among these groups.

The objectives of this research are to present information regarding: (1) the existence of unmarried sexually active youth in Indonesia, who need effective family planning information and services; (2) the findings that come from analysing the associations between the general demographic, peers influence, the knowledge of contraceptive methods, and being sexually active using the 2012 IDHS data of 5,150 unmarried adolescents aged 15 to 24 years on the island of Java; (3) the new recommended guidelines in applying a human rights based approach into family planning programs that can fulfil the unmet need for family planning.

Methods

Ethical Review. This research does not involve access to personal records or confidential information. Procedures and questionnaires for the 2012 IDHS survey had been reviewed and approved by the ICF International Institutional Review Board (IRB), and the survey protocols have been reviewed by the ICF IRB, the Indonesian Ministry of Health, and the BKKBN for the protection of human subjects, in compliance with Indonesia’s laws and norms.

This study utilised the 2012 IDHS data set. The 2012 IDHS collected data between the 7th of May and the 31st of July in 2012, with samples representing all 33 provinces of Indonesia. Out of the total of 44,302 households, interviews showed a household response rate of 99%.⁶

Data used for analysis in this research was derived from the Women’s Questionnaire and the Never Married Men’s Questionnaire. A subset of data was taken from the 6 provinces of the island of Java (Banten, Jakarta, West Java, Central Java, Yogyakarta, and East Java) with a total of 5,150 unmarried adolescents aged 15 to 24 years. This research was focused on Java because it is the most populated island in Indonesia, inhabited by over half (57.5%) of the total 237.6 million population.¹³ It is estimated that 15.34% of the population were

unmarried adolescents aged 15 to 24 years in the six provinces of Java. These provinces are considered as the more competent regions in delivering family planning services, as shown in the 2012 IDHS. The number of unmarried women and men aged 15 to 24 years who have heard of modern contraceptives is the highest in Java (average of 97.25%) compared to other islands in Indonesia. However, if contraceptive services in the more accomplished regions, such as Java, has barely met the sexual health needs of their adolescents as a basic human right, the inadequacy of services for adolescents in other provinces would be even greater.

Univariate and bivariate analysis (chi-square) was completed using the SPSS 22 software to explore the differences between young women and men aged 15 to 24 who have had sexual intercourse and those who have not. Independent variables consisted of three groups: (1) demographic characteristics (sex, age at the date of interview, education level); (2) peer influence (high risk behaviours such as smoking, drinking alcohol, or drugs, dating status, having friends who engage in sexual activity, and self-approval of premarital sex); and (3) knowledge of contraceptive methods (whether respondent has ever heard about withdrawal methods, the contraceptive pill, condoms, or the emergency contraceptive pill. Lastly, a multivariate logistic regression was used to show determinants of being sexually active whilst unmarried, and the odds ratios (ORs) with 95% confidence intervals (CIs) were also determined using SPSS software.

Results

Univariate analysis found that only 210 (4.1%) of the total 5,150 unmarried adolescents aged 15 to 24 years in Java, reported they had previously had sex. Results showed that there were more males (79.7%) than females who had engaged in sex, and the proportion of those younger than 20 years was about one fourth (26.7%) of the population, with almost half (47.1%) first having sex at an age of \leq 18 years. Additionally, 76.4% first had sex before the age of 22 years, excluding 16.8% who had already been living together but did not reveal their age at the time they first had sex, and 36.5% declared that place they first had sex was in their own home.

The bivariate analysis on the differences between those who had ever had sex and the three groups of variables (demographic, peers influence and knowledge of contraceptive methods) are presented below (Tables 1-3).

Table 1 shows that the proportion of unmarried male adolescents engaging in sexual intercourse is much higher than female adolescents, 5.8% compared to 1.9%. The older age groups appeared to have a higher proportion of adolescents who were sexually active,

11.7% in the age group of 22 to 24 years, compared to 1.5% in the 15 to 18 year age group. Having higher education levels negatively correlated with being sexually active early, 3.3% compared to 5.3% of those with lower education levels.

Table 2 highlights that those who have ever tried smoking, drinking alcohol, or/and drugs have a higher likelihood of being sexually active, 5.8% compared to

3.1%. Having a boy/girlfriend correlated to a higher possibility of being sexually active, 5.8% compared to 2.2%. The occurrence of sexual activity is higher amongst those who have friends who have previously had sex rather than those who have not (5.4% compared to 2.2%). Finally, those that approve of premarital sex are much more likely to engage in sexual activities than those who do not (20.1% compared to 2.1%).

Table 1. Bivariate Analysis of the Demographic Characteristic Factors that Relate to those Who Have Ever Had Sexual Intercourse (n = 5,150)

Variables	Category	Engaged in Sexual Intercourse		OR	95% CI	p-value
		No	Yes			
Sex	Male	2738 (94.2%)	167 (5.8%)	0.3	0.2-0.5	<0.001
	Female	2202 (98.1%)	43 (1.9%)			
Age	15-18 years	2779 (98.5%)	42 (1.5%)	2.9	1.9-4.5	<0.001
	19-21 years	1354 (95.7%)	61 (4.3%)			
	22-24 years	807 (88.3%)	107 (11.7%)			
Education	High (senior high, academic, university)	3019 (96.7%)	103 (3.3%)	1.6	1.2-2.2	0.003
	Low (no schooling, primary, junior high)	1921 (94.7%)	107 (5.3%)			

Table 2. Bivariate Analysis of The Peer Influence Factors Relating to Sexual Intercourse (n = 5,150)

Variables	Category	Engaged in Sexual Intercourse		OR	95% CI	p-value
		No	Yes			
High risk behaviour	No	3161 (96.9%)	101 (3.1%)	1.9	1.4-2.6	<0.001
	Yes*	1779 (94.2%)	109 (5.8%)			
Dating status	No boy/girlfriend	2386 (97.8%)	54 (2.2%)	2.7	1.9-3.8	<0.001
	Have boy/girlfriend	2554 (94.2%)	5.8 (5.8%)			
Having friends who had sex	No	2082 (97.8%)	46 (2.2%)	2.5	1.7-3.8	<0.001
	Yes	2858 (94.6%)	164 (5.4%)			
Approval of premarital sex	Disapprove	4486 (97.9%)	96 (2.1%)	11.8	8.3-16.9	<0.001
	Approve	454 (79.9%)	114 (20.1%)			

* Tried at least one (smoking, drinking, drugs)

Table 3. Bivariate Analysis of The Knowledge of Contraceptive Methods Relating to Sexual Intercourse (n = 5,150)

Variable	Category	Engaged in Sexual Intercourse		OR	95% CI	p-value
		No	Yes			
Ever heard of the withdrawal method	Never	3655 (97.4%)	96 (2.6%)	3.4	2.4-4.7	<0.001
	Ever	1285 (91.8%)	114 (8.2%)			
Ever heard of the pill	Never	533 (98.2%)	10 (1.8%)	2.5	1.2-5.1	0.017
	Ever	4407 (95.7%)	200 (4.3%)			
Ever heard of condoms	Never	648 (97.7%)	15 (2.3%)	1.9	0.98-3.8	0.062
	Ever	4292 (95.7%)	195 (4.3%)			
Ever heard of the emergency contraceptive pill	Never	4423 (96.2%)	176 (3.8%)	1.6	1.0-2.6	0.030
	Ever	517 (93.8%)	34 (6.2%)			

Table 4. Final Model of Factors Related to Ever Having Sexual Intercourse

Variables	Category	Engaged in Sexual Intercourse		
		<i>p-value</i>	OR	95% CI
Sex	Male	0.065	0.63	0.4-1.0
	Female			
Age	≤ 18 years	<0.001	2.36	1.5-3.8
	19-21 years			
	22-24 years			
Education	High	<0.001	2.1	1.4-3.1
	Low			
Current dating status	No boy/girlfriend	<0.001	2.38	1.6-3.5
	Have boy/girlfriend			
Approval of premarital sex	Disapprove	<0.001	8.50	5.8-12.5
	Approve			
Ever heard of withdrawal method	Never	<0.001	2.10	1.4-3.2
	Ever			
Ever heard of the pill	Never	0.062	2.33	0.9-5.6
	Ever			
Ever heard of condoms	Never	0.121	0.51	0.2-1.2
	Ever			

Being unmarried but sexually active shows a positive correlation with knowledge regarding traditional family planning methods, such as withdrawal methods and periodic abstinence. Awareness on more modern contraceptives that are common and easy to find, such as the contraceptive pill, condoms, injectables, and intrauterine devices is minimal, and there is even less awareness on the emergency contraceptive pill, which is often difficult to obtain. This clearly indicates that adolescents in Indonesia need a greater education regarding more effective modern contraceptives that are available to them.

Results of logistic regression analysis (Table 4) indicated that respondents in the 19 to 21 and 22 to 24 age groups, with lower education status, with a boyfriend or girlfriend, who approved of premarital sex, and had knowledge of the withdrawal method, were predictors of being sexually active. Approval of premarital sex was the highest predictor (OR of 8.5) of being sexually active. Self-approval of premarital sex is affected by sex, the identified confounding variables. The other confounding variable is knowledge of the contraceptive pill and condoms as a method of contraceptive. Confounding variables are defined as extraneous variables that can adversely affect the relationship between the independent variable and the dependent variable.

Discussion

In 2015, a road map was published for the implementation of human rights in family planning programs, known as the 'Rights-Based Family Planning: 10 Resources to Guide Programming'. The emphasis is not only on the implementation of 9 human rights standards and principles, but also on monitoring evidence

systematically using the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach developed by the WHO and others.¹⁴ The 9 human rights standards include: 1) non-discrimination; 2) availability of contraceptive information and services; 3) accessibility of contraceptive information and services; 4) acceptability of contraceptive information and services; 5) quality of contraceptive information and services; 6) informed decision-making; 7) privacy and confidentiality; 8) participation; 9) accountability.

A danger of allowing an incorrect interpretation of the laws in Indonesia is due to the increased practice of 'conscientious objection' on the part of healthcare providers. This is when a healthcare institution refuses to provide family planning information and services to a client in the name of religion or beliefs. The government needs to consider applying changes to address this as a conscientious objection can only be exercised on behalf of an individual, not an institution. The government has an obligation to regulate conscientious objection by requiring that: 1) the conscientious objectors refer patients to non-objecting healthcare providers; 2) health facilities have non-objectors available to provide medical services and goods; 3) objectors submit their objections in writing for review; and 4) individuals who are not engaged directly in the provision of the service (including administrative staff) are prohibited from exercising conscientious objection. In each stage of the reproductive life cycle, a young woman or man may engage in risky behaviours, such as premarital sexual relationships.¹⁵

However, non-discriminative access to information and services can make a difference. If a young woman, who is not sexually active, has access to information about family planning she is able to make the decision to

delay becoming sexually active until she is older.^{16,17} If she is already sexually active and has access to family planning information and services, she can avoid unplanned or unwanted pregnancy, and incurable or possibly fatal sexually transmitted diseases such as Herpes (Simplex or HPV) or HIV/AIDS.¹⁸⁻²⁰ If she find herself pregnant unexpectedly, access to family planning counselling can avoid unsafe clandestine abortions.^{21,22} Similarly, if she has already contracted an STD, then she can access family planning counselling to avoid transmitting the infection to her baby or partner(s).^{23,24}

As such, the BKKBN's narrow interpretation of Law 52/2009 on population, which stipulates that the targets of the national family planning programs are limited to married couple, has contributed to discrimination in the delivery of family planning information and services. In the last two decades, sexually active adolescents and unmarried women and men were disproportionately subjected to discriminatory behaviour from health providers when compared to their married counterparts. Contraception is needed to prevent unplanned and unwanted pregnancies amongst sexually active unmarried women, and condoms are needed to prevent sexually transmitted infections among unmarried men and women.^{5,18,25-27} However, unmarried sexually active adolescents seeking to obtain contraceptive services have great difficulties gaining access because the policy set forth in Law 52/2009 on population stipulates, that the targets of the national family planning program are limited to married couples only. This is an ethical dilemma on the provision of family planning information and services to adolescents and unmarried women who are sexually active.

In each stage of a reproductive life cycle, from childhood to adolescence, unmarried young adulthood, married adulthood, pregnancy, birth delivery, postpartum, to the menopausal period, the family planning program has the capability and responsibility to prevent further harmful complications. When adolescents run into significant barriers accessing contraceptive information and services, it results in a high rate of unintended pregnancy and an increased risk of contracting HIV and STIs. By 2019 the government's new Universal Health Insurance (JKN) is supposed to cover all primary health care services, including access to contraceptive information and services for all Indonesians, and by 2020 we expect to see that contraceptive supplies and services are available, accessible, acceptable, and of good quality for everyone who requires them.

The human rights dimension of family planning programs has been recognised for nearly 50 years, and the Right to Health, as articulated in comment 14, article 12 of the International Covenant on Economic, Social and Cultural Rights, is a fundamental human right that should be applied in family planning programs.

Nonetheless, this rights based approach is relatively new to Indonesia, namely The BKKBN and MoH. After two decades, a gap persists between the rhetoric of human rights and integrating these rights into actual family planning practices and an acceptable guideline is still required.

Findings showed that a lack of legal access to family planning programs resulted in inadequate knowledge regarding modern contraceptives that are common, safe, and much more effective than traditional family planning methods, such as withdrawal methods and periodic abstinence. Law 52/2009 on Population Development and Family Planning and Health Law 36/2009 require a different interpretation that does not restrain the BKKBN and the MoH in delivering effective family planning information and services to unmarried young people. These laws should be seen as the steward or guardian of the People of Indonesia. Stewardship is an ethic that embodies the responsible planning and management of resources to safeguard the valuables and well being of others. The current ambiguity of interpretation of the laws allows discrimination against unmarried adolescents who are sexually active.

A limitation of this study is that this is the first IDHS with sexual and reproductive health related questions for young unmarried women and analysis of the 2012 IDHS data in this research was limited to proxies, namely variables such as peer influence (high risk behaviours), dating status, having friends who engage in sexual activity, and self-approval of premarital sex. As such, the data did not contain all of the ideal risk factors for reporting if respondents had ever had sex. In addition, the dependent variable of 'have you ever had sex' is a self-reported measure hence, its magnitude and trend need to be verified in the next IDHS.

Conclusions

After two decades, a gap persists in the Indonesian family planning program that does not recognise that sexual initiation is an event that most adolescents experience as part of their transition to adulthood. Attempts to restrict unmarried young individual from family planning services have resulted in further harmful complications. Findings showed that among those aged between 19 and 21 and 22 and 24 years, self-approval of premarital sex was the highest predictor (OR = 8.5) of sexual activity (Table 4). Following this study, we suggest two possible solutions. First, for the BKKBN to revisit the interpretation of the law that states "...according to religion", and to organise open forum discussions regarding whether religious teachings can emphasise punishment or prevention of good health outcomes. Second, for the Ministry of Health to emphasise a public health perspective that upholds the concept that prevention is better than treatment, and

how can family planning information provide adolescents with education on how to avoid pregnancy should they want to, whilst at the same time providing them with a motivation to avoid pregnancy as adults in the future. As more young people enter their reproductive years, Indonesia needs to remove barriers to adolescents' access to contraceptive information and services.

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Conflict of Interest Statement

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