Young and Single as Non-sexual Beings: Politics of Reproductive Health in Indonesia

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Abstract. *The justification of this paper is to see how Indonesia's socio-cultural, religious and political settings surrounding reproductive health education and services for young people have evolved and whether any progresses have been made since the 1994 ICPD Population Program of Action. Why do the Indonesian government still demonstrate a very conservative approach towards sexuality even though increasing numbers of STDs/HIV/AIDS, premarital sex and unsafe premarital abortion are more apparent among young people? Why is reproductive health still absent from the public policy agenda? And why has these issues been 'forgotten-hidden' and not being properly addressed? Discussion will also be focus on how the government still treats young Indonesian as a non-sexual being. This paper is based on the 1994/95 Sexuality and Marriage Values Survey and field research in Indonesia during August 2000-March 2001. The survey was funded by the Demography and Sociology Program, Australian National University while the Australian's Department of Education, Training and Youth Affairs through the Merdeka Fellowship program sponsored the second part of the data collection.*

Keywords: Sexuality, young people, policies and programs, Indonesia.

1. THE YOUNG GENERATION

The older generation has a very different demographic characteristics and experiences compared to the young generation of today. The older generation in this paper is defined as those who were born during or after the Indonesian Independence (1945), and thus now are in their early sixties and late fifties. The latter referred to in this paper as young people is defined as those who are still single aged between 15-

24 years old. The most contrast difference between the two generation is that the young generation is exposed to HIV/AIDS, while the older generation was not expose to HIV/AIDS when they were young. When the older generation were young, they were less mobile, married earlier, more likely to experience arrangement of marriage, settle down with family and children, male breadwinner oriented, and have traditional view of female domestication. On the reproductive front, they are less likely to face premarital pregnancy, premarital abortion, practice safe sex, and involve in same sex relationship. Work wise, they have more stable jobs, are less likely to change jobs, thus less likely to change residential address and to some extent not so progressive and totally depended on the rapid development of sophisticated communication and computer technology.

The young generation faces more and difficult challenges as compared to the older generation. They are more mobile, married later, if decided to have a family---have fewer children, more likely to experience love marriage, better and more educated, more understanding that both husband and wife have to work for economic reward, have less stable jobs, face more competition in the labor market and trained to be more skilled in the field of high technology. The young generation is also exposed to more premarital sex, premarital pregnancy, premarital abortion, STDs and HIV/AIDS.

It is understandable why young people of today faces more risk to STDs/HIV/AIDS. While the older generation have sex largely within marriage and are more likely to have fewer lifetime sexual partners, the younger generation marry later, more are having sex before marriage, may be involve with multiple partners and even casual sexual relationship or a one night stand. Hence the later is more at risk for STDs, including HIV/AIDS as well as unplanned pregnancy (Population Reports 1995) and abortion.

In the previous generation, young people had only their family, their ethnicity and their religion as reference points. Peer pressures and drug use was not as apparent as today. The threat of uncensored information and globalization values were minimal as their world was not as computerized as today and the Internet did not exist. If there was a youth culture, it was a culture related to the achievement of political independence and economic development, that is, to group ideals rather than to personal ideals. Today's young people look also to their peers, the education system, the government, the media, the rapid technology development and Western values as portrayed by media and the Internet. In contrast, young people today are freer to express themselves as individuals and as part of peer groups of young people. They have developed their own popular culture which extends to the creation of a distinctive 'youth dialect' which most older people have difficulty to

understand (Utomo and McDonald, 1996; Field observation in Jakarta, 2002) as well as trendy fashion wear, cultural and Muslim modern clothes among young women and for some, body piercing, tattooing and coloring of their hair to colors other than black. Night lives and entertainments among young people of today have dramatically changed compared to previous generation. Among the young generation night lives accounts a significant portion of their life where they spend time with their peers going to cafes, eating out, listening to very loud music and dancing in bars and discotheques'.

On the extreme end, religious cautiousness and understanding is more apparent among the young generation as more are affiliated to religious groups, attend Islamic schools that have mushroomed and popular since a decade ago especially among the middle and upper-class. More female young people of today also wear modern Muslim attires with tight and colorful head scarf wrapped along their neck, tight jeans and long sleeve T-shirt, modern stylist accessories, matching hand bag and sandal as well as mobile phone. During the youth period of the older generation, religious youth affiliation, going to Islamic school and Muslim female clothe with head scarf was not the fashion.

In regards to reproductive health information and services, the older generation was not exposed to either information or services, while the younger generation has different experiences in these aspects. Unlike countries in Northern Europe, Denmark, Finland, Sweden, the Netherlands and the United States where reproductive health education and services for young people is given, Indonesia is still far behind (Jones, 1997; Jones et al, 1989 and Utomo 1998). In the 1992 Law on Population and Family Welfare, it is stated clearly that reproductive health information and services are only provided for married couples. Even though this law is currently being revisited and under discussion for revision, the law reflects how conservative the Indonesian government is in providing reproductive health and sexuality education and services to unmarried young people.

In term of size, in 1985 young people constituted one-fifth of the world population or there were just over a billion of young people. Eighty-three percent of these young people lived in the developing countries, where they made up 23 percent of the total population. By the year 2020, using the United Nations medium projection, the young population will increase to over 1.3 billion, an increase of 27 percent in 35 years. In Southeast Asia in 1995, adolescent population consisted of 150,947 millions and the number will increase to 174,584 millions in the year 2020 (United Nations, 1994). In 2000 in Indonesia, there were 43.3 million young people aged 15-24, comprising 21 percent of the total population (Utomo, 2003).

Regardless of the larger share of young population as compared to the share of the elderly (Jones, 1997), Governments in Southeast Asia are still at a preliminary stage of developing policies and programs related to adolescent reproductive health. 'Conservative governments' in this region still see adolescent reproductive health as a '*non-issues*'(Gubhaju, 2001) and some still treat young people as a '*non-sexual beings*'. Reservation to limited access to reproductive health information and services might be caused by inadequate knowledge and understanding that sexuality education and services might increase young people's sexual behavior. Studies in various settings have proven that sexuality education and school-based reproductive health clinics does not increase sexual behavior (Grunseit and Kippax, 1993; Kirby, 2001; Smith, Kippax and Anggelton, 2001).

Earlier strategies developed by Indonesia on adolescent reproductive health initiatives have to be changed to a stronger and committed program where the government is strong enough to make sexuality education and services a national agenda. Why wait, the young generation is facing increasing possibilities of adolescent childbearing and STDS/HIV/AIDS which may carry significant social and financial cost not just for individuals experiencing the disadvantage, but also for the society and the country.[a] This paper will evaluate how reproductive health education and services have been implemented in Indonesia.

2. POLICY MAKERS' CONFLICT OF INTEREST: THE INDONESIAN SETTING

The theory on the public and private persona developed by Goffman (1956) may explain the different behavior and attitudes between the older generation and the younger generation. With the later, the gap between their private (behavior) and public (expressed attitudes) persona is not as great as it is compared to the older generation. The 1994/95 Jakarta Marriage Values and Sexuality Survey (see Table 1) suggest that older men are least honest about sex, there is a large discrepancy between their public attitudes and their private sexual behavior. Thus they are more hypocritical in this regards. There are strongly apparent generational changes in marriage values and premarital sexual attitudes and values in Indonesia. Even though the older generation expressed more conservative attitudes and values towards premarital sex, the premarital behavior of the two generations appears to have been similar. Young and older women seem to have similar values, attitudes and behavior; in contrast, young men compared to older ones have

significantly different values and attitudes but similar behavior (Utomo and McDonald, 1996).

The problem in Indonesia is that most policy makers belong to the older generation. Therefore it is understandable why they are in the forefront of opposition to the provision of sex education in schools or reproductive health services. Even though the older generation expressed a very conservative attitude toward issues related to sexuality and reproductive health, many demonstrate double standard behavior. It is public knowledge that there are officials and even members of the parliament, who are involved in extramarital sexual relationship, have mistresses or multiple wives and demonstrate other double standards behaviors for example, pretending to be clean but involved in nepotism and corruption. But do we have to wait until the current policy makers retire before making sure to have an explicit national agenda on sexuality-reproductive health education in the school curricula and reproductive health services for young Indonesian? Will the state manage to carry the financial burden and other costs related to premarital pregnancy, premarital abortion and STD/HIV/AIDS that may be caused by delaying such policies? The state has intervened dramatically into the reproductive life and marriage regulation of the Indonesian people, yet discrimination towards its single young people is still strongly apparent.[b]

In short, conservative policy makers are the older generation. Their conservative policies might be related to their previous experiences when they were young where sexuality related behaviors and its consequences were not as great and risky as today. Having not experienced receiving sexuality information and education from their parents, older generation is also reluctant and does not have appropriate knowledge to deliver sexuality information and education to their children. These realities in addition to their double standards attitude and behavior make it more difficult to materialize the implementation of reproductive health-sexuality education and services for young people as a national agenda.

3. THE PUSH TO A MORE LIBERAL ADOLESCENT AND REPRODUCTIVE HEALTH POLICIES AND PROGRAMS

The 1999 fiscal year marked a significant moment for Indonesia. It is in this year that Khofifah Indarparawangsa, previous Women's Empowerment Minister during Abdurahman Wahid's Era, initiated a new *Adolescent and Reproductive Rights Protection Directorate* at the National Family Planning Coordinating Board (NFPCB/BKKBN) and a similar division at the State Ministry of

Women's Empowerment. Five years after the ICPD Population Program of Action and after more than a decade of debate on the need of policy and programs on Adolescent Reproductive Health (ARH) that Khofifah, the innovative Minister has the courage to develop national strategies on this issue. Even though sporadic programs have been implemented as pilot projects in several provinces, ARH programs funded by donor agencies, mainly by the World Bank, UNFPA and Ford Foundation, only concentrated on 'out of school' program. The Department of National Education has also been quite successful with the out of school programs but not as successful in developing and implementing ARH education in school which has become a 'hidden agenda' for many years.

Khofifah made another remarkable policy shift when she declared that pregnant students should be given a chance to finish their schooling. Pregnant students should not be expelled from school but be given a 'break' from school during their pregnancy. By doing this, two goals can be achieved, giving the pregnant student an opportunity to proceed with her education-career development and also to reduce the incidence of premarital abortion. Even though this statement was disapproved by some people, thinking that the policy would encourage 'more students to become pregnant', Khofifah disagreed and thought that people would rather take a preventive steps compared to the curative one. She also preferred that emergency contraceptives should be given to those who have experienced premarital abortion (Kompas, 2000). This is a big policy leap into an area that was once very controversial and taboo to be discussed openly. Towards the end of 1999, several policy discussions were brought up by policy makers in Health and Education Department to emphasize the importance of providing reproductive health education in the school curricula (Media Indonesia Online, 2000), but until now nothing have eventuated.

In Indonesia, dialogue on the importance of ARH-sex education have started in the 1980s since the government started to implement Population Education in school, though the information given is heavily loaded towards family planning instead of reproductive health matters. Then an official from the National Education Department wanted to include sex education in the curriculum but her book on sex education was band by the government. Started in 1995, discussion about ARH education became more apparent among government officials with a peak in 1997 when the government started school-based HIV/AIDS education policy. But again whether HIV/AIDS education is incorporated in the national education agenda is still questionable.

Compared to ARH programs developed by the government, the NGO's have been very innovative and up-front in dealing with ARH programs. First because they do not have the barriers in designing

programs that can be regarded as more liberal, second because most personnel working with NGO's are still relatively young and hence understand and are more attached to young people. Even though most NGO's are project oriented in nature, documentation, monitoring and evaluation of these projects are limited and of poor quality, thus making it problematic to standardize best project approaches or sharing of information between NGO's. Thus one could understand why NGO's continue to work individually and continue to reinvent the wheel. Regardless of availability of funding from donor agencies, Indonesian NGO's are very passionate in devoting their work to ARH related programs. To note, future action must be taken to support NGO's' ARH activities with more sustained funding.

In Indonesia, due to socio cultural religious and political reasons, the government to a certain degree may only encourage the availability of ARH education and not services. Even though donor agencies like USAID, UNFPA, Ford Foundation and World Bank have been providing funding for ARH programs to be implemented and trial as pilot projects in several provinces in addition to the existing activities provided by NGO's, ARH programs in Indonesia hasn't been considered as a national program. The efforts to turn ARH as the national program just started in 1999 by considering ARH in the 1999 National Development Program *Propenas* (Hasmi, 2001; Hasmi, 2002).

4. POLITICAL AND GOVERNMENT BARRIERS IN THE IMPLEMENTATION OF REPRODUCTIVE HEALTH EDUCATION AND SERVICES IN INDONESIA

The push towards a more liberal reproductive health education initiated by Khofifah is challenged by other more pressing issues needed to be resolved. For example the impact of the 1997-1998 economic crisis, the fall of the New Order in 1998 and the implementation of the decentralization law that shifted government responsibilities to the district level in 2001. These significant turmoils as well as the changing of presidents from Habibie, to Abdulrahman Wahid, Megawati Soekarno Putri then Soesilo Bambang Yudhoyono in less than a decade resulted in total restructuring of bureaucracy and government personnel movement, economic hardship and people's welfare related problems. Thus pressing issues on the need of reproductive health education and services were buried under other problems that instantly needed to be resolved. Former progresses relating to ARH policies and programs have been placed in a stand still position during late 1990s and a few years after the *Adolescent*

and Reproductive Rights Protection Directorate at the BKKBN and ARH division at the Ministry of Women's Empowerment were established. Both newly established Directorate and the Division were also trying to focus and direct policies and programs on ARH.

Meanwhile other government institutions that have also worked and focused on ARH include the National Education Department which focuses on curriculum development on sexuality-reproductive health; the Department of Health which is responsible for family planning clinical services and HIV/AIDS prevention and treatment, the Department of Religion which is responsible in preserving the morality and conservativeness towards sexuality.

Existing legal barriers significantly play a major role in the long-drawn-out process of the establishment of policy on ARH. These include Law No. 10/1992 on Population and Family Welfare currently under review for amendment which restricts family planning services for single young people; Law No. 23/1992 defines abortions as illegal even though it is public knowledge that abortions are widely provided by both medical and non-medical personnel; Law No. 1/1974, the Marriage Law, which stated the minimum legal age at marriage is 16 for women and 19 for men. The legal age at marriage for women should be raised so that more women marry after they are at least 18 years old and graduated from high school. Thus it is understandable why single women would turn to illegal abortion services as family planning and reproductive health services can not be easily accessible. Of these women, the attempt to abort using unsafe abortion services provided by traditional healers or self abortion attempts may end in fatality.

Recently ever since local governments have authority to regulate its own district,. Local Regulations implementing *syariah* law have mushroomed especially in Aceh, West Java, West Nusa Tenggara, and South Sulawesi. It has been documented that there are 54 District Regulations on women's Muslim wear with head scarf for workers and students, restriction of women movement without the accompany of man-nearest kin, and night restriction of movement for women, prostitution, drinking and gambling (Utomo, 2006). The draft law on Anti Pornography and Porno Actions is currently under discussion in the Parliament. Even though prominent women activists and NGO's are strongly against the *syariah* laws and the draft law on Anti Pornography and Porno Actions which strongly discriminate against women and marginalized anything that is related to sex, the government is not responding to the protest and seems to be in agreement with these regulations and law which can hinder any progress towards the availability of reproductive health education and services.

Almost three decades ago the government has established nine years of basic education compulsory for all (Law No. 2/1979). The government can take a significant step by establishing Government Regulation (*Peraturan Pemerintah*) attached to this law underlining the importance of reproductive health education during these nine years compulsory education. In developing such regulation it is wise to consider providing both ARH education and introduction to gender issues and empowerment given that unsafe sexual behaviors persist due to limited information and knowledge on sexuality and reproductive health. Inclusion of this information is also important given that sexual double standards, the importance of virginity status for women in marital relationship, sexual harassment, sexual assault and crime continue as a result of a deep gender gap between females and males. Most beneficial if reproductive health education is included in school curricula is that the next generations would understand the risks and consequences of unsafe sex, sexual harassment and assaults, and drug-related behavior. If the government would consider introducing gender issues and empowerment in the curriculum and combined it with reproductive health matters, then young generations of Indonesia would understand that sexuality and reproductive health matters is the responsibility of equal share between male and female and diminishing stereotype understanding that reproductive health, family planning, childbearing, childrearing, caring and family health is not solely the responsibility of female/mother.

Indonesian young people are comforted with the same problem when seeking for reproductive health services. In Indonesia, NGO's' works in this field is more innovative and advance (Field observation, April 2002). In her review, Mepham (2001) observed 21 NGO's working in promoting ARH education and services located in several provinces in Indonesia. She concluded that ARH education and information are provided in various venues for example, street-based, community-based, NGO-based, workplace, Youth Centers, and peer education program.[c] Indonesian Planned Parenthood Association is developing adolescent Reproductive Health on-line counseling and chats lines.[d]

Reproductive health services surveyed by Mepham (2001), some provided family planning and clinical services, health referrals, voluntary counseling and testing for HIV/AIDS, counseling services and condom distribution. Problems arisen as dialogue between NGO's are limited. Due to the isolation in developing ARH education and services, program developed by NGO's may overlap and not be shared with others. Another constraint is that NGO's' works mostly are concentrated in ARH education, while clinical services and support are much less provided. [e]

5. CONCLUSION AND RECOMMENDATION

The young generation faces more and difficult challenges as compared to the older generation in regards to reproductive health and sexuality matters. Because both generations have very different reproductive health and sexuality experiences, the way they are dealing with the problems are also different. Unfortunately, the risks that the young generation is facing is much greater compared to the older generation, because the later is having premarital sex longer than the previous generation, exposed to various media and internet sources and exposed to extended reference groups far beyond their family. Sadly policy makers dealing with reproductive health issues are from the older generation with no experience of receiving information and sexuality-reproductive health education and services when they were young. Thus they are very reluctant in providing it to the next generation even though the need of such education and services is very crucial due to increasing premarital unsafe sexual relations, premarital pregnancy, premarital unsafe abortion and STDs/HIV/AIDS. Government institutions and NGO's have been working on this issue for more that two decades, but the sporadic and at time un-coordinated programs have not resulted in a prominent inclusion of ARH education in the school curricula as well as making ARH services available for single young people. Barriers include strong social cultural conservativeness, existing legal laws and local decentralization regulation with *syariah* law in several provinces. The following are policy recommendations to materialized reproductive health education and services;

- Socialization, campaigns and advocacy on the importance of ARH education and services among policy makers, program implementers, politicians, members of parliaments, religious leaders, and parents.

- Young people participation in policy and program formulation. Adolescent reproductive health program, whether it is IEC, or services are for adolescent, thus it is very crucial to include young people in the process of developing the program.

- Research, documentation, recording and data collection systems. Data related to adolescent's sexuality is very limited. Thus reproductive health survey should also include young people who are still single. Monitoring and assessment system for ARH should also be developed. Data collection system related to ARH is still limited in Indonesia.

- Parents should be equipped with appropriate knowledge on ARH, so parents can be used as the first agent to pass on knowledge on reproductive health issues. The problem is that parents do not have enough knowledge in this field. It is also problematic because parents feel reluctant to talk to their children about sexuality because of cultural, psychological and communication barriers. After all parents never had the experience and they did not receive any information relating to sexuality when they were young. Educational program for parents should be developed if the government wants to depend on parents as source of reproductive health education.

- Ideally, reproductive health IEC should start in the home through parent-child dialogue. Reproductive health, sexual hygiene, sexual health responsibilities and gender equity should be discussed started as early as possible in family environment.

- School-based compulsory sexuality-reproductive health education should start in elementary school as studies in the US confirmed that intensive early childhood programs promote long-term healthy behaviors (Manlove et al. 2001:43). Including the biological as well as the socio-cultural aspects of reproductive health education such as moral positioning, relationship skills, sexual negotiating skills, gender equity in reproductive health behavior and responsibilities, drugs, alcohol and sexual risk reduction skill, and dealing with peer pressures is important in improving reproductive health knowledge of young people.

- The availability of confidential, gender sensitive, friendly, affordable and easy to reach reproductive health clinics for young people regardless of their marital status.

- Collaboration between the government institutions and NGOs in developing ARH education and services program should be enhanced.

APPENDIX

Table 1
PERCENTAGE OF RESPONDENTS AGREEING WITH PREMARITAL SEXUAL INTIMACY AMONG DATING AND ENGAGED COUPLES AND REPORTED PREMARITAL SEXUAL BEHAVIOUR, JAKARTA, 1995[a]

Agreed Premarital Sexual Intimacy	Sexual Attitude						Reported Premarital Behavior		
	Going Steady (b) (*Pacaran*)			Engaged (c) (*Tunangan*)			Ever Experienced (d)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Young People (N=519) Aged 15-24 years									
Holding hands	93.6	94.6	94.2	97.0	96.7	96.8	83.9	80.4	81.9
Embracing	81.5	80.4	81.1	91.5	92.0	91.8	68.6	61.8	64.9
Hugging	74.1	69.9	72.0	88.0	88.0	88.1	59.7	50.7	54.7
Kissing cheek	74.5	78.2	76.6	86.0	88.2	87.3	55.9	53.6	54.5
Lips kissing	63.4	47.9	55.2	80.4	67.5	73.6	41.1	29.3	34.5
Breast fondling	41.3	23.6	31.9	60.0	42.1	50.6	33.1	21.8	26.4
Genital fondling	27.2	6.4	16.0	43.0	16.8	29.0	24.6	10.0	16.6
Intercourse	8.9	2.5	5.4	17.9	2.9	2.9	6.8	4.3	4.2
Older Respondents (N=120) Aged 25 or older									
Holding hands	82.1*	98.4	90.8	87.5**	100.0	94.1	76.8	93.7*	85.7
Embracing	60.7**	79.4	70.6*	76.8**	85.7	81.5**	62.5	74.6	68.9
Hugging	45.5**	69.8	58.5**	67.9**	79.4	73.9**	53.6	69.8**	62.2
Kissing cheek	41.8**	61.9*	52.5**	55.4**	71.4**	63.9**	46.4	65.1	56.3
Lips kissing	27.3**	38.1	33.1**	33.9**	57.1	46.2**	37.5	47.6*	42.9
Breast fondling	12.7**	17.5	15.3**	21.4**	19.0**	20.2**	21.4	15.9	18.5
Genital fondling	36.0**	4.8	4.2**	10.7**	7.9	9.2**	10.7	6.3	8.4*
Intercourse	3.6	-	1.7	7.1*	3.2	5.0	7.3	1.6	4.2

Notes: a. Data are from the 1994/1995 Jakarta Marriage Values and Sexuality Survey. For the older respondents reported premarital behaviour was asked in relation to their experience when they were still young and not yet married. Hence during the older respondents youth, age at marriage was much lower than today. The test of significant difference between the young people and the equivalent cell for older respondents is based on Chi Square, **significant difference at less than one percent, * significant difference at less than five percent.

b. Going steady in Indonesian is *pacaran*. Before going steady, usually the middle class young people go on a date, the trends now are going to the movies, hanging around in cafes, shopping malls, eating out, or *jalan-jalan* (going out without any specific destination). The idea for the date is to be able to spend time talking to each other (HAI, 1996: 88-89).

c. Engaged (***tunangan***) in Indonesian means when a couple are formally engaged and the male's parents have proposed to the female's parents. Generally, among the middle-class the engagement is formally announced at an engagement party where the couple exchange engagement rings with each partner's name engraved inside the ring. In some cases, wedding date, wedding party, wedding expenses are also discussed when the male's parents propose to the female's parents.

d. Ever experienced premarital sexual behavior with the opposite sex.

NOTE

a. In the US, it is estimated from the mid-1990s an annual cost of $6.9 billion per year is associated with childbearing before age 18 (Maynard, 1997).
b. The following are related Laws dealing with marriage and reproductive health issues: Law No. 1/1974 on Marriage, stating legal age at marriage is 16 years for women and 19 years for men. Law No. 10/1992 on Population Development and Family Welfare, restricts family planning services for single young people. Regardless of one's marital status, men and women should have equal rights to family planning and reproductive health information and services. Shared reproductive health responsibilities should be encouraged ever since early adolescent before the entry to marital life. The latter may be institutionalized and socialized through education and media and community campaign. Law No. 23/1992 defines abortion as illegal even though it is public knowledge that abortions are widely practiced in Indonesia by both medical and non-medical personnel. Article 15 section 2 paragraph (1) stated that: "In case of emergency, and with the purpose of saving the life of a pregnant woman or her fetus, it is permissible to carry out certain medical procedures." Hence it is only if a woman's life or the teen's life is in danger then abortion can be performed. Thus it is understandable why young women who have experienced premarital pregnancy often turn to traditional healers or other unprofessional health practitioners when decided to abort their pregnancy.
c. Mepham's observation covered NGO's in Jakarta, Surabaya, Makassar, Manado, Malang, Medan, Pekanbaru, Batam, Mataram, and Maumere.
d. Directorate for Adolescent and Reproductive Right Protection – National Family Planning Coordinating Board has recently developed a Website on ARH both for young people and parents. The Website is called CERIA (http://www.bkkbn.go.id/hqweb/ceria/index.html) the Indonesian acronym for *Cerita Remaja Indonesia* (Indonesian young people's stories).
e. Clinical services are only provided by Indonesian Planned Parenthood Association (IPPA), Yayasan Pelita Ilmu, Yayasan Kusuma Buana, Kra Aids, Centra Mitra Remaja (CMR/IPPA), Yayasan Humaniora, Yayasan Mitra Kesehatan Kemanusiaan (YMKK Batam) and Tim Relawan untuk Kemanusiaan-Flores (TRUK-F).

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Prof. Dr. Terence Hull

Dr. Sonny Harry Budiutomo Harmadi

Dr. Salut Muhidin

Dr. Suahasil Nazara

Dr. Omas Bulan Rajagukguk

Dr. Iwu Dwisetyani Utomo