Adolescent reproductive health and premarital sex in Medan

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Declaration

Except where indicated, this thesis reports an original research which I carried out as a scholar in the Demography Program, Division of Demography and Sociology, Research School of Social Sciences, The Australian National University.

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For my family, Keluarga Besar H.B. Situmorang

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Abstract

Young people of today face demands, expectations, risks and temptations that are more numerous and complex than any facing youth in the previous generation. They are more mobile, more educated, reach menarche earlier and tend to marry later. These massive changes, including the explosion of information across international frontiers, have increased the exposure of young people to a variety of risks related to reproductive health such as unwanted pregnancy, abortion, and STDs including HIV. However, because of socio-cultural and political concerns, unmarried young people in many developing countries, including Indonesia, receive limited parental guidance and community, and government support.

This study concerns single young Indonesians' attitudes and behaviour regarding reproductive health and premarital sex including puberty, unwanted pregnancy, abortion and sexually transmitted diseases including HIV/AIDS. Data used in this thesis were mainly obtained from the 1997/1998 Medan Adolescent Reproductive Health Study, which I conducted over a period of seven months. The study included a survey of 875 unmarried young people aged 15-24 in the city of Medan. The respondents came from various ethnic and social groups including those in high school and university and those working and unemployed. Data obtained from the survey were analyzed through descriptive statistics, including frequency and percentage distribution, bivariate analysis including cross-tabulation and the chi-square test and logistic multivariate regression analysis.

In addition to the survey, qualitative data were collected. Methods included in qualitative approach are in-depth interviews and focus group discussions. A total of 48 in-depth interviews were conducted involving married and unmarried young people, parents, experts, NGOs representatives and policy makers. Eight focus group discussions were conducted among high school students, university students, working youth, street youth and married young people.

Young people in Medan are increasingly tolerant of premarital sex. Although for most of them a woman's virginity is a great concern, it is no longer seen as the most important factor in choosing a future spouse. The demise of parental arrangement of marriage and the growing opportunity to know the future spouse long before marriage means that the potential wife's personality is now of more significance than her virginity. Losing virginity does not necessarily mean losing respectability. Of 875 unmarried young people studied, nine per cent of women and 27 per cent of men reported having had sex; these figures doubled for those who approved of premarital sex. Men had more positive reactions to their first sexual

intercourse than women. More than half of men who reported having had sex did not feel guilty or sinful the first time they did so, compared to only 20 per cent of girls.

Religious affiliation significantly influences adolescents' attitudes for both sexes, but it was insignificant as a determinant of differences in respondents' reported sexual experiences. On the other hand age appeared to be important factors in predicting the likelihood of reporting sexual experience among male respondents, but they were not significant in predicting attitudes. Respondents' main activities, whether they are studying, working or unemployed was the most important predictor of the likelihood of approving of premarital sex as well as the likelihood of reporting experience of premarital sex. Out-of-school young people are more likely to approve of premarital sex and more likely to report having had sex.

Many young people engage in risky sexual behaviour out of ignorance. Misconceptions about the onset of puberty, human reproduction, STDs including HIV/AIDS and contraception among young people are evident. Many young people believe that a woman cannot become pregnant from a single act of sexual intercourse; therefore, to avoid causing a pregnancy, some young men prefer to have sex in a casual relationship or have sex only once in a month with the same girl. Although the majority of Medan young people have known about STDs and AIDS, misinformation still abounds. The most common errors are the belief that STDs including HIV can be avoided by maintaining physical stamina and the belief that someone who is 'clean' and comes from a better-off family cannot possibly have STDs. Misconception about the side-effects of using condoms are also found. Fears that condoms may cause 'weakness' (*lemas*) and discomfort are evident.

Young people urgently need comprehensive sex education as well as access to safe and effective reproductive health services if they are to achieve better reproductive health. Most young people in this study suggested that adolescents, regardless marital status should be given such services. For some adolescents, especially street youth, the issue is no longer on how to prevent premarital sex, but on reducing risks attached to unprotected sex.

1 Introduction

The study concerns single young Indonesians' views and experiences regarding sexual and reproductive health including puberty, premarital sex, premarital pregnancy, abortion and sexually transmitted diseases including HIV/AIDS. Given the fact that sexuality is socially constructed, a special attempt is made to explore the dynamics of these sensitive issues and to identify some of the socio-cultural and demographic factors associated with young people's views and experiences. This study focuses on the age group 15 to 24 in the city of Medan, North Sumatra. The respondents come from various ethnic and social groups including those in high school and university and those working and unemployed.

1.1 Background of the study

Adolescence is an important period in an individual's reproductive life. This is the period when boys and girls establish the foundation of their reproductive lives. Many critical and defining events of reproductive health life like puberty, first coitus, first marriage and first childbearing occur during this period. Therefore, behaviour and decisions during this time will have a crucial influence on an individual's future life, not only in reproductive health but also social and economic life (Mensch *et al.*, 1998). The importance of the young adult period in demography is noted by Rindfuss (1991). As many demographic events such as fertility, residential mobility and marriage reach their peak in this age group, Rindfuss regards this period of life as 'demographically dense' (Rindfuss, 1991:496).

Despite the importance of the adolescent period, concern about the reproductive health needs and behaviour of adolescents and young adults is relatively new in

the developing countries. Young people in the past were not expected to need reproductive health services. Unmarried young people were regarded as not sexually active. Those who married were assumed not to need pregnancy prevention, since in most societies women were expected to have children soon after marriage.

The growing awareness about young people's sexual and reproductive health is significantly related to socio-demographic changes that have most affected young people in developing countries. As Feldman and Elliott (1990:479) noted, young people of today face demands and expectations, as well as risks and temptations, that seem more numerous and more complex than any facing youth in the previous generation. Apart from the increase in the population aged 10-24, many studies indicate that today's young people are more mobile, stay longer in school, reach menarche earlier, marry later and are more likely to engage in premarital sexual activities (Hofferth, 1990; Morris, 1993; Bongaarts and Cohen, 1998; Caldwell *at al.*,1998; Singh, 1998; Zabin and Kiragu, 1998). These important changes, together with urbanization and the explosion of information across frontiers, have increased the exposure of young people to the risks related to reproductive health.

It is known that most sexually active young single people practise unprotected sexual intercourse. As a consequence many of them experience unplanned pregnancies which often lead to unsafe abortion or early marriage. Furthermore, as many of these young people, especially single men, often have sex with multiple partners including prostitutes, they are also vulnerable to the risks of sexually transmitted diseases (STDs), including HIV and AIDS infections. Data from the Population Reference Bureau in 1994 indicated that one in 20 teenagers throughout the world contracts STDs; about half of all HIV infections so far have occurred in people younger than 25; and 4.4 million adolescent women have abortions in developing countries each year (Keeting, 1995:29). Considering the

fact that abortion is legally restricted in most countries, it is likely that most of these procedures were performed illegally and under unsafe conditions.

Regardless of marital status, young women who bear children, especially those under age 16 or lacking prenatal care, or both, face serious health risks for themselves and their children (Friedman *et al.*, 1990:457; Senanayake, 1990:473; Zabin and Kiragu, 1998:211). However, in countries such as Indonesia, where premarital sexual activity is widely condemned, the risks related to reproductive health for single young people may be higher than for those who are married. Although marriage does not alleviate biological health problems for the very young women, it can provide a support system and increase access to care. Many governments in developing countries are reluctant to provide reproductive health services for single young people. Although evidence from many countries indicates the opposite, some governments still believe that providing reproductive health services to young people could encourage irresponsibility or even promiscuity (Xenos, 1990; *Population Reports*, 1995). Moreover sexually active unmarried young people face special problems and sanctions that discourage them from seeking advice and care from parents, teachers or health professionals (Friedman *et al.*, 1990:457; Koetsawang, 1990:494; Gorgen *et al.*, 1993:288; Ladjali, 1993:562; Hawkins & Meshesha, 1994:213). These have given rise to the increased risks of unsafe abortion, STDs and HIV/AIDS.

1.2 Relevance of the study

Young people aged 15-24 years constitute a large proportion of the Indonesian population. The Indonesian Population Censuses of 1980 and 1990 showed that this group made up 19 per cent of the total population of Indonesia in 1980 and increased to 20 per cent in 1990. It is projected that the number of young people in Indonesia will continue to grow until 2020 (Jones, 1998:24). Like their peers in most developing countries, Indonesian young people are also experiencing rapid social, cultural and demographic changes. As a result of the improvement in

education facilities, more Indonesian young people are attending school (Oey-Gardiner, 1997:160). Over a decade, the proportion of those who are in school increased from 19 per cent of the population aged 15-24 in 1980 to 24 per cent in 1990. In line with the education improvement, the singulate mean age at marriage of women aged 15-49 increased from 20 in 1980 to 21.9 in 1990 (BPS, 1993a: 37). As a consequence, the proportion of young single women increased from 38 per cent of women aged 15-24 in 1980 to 42 per cent in 1990. The proportion of young people in the labour force also slightly increased from 45 per cent of population aged 15-24 in 1980 to 46 per cent in 1990 (BPS, 1981, 1991).

The exposure of Indonesian urban youth global information, including modern liberal sexual norms, has to some extent lessened their belief in conservative and religious norms and values related to sexuality (Sarwono, 1981; Muninjaya, 1993; Singarimbun, 1996; Utomo, 1997:169). Chastity became less important. A study among unmarried youth aged 15-24 in Medan revealed that only 18 per cent of 301 respondents agreed that virginity was an indicator of being a respectable woman (YKB, 1993). Another study among medical students in one private university in Jakarta reported that 35 per cent of respondents agreed with premarital sex (*Republika Online*, 12 April 1999). Although there are no national data on the sexual life of young unmarried people in Indonesia, many micro-studies suggest that the number of young people engaged in premarital sex has increased (Sarwono, 1981; Sudana *et al.*, 1991; Muninjaya, 1993; YKB, 1993; Singarimbun, 1996). Studies in 12 big cities in Indonesia indicated that between five and 30 per cent out of 300 unmarried young people aged 15-24 in each city reported having had sexual intercourse (YKB, 1993). The Indonesian Planned Parenthood Association (PKBI)'s study in 1997 found that 75 of 100 unmarried adolescents in Lampung reported having had sexual intercourse (*Republika Online*, 25 April 1999). Analysis from the 1991 Indonesian Demographic and Health Survey among married women aged 15-49 indicated that for one in five women aged 20-24 years at the time of the survey, the first child was conceived out of wedlock (Ono-Osaki, 1992 cited in United Nations, 1993:150).

Despite the growing awareness of the importance of young people's reproductive health in Indonesia, there is no clear policy. The suggestion to give reproductive health information and services to single people in Indonesia is still controversial; the government is trying to reach consensus in this highly contentious area. Programs and studies related to unmarried young people's reproductive health in Indonesia are relatively few. In addition to the sensitivity of the issues, the availability of data that can be used to design efficient and effective programs for unmarried youth is not sufficient. Most studies and programs related to unmarried youth focused only on students; the needs and views of those not in school are still relatively unknown. Because young people are a heterogeneous group, their needs, attitudes and behaviour related to reproductive health are likely to vary. Therefore there is a great need to study issues related to single young people's sexual and reproductive health with due regard to the various socio-cultural and economic backgrounds that influence adolescents' lives.

1.3 Objectives of the study

This study aims to generate a broader understanding of the needs for sexual and reproductive health information and services by unmarried young people in Indonesia through a case study taking a socio-cultural perspective in the city of Medan, North Sumatra.

Specifically, the objectives of this study are:

1. To explore young people's knowledge, attitudes value and behaviour regarding sexual and reproductive health including puberty, premarital sex, premarital pregnancy, abortion and sexually transmitted diseases including HIV/AIDS.
2. To examine some socio-cultural and demographic aspects of single young people's sexual and reproductive health attitudes and behaviour. These

aspects include age, sex, activity, religion ethnicity, living arrangement and parental backgrounds

3. To explain why the needs of young women and men are different or complementary.

1.4 Defining adolescents

Adolescence is variously defined as a period of transition from childhood to adulthood, suggesting that the period itself is a single (although potentially long) transition period. It involves a rapid change in many aspects including the biological, psychological and social-cultural. Therefore not surprisingly both biological and social factors help to define adolescence. Biologically, an individual's entry into puberty is the most widely accepted indicator of beginning adolescence. Since there is no meaningful biological marker to denote the end of adolescence, social factors are usually used to define entry into adulthood. These include marriage, entry into the labour force or financial independence.

The World Health Organization (WHO) has defined adolescence as progression from the onset of secondary sex characteristics to sexual and reproductive maturity; development of adult mental processes and adult identity and transition from total socio-economic dependence to relative independence (WHO, 1975 cited in *Population Reports*, 1995:3). Adolescents can be defined as a group of people who are not fully members of the adult world but at the same time are more competent and independent than children. Graber *et al.* (1998) used the phrase 'betwixt and between' to indicate this ambiguous status. They argued that adolescents' experiences, as they develop a sexual identity or a sense of self as a sexual being clearly fit the notion 'betwixt and between', as adolescents' behaviour frequently does not match the expectations expressed by parents and other adults (Graber *et al.*, 1998:271).

In line with the definition of puberty, the period of adolescence varies, depending on the culture. In some traditional societies, it is very short or even does not exist. Children are regarded as adults after they have gone through a social rite of passage or reach biological maturity and enter the social institution and sexual activity of marriage. Once individuals are married they are generally regarded as adults regardless of their age. For the unmarried the acknowledgement of adulthood may be defined by occupation or social ceremony.

In modern societies the period of adolescence may be even longer. Elliott and Feldman (1990:2) divided adolescence into three periods: early (ages 10-14), middle (ages 15-17) and late adolescence (ages 18 to the mid-20s). Early adolescence is marked by the profound physical and social changes that occur with puberty as maturation begins. During this period social interactions become increasingly centred on members of the opposite sex. Middle adolescence is a period of increasing independence. Late adolescence occurs for those individuals who, because of educational goals or other social factors, delay their entry into the adult role. In many countries these subdivisions have been incorporated into the educational structure: junior high or secondary school, senior high school, and college. Young people in this study are defined as single people aged 15-24 years, or those in middle and late adolescence, as most Indonesian adolescents are likely to make the transition from virgin to non virgin during these years.

1.4.1 Biological aspects of puberty

The major defining biological aspect of adolescence is the process of attaining sexual and reproductive maturity. It is marked by the dramatic increase in overall growth, the appearance of secondary sex characteristics and the development of reproductive potential (see Chapter 4). Physical developments during puberty were reviewed in detail by Tanner (1990). Adolescents' physical development is associated with a complex biological process which begins when

the hypothalamus stimulates the pituitary gland to secrete gonadotrophins into the bloodstream. Then gonadotrophins stimulate increased production of sex hormones by either the testes in boys or ovaries in girls (Moore and Rosenthal, 1993:46). These 'raging hormones' are often considered as a cause of the increased sexual arousal and upsetting behaviour among adolescents.

As a group, girls mature sooner than boys (Tanner, 1990:64). Still within both groups some individuals mature much earlier and others much later than average. As a result, for the group, some individuals may have experienced puberty while others have not. In many societies including the United States and several European countries, the mean age at menarche has declined by two to four months each decade since the nineteenth century (Eveleth, 1986 cited in Voydanoff and Donnelly, 1990:38; Wysack and Frisk, 1982 cited in Bongaarts and Cohen, 1998:99). Recent data indicate that the mean age at menarche in the United States and British population is around 12.5 years. The decline in the mean age at menarche is associated with improvements in quality and quantity of diet and in nutritional status. Therefore it is assumed that the age of menarche is also declining in developing countries along with the improvement in socio-economic status of the societies (Bongaarts and Cohen, 1998:99).

The age of biological maturity for males is difficult to establish and there are no historical data; however, it is estimated that in recent years American males reach biological maturity at around 13 years of age (Voydanoff and Donnelly, 1990:38; Faust 1977 cited in Moore and Rosenthal, 1993:48).

1.4.2 Socio-cultural aspects of puberty

In most cultures, adolescence is a very important period. This is the time in which a sense of responsibility, along with the goals of the society is inculcated in the growing child (Cohen, 1964:11). Though culturally adolescence is associated with biological maturity, it is also culturally defined as indication of

individuals' maturity and readiness for marriage and sexual activity. Thus the societies' reactions to these developments varies. To mark these important developments, many traditional societies celebrate them by a special ritual, commonly called initiation rites.

According to Gennep initiation is ritual separation from 'the asexual world which is then followed by rites of incorporation into the world of sexuality in all societies and all social groups into a group confined to persons of one sex or the other' (van Gennep, 1960: 69). This may be the reason why in many societies initiation rites involve an individual's reproductive organ, as in circumcision. These rites are also designed to train young people for adult roles and to remind them of membership in and loyalty to their culture (Hotvedt, 1990:164).

Societal reactions on development during adolescence may influence the sexual activities of young people. It is argued that compared to biological factors, social and cultural aspects have more influence in determining adolescent sexual activity. Serbin and Sprafkin (1987) stated that since erotic pleasure may be experienced during childhood, and since there are significant differences in adolescents' sexual behaviour among different societies, the increased sexual drive during adolescence may be more due to the effect of social factors. Furthermore, they argued that the awareness of girls or boys about their new roles as sexual beings then leads them to engage more in sexual activities because of the societal 'pull' in which things of a sexual nature begin to take on a social meaning, rather than the biological 'push' (Serbin and Sprafkin, 1987:184).

As puberty is a biological development that may be viewed as a cultural event (Cohen, 1964:11; van Gennep, 1960; Brooks-Gunn and Reiter, 1990:35), every society may interpret these changes differently. As a consequence, although biological developments during puberty are universal, the effects of these changes on young people's lives vary between cultures, subcultures and social groups.

1.5 Defining reproductive health

The concept of reproductive health has emerged in the light of socio-demographic changes that have taken place in the developing countries in the last two decades. The comprehensive health definition of the WHO convey a broad area of thought for establishing the concept of reproductive health (Ford, 1998:14). The 1994 International Conference for Population and Development Programme of Action (ICPD-POA) in Cairo defined reproductive health as:

> a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes (paragraph 7.2).

Reproductive health therefore implies that:

> People are able to have a satisfying and safe sexual life and they have the capability to reproduce and the freedom to decide if, when and how often to do so (paragraph 7.2).

ICPD-POA affirmed the rights of men and women as couples and individuals, to have free and responsible control over their fertility and to attain the highest standard of sexual and reproductive health (paragraph 7.2 and 7.3).

The 1994 ICPD also recognize reproductive rights of people of all ages. The ICPD-POA stresses the importance for developing innovative programmes in order to make information, counselling and services for reproductive health accessible for both women and men including adolescents. Furthermore, the text also stresses 'that countries must ensure that programmes and attitudes of health-care providers do not restrict adolescents' access to the services and information they need' (paragraph 7.5).

1.6 Socio-cultural factors associated with adolescent sexual and reproductive health issues: previous studies

Previous studies have identified numerous socio-cultural factors associated with aspects of the sexual and reproductive health of unmarried young people.

Among those are family environments including parental backgrounds, parents' and children's relationship and living arrangements (Schofield, 1969; Thornton and Camburn, 1987; Casper, 1990; Haurin and Mott, 1990; Pick de Weiss *et al.*, 1991; Jaccard *et al.*, 1996), societal environments including culture and peer group (Gagnon and Simon, 1973; Furstenberg *et al.*, 1987; Steinberg, 1990; Trost, 1990; Baker and Rich, 1992; Day, 1992; Kiragu and Zabin, 1993; Hill and Lynch, 1998); and social institutions including school, religion, government and mass media (Moore and Caldwell, 1981; Collins and Robinson, 1986; Howard and McCabe, 1990; Lacson *et al.*, 1997). Family is regarded as a central foundation in which young people establish their attitudes and behaviour. Parents are expected to provide norms and values in the family and to teach young people about sexual and moral values based on societal norms, whereas the social environment and social institutions are also crucial in affecting young people's sexual attitudes and behaviour through establishing norms, values, and policies. In most cases some of these factors work simultaneously. The review of literature in this study is grouped into three parts: family environments, society environments and social institutions.

1.6.1 Family environments

Parents are regarded as the primary socialisers of their children. The attitudes and values transmitted by parents directly influence decisions along the life course. Thornton and Camburn (1987) noted four different paths through which the parental family might influence the sexual attitude and behaviour of their children: parental attitudes and values regarding premarital sex; marital and childbearing behaviour of parents; parental religious affiliation and commitment; and parental educational and work patterns.

Other studies (Newcomer and Udry, 1985; Noller and Callan, 1991:43; Moore and Rosenthal, 1991; Rind, 1991; Billy *et al.*, 1994; Jaccard *et al.*, 1996; Mott *et al.*, 1996) suggested that parent-child communication and relationships are very

important in determining young people's reproductive behaviour. Young people whose parents held conservative attitudes to sex and communicated these to their children were less likely to have had intercourse. Jaccard *et al.* (1996) found that young people's relationship with their mothers is significantly related with their sexual experience and contraceptive use. Nevertheless most parents, especially fathers, find talking about sex with their teenage children extremely difficult. Many studies have suggested that compared to fathers' influence on their children, mothers' influence is stronger (Noller and Callan, 1991; Rind, 1991; Billy *et al.*, 1994; Mott *et al.*, 1996; Jaccard, 1996). This is because children, regardless of their sex, are closer to their mothers than to their fathers. Noller and Callan, (1991) examined parents' and children's communication on 14 topics including sexuality: they found that adolescents talked more to mothers than fathers about nine of the 14 topics including sexual attitudes, problems and information.

Parental education and labour force participation were also noted by previous studies (Rind, 1991; Billy *et al.*, 1994; Mott *et al.*, 1996:13-18) as factors associated with adolescents' sexual behaviour. Mott *et al.* (1996:13-18) indicated that mothers' sexual experience and work patterns influenced their children's sexual behaviour. They found that children are more likely to become sexually active before age 14 if their mother had sex at an early age and if she has worked extensively. However, Billy *et al.* (1994) suggested that on the one hand mothers' labour force participation may decrease parental supervision, but on the other hand it also provides young people with information about the advantages of achieving specific occupational objectives and the disadvantages associated with early motherhood. This view is supported by Rind (1991). Examining the relationship between first intercourse and first contraceptive use among teenagers, Rind (1991) found that the daughters of well-educated women were more likely than those of less-educated women to have used condoms at first intercourse, regardless of race.

Living arrangements of young people, whether they stay with both parents or not, may also be a factor influencing young people's premarital sexual behaviour (Kiragu and Zabin, 1993; Billy *et al.*, 1994; Mensch *et al.*, 1998). Kiragu and Zabin (1993) found that boarding-school males were more likely than those who lived with parents to be sexually active. Hetherington (1972) found that girls whose father was absent from the home were more likely to seek physical proximity to men through behaviour seeking attention and physical contact.

1.6.2 Social environments

It has been argued that the family's relationships and communications are very important to the reproductive health behaviour of young people; nevertheless because of cultural norms both parents and children often find it very difficult to initiate open discussions about sexual matters (Forrest, 1990; Barker and Rich, 1992: 199-210). So it is not surprising to find that young people are very much influenced by people outside the family, especially their peers on issues related to sex. In addition, as noted by Ausubel *et al.* (1977), as the child develops into adolescence, the locus of expectation shifts from the parents to the worlds that the adolescent begins to choose. Teenagers begin to examine, evaluate and possibly adopt values that may be different from those of their parents.

The society's influence -through setting norms and values for its members- on adolescents' reproductive behaviour may be both positive and negative. On the one hand societal norms and values on sexuality together with social sanctions may restrict premarital activities. Pick de Weiss et al. (1991:74-82) suggested that adolescents' acceptance of traditional family and societal norms, together with open communication with parents and peers about sex, were factors that significantly influenced the likelihood of adolescent girls' sexual activity, use of contraception and premarital pregnancy. On the other hand social norms may restrict communication related to sexuality, especially by the unmarried (Barker

and Rich, 1992). Parents who have conservative attitudes about sex are less likely to communicate to their children about it.

Billy *et al.* (1994) explored the effect of a wide range of community characteristics on aspects of girls' sexual behaviour such as the likelihood of experiencing premarital sex, frequency of sexual intercourse and the consistency of girls' exposure to intercourse. They found that a number of societal characteristics including social disorganisation, socio-economic status, religiosity, female labour force participation, population composition and the availability of family planning services affected the likelihood of first intercourse and subsequent sexual behaviour of teenage girls.

Previous studies also found that adolescents' reproductive health behaviour, including premarital sex, pregnancy and contraceptive use, is significantly influenced by ethnicity and race (Zelnik *et al.*, 1981; Furstenberg *et al.*, 1987; Day, 1992). Furstenberg *et al.*'s (1987) study among unmarried young people in United State indicated that blacks are about four times more likely than whites to report ever having sex. Day's study (1992:760) among racially and culturally diverse youth suggested that each gender and culture examined had a different 'profile' of variables that significantly related to the likelihood of young people engaging in premarital sex.

1.6.2.1 Gender

It is suggested that gender role differentiation intensifies during adolescence, especially in relation to reproductive health behaviour (Gagnon and Simon, 1973:54; Hill and Lynch, 1983:203). Gender perspective is associated with the different roles of men and women as determined by the society. It is very important in determining young people's reproductive health status and needs. Soon after boys and girls achieve reproductive maturity they are taught differently. Girls' activities often will be restricted and on the contrary, boys will

have more freedom and autonomy from their parents and society (Martin, 1996:6; Mensch *et al.*, 1998: 44).

Most societies also have different sexual scripts for girls and boys. A girl is expected to be passive, waiting until the right person comes along, and not to express her sexuality, while a boy is expected to be active and expressive, and to take control of sexual relationships (Gagnon and Simon, 1973; Zellman and Goodchild, 1983; Moore and Rosenthal, 1993:83; Kiem, 1993:149-150). Because of the differences in sexual script, most societies are more permissive to men than women regarding premarital sex activities. As a consequence, boys are more likely to engage in premarital sex and have more sexual partners than girls do (Singh *et al.*, 2000:23). Furthermore, compared to men, the quality of the intimate relationship is more important to women. Many studies suggest girls are more likely to want a steady sexual relationship and have more emotional attachment than do boys (Zabin *et al.*, 1984: 181-185; Dusek, 1991 cited in Moore and Rosenthal, 1993:93; Dixon-Mueller, 1993:272). Boys are less likely to report that their first partner was someone special such as a steady girlfriend; in some countries boys are likely to have their first sexual experience with a prostitute (Dixon-Mueller, 1993:271; Lee, 1995).

1.6.2.2 Peers

Previous research suggested that adolescents develop stronger ties with the society, especially with peers, at the same time as they develop increasing autonomy with respect to relationships with their parents and family (Nollar and Callan, 1991: 51; Steinberg, 1990). The influence of the peer culture on adolescents to some extent complements the influence of family. Nevertheless these may also conflict (Vanlandingham *et al.*, 1995). Trost (1990:174) suggested that in the situation where peers' norms and values are in conflict with those of their parents, young people are more likely to choose their peers' norms. Social

pressure from peers may be viewed as more significant to most young people than pressure from family.

Moore and Rosenthal (1993:66) suggested two ways in which peer groups could influence young people: first as a source of information regarding sex, which may be used to guide young people in decision-making about sex; second, young people may accept peer attitudes about sexual behaviour. In a society where parent-child communication is rare and social institutions do not provide the information, peers and mass media including pornography become the main sources of information concerning sex and reproductive health.

Many studies reported a strong positive relationship between adolescent reporting of sexual intercourse experience and their friends' sexual behaviour (Smith *et al.*, 1985; Kiragu and Zabin, 1993; Furstenberg *et al.*, 1987; Trost, 1990:173-180). Adolescents who associate with sexually experienced colleagues are much more likely to be sexually experienced (Smith *et al.*, 1985; Furstenberg et al., 1987; Nollar and Callan, 1991: 515; Kiragu and Zabin, 1993). Trost's (1990:173-180) study indicated the strong influence of peer groups in adolescents' attitudes and behaviour related to sexual activity, abortion and contraception.

1.6.3 Social institutions

The main roles of social institutions such as government, schools, religion and mass media on adolescents' reproductive behaviour are in providing a set of policies or laws, norms and values, as well as information and services related to reproductive health care.

1.6.3.1 Government

Despite the growing awareness of the importance of providing sexual and reproductive information and services for young single people, heated debates

still continue about when, how much and what kind of information and services young single people should receive. In most Western countries, the governments indicate positive attitudes toward young people's reproductive health needs by providing them with information and services regardless of marital status (Moore and Caldwell, 1981; Howard and McCabe, 1990). In contrast governments in most developing countries especially in the Asia-Pacific region, oppose those ideas (Xenos, 1990; Cruz and Berja, 1999; Jones, 2000).

The main role of government in young people's sexual and reproductive health is setting the laws regarding issues such as marriage or legal age to engage in sexual intercourse and an individual's right to be treated as medically adult, including the right to give consent to medical or surgical treatment such as prescribing contraception or termination of pregnancy without the consent of parents (Moore and Rosenthal, 1993:76). These laws may be a social expression of the society's beliefs that young people need to be protected from the damage caused by too early sexual involvement: they reflect the overt, but not necessary the implicit sexual values of a society (Moore and Rosenthal, 1993:78).

The attitude of governments to the sexual and reproductive health needs of young single people significantly affects their knowledge, attitude and behaviour on related matters (Moore and Caldwell, 1981; Howard and McCabe, 1990; Grunseit *et al.*, 1997). Moore and Caldwell (1981:130) found that the availability of subsidized family planning services was negatively related to the occurrence of premarital pregnancy among older black adolescents. Furthermore they argued that there was no relationship between access to family planning service and the probability of continuing a premarital pregnancy to an out-of-wedlock birth. Reviewing 52 reports on young people's sexual behaviour, Grunseit *et al.*, (1997:439) found that in countries where there were open and liberal policies as well as the provision of sex education and related services, there were lower pregnancy, birth, abortion and STD rates.

1.6.3.2 School

Formal sex education programs through schools are regarded as an appropriate and important way of providing sexual and reproductive information for single young people (Dawson, 1986; Gorgen *et al.*, 1993; Amazio *et al.*, 1997; Grunseit *et al.*, 1997). Given the cultural obstacles to parents' and children's communication regarding sex and the misleading information from peers, school is expected to provide the right information for young people. Yet this issue is still controversial in many countries. Arguments have raged over how explicit sex education material should be, how much of it there should be, how often it should be given and at what age or level to initiate instruction (Grunseit *et al.*, 1997:422).

In many developing countries, because of fears that providing sex education will arouse young people's curiosity and encourage them to engage in sexual activity, sex education is not included in the school curricula (Xenos, 1990; Jones, 2000). Nevertheless, many studies in developed countries have demonstrated that exposure to formal sex education is not significant to the probability of adolescents' sexual debut, but it influences the sexually active young people to practise safe sex (Moore and Caldwell, 1981; Dawson, 1986, *Population Reports*, 1995; Grunseit *et al.*, 1997).

1.6.3.3 Religion/religiosity

Historically, religious institutions have taken a prominent role in prescribing standards of appropriate sexual conduct and instituting a system of sanctions to enforce their religious doctrine. Thus, as most religions promulgate conservative sexual values, it is not surprising to find out that religion and religiosity have a negative relation to premarital sex, abortion and contraceptive use (Collins and Robinson, 1986; Studer and Thornton, 1987; Lacson *et al.*, 1997). A religious person is less likely to have premarital sex and abortion, but he or she is also

more likely not to use contraceptives when having a premarital sex relationship, because such use requires a degree of premeditation that is less likely among more religious persons.

Religiosity indicators are mostly measured by religious activities attendance, such as church attendance, frequency of daily praying and listening to religious teaching (Lee, 1995). Lacson *et al.*'s (1997) study among urban university students in the Philippines found that students who attended church regularly were more likely to be sexually abstinent than those who did not.

Nevertheless sexual conservatism among religious young people may not be solely the result of religious values *per se* (Thornton and Camburn, 1987; Remez, 1990). Religious young people are likely to associate with other religious youth; thus the norms of the salient peer group may enforce the values of religion. As Thornton and Camburn (1987) pointed out, not only does religious participation reduce the likelihood of premarital sexual experience, but the effect works in the other direction as well. Young people's sexuality significantly influences religious involvement.

1.6.3.4 Mass media

In countries where communication in the family is limited and sex education is not available, the influence of mass media on young people's sexual behaviour becomes very significant. Many studies have indicated that most young people obtained information regarding sexual matters from mass media, including pornographic materials (Szirom, 1988:86; Barker *et al.*, 1992; Makinwa-Adebusoye, 1992; *Population Reports*, 1995:24). Fine *et al.* (1990:248) suggested that, since adolescents commonly rent and watch videos in groups, it is possible that the combination of pressure and bravado inherent in the adolescent peer-group context helps to explain why much adolescent video viewing involves pornographic films.

The influence of media in the sexual socialization of adolescents is very important (Katchadourian, 1990:333). As pointed out by Sachs *et al.*, (1991cited in Moore and Rosenthal, 1993:72), young people are socialized into a world characterized by a vast array of media forms. Relationships between the sexes, ideas of attractiveness, and models of sexual expression are presented to adults and adolescents alike through the various media sources. The messages contained in these media representations of life are both direct and subtle. The shallow romance of soap operas on television and in movies, the nudity of soft-core pornographic magazines, the suggestive and explicit lyrics of rock music and the vulgarity of hard-core pornographic magazines and movies are often the raw materials from which adolescents' erotic fantasies are fashioned (Katchadourian, 1990:333. These media messages may be especially potent influences on young people's sexual behaviour.

1.7 Organisation of the thesis

This thesis consists of eight chapters. Following this introductory chapter, Chapter 2 provides the social and cultural context of single young people in Medan. The socio-demographic changes and historical background of the people of Medan are explored in this chapter. Chapter 3 discusses the strategy in collecting and analyzing the information used in this study. It includes the data sources, research setting, obtaining of research permission and the methodological approach for data collection employed in my study as well as the characteristics of the young people being studied.

The findings of this study are presented from Chapter 4 to Chapter 7. Chapter 4 explores the knowledge, attitudes and experiences of Medan's young people at puberty, especially in relation to the onset of reproductive maturity. These include young people's knowledge about human reproduction and ovulation. The discussions about young people's attitudes and experiences related to virginity and premarital sex are presented in Chapter 5. Through both bivariate

and logistic multivariate regression, some socio-demographic factors affecting young people's attitudes and experience of premarital sex are analyzed in this chapter. Then in Chapter 6 the health problems resulting from risky sexual behaviour in young people are discussed. This chapter also explores factors influencing young people's knowledge and attitudes towards issues such as premarital pregnancy, abortion including sexually transmitted diseases (STD) including HIV/AIDS.

Chapter 7 examines the programs and policies related to sexual and reproductive health for young single people. Young single people's knowledge, attitudes and behaviour regarding contraception are also presented in this chapter. The summary and the significance of this study's findings and its recommendations for policy implication are provided in Chapter 8.

2 Young and single in Medan: social and cultural context

2.1 Introduction

It has been argued that young people's sexual and reproductive health values, attitudes and behaviour are shaped by the particular context in which they live. Where, when, with whom and how young people spend their time and invest their energies affect who they are and what they will become. Thus young people's sexual and reproductive behaviour cannot be explained completely without explaining their social setting.

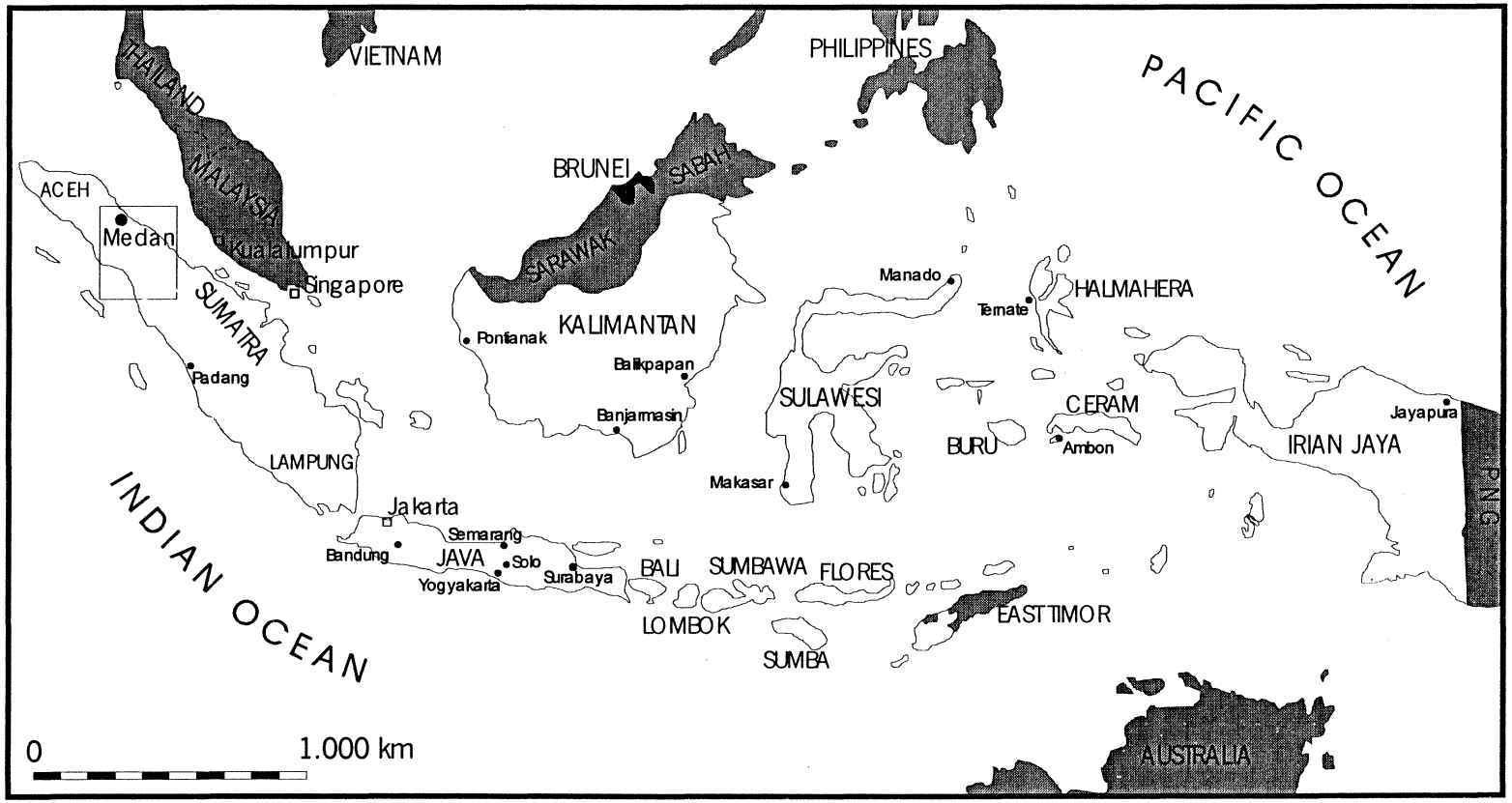
To gain a foundation for understanding Medan's single young people, this chapter provides the socio-cultural and historical backgrounds of Medan's population. It first describes the of historical development of Medan and the traditional views of Medan people regarding puberty and sexuality. Then using the 1980 and 1990 Indonesian population census data, this chapter explores the socio-demographic characteristics of Medan single young people and the changes they are experiencing.

2.2 The people of Medan: historical development and culture

Ini Medan Bung! (this is Medan, man!). This slogan is typical of Medan. It is commonly used by Medan people in dealing with newcomers or people from other cities, especially those from Java[1]. The connotation of this slogan can be either positive or negative. It may be used to describe Medan people's pride in their city. However, it also may be used to justify 'local rules' that may be different from regulations found in other regions. Medan has become a major destination for migrants from around the region since the Dutch colonial government introduced various plantations to the area in the nineteenth century. Currently, with the population of 1.9 million in 1995, Medan is the largest city outside Java, or the third largest city in Indonesia after Jakarta and Surabaya (see Figure 2.1).

[1] Java is known as the most populous and developed region in Indonesia.

Figure 2.1 Map of Indonesia



(Source : Sears, 1996: 2)

2.2.1 Historical development and population growth

In the Malay language, Medan means *tempat berkumpul* (a meeting place)[2] (Sinar, 1991:53). This is because in the past, Medan became a meeting place of Malay people from surrounding places such as Hamparan Perak, Sukapiring and Labuhan for trading, betting and other activities. Medan became an urban area in 1886 when the Dutch colonial government officially gave the status of town (*negarijraad*) to the area (Pelly, 1983:96). This city is located on the east coast of North Sumatra (see Figure 2.2). From the mixture of homelands where the city is located, the indigenous peoples of Medan were the Malay, the Karo Batak and the Simalungun Batak (Bruner, 1974:259).

The city of Medan grew rapidly after the Dutch introduced tobacco, palm oil, rubber, coffee, sisal, tea and cocoa plantations in the east coast of North Sumatra during the nineteenth and the early twentieth centuries. Various plantation companies established offices and other businesses, such as trade and transport, in the town. At the end of the nineteenth century, the east coast of North Sumatra was known as a producer of a very high quality of tobacco. Tobacco cultivation reached its peak in 1890 with a total of 170 plantations; to fulfil the demand for labour in the plantations a large number of Chinese were brought from Singapore and Malay. Then in the 1890s, because of the recession in the international tobacco market, a gradual diversification of crops began to be introduced to the area (Seifert, 1987:469-470). In the late nineteenth century, the cultivation of coffee, tea and cacao began there, followed by rubber and palm oil plantations in the early twentieth century. These resulted in a tremendous demand for labour and thousands of workers were brought from Java (Reid, 1979:40).

In line with the rapid growth of the city, many people from around the area such as the Mandailing Batak who live in South Tapanuli the Minangkabau from West Sumatra and the Toba Batak from North Tapanuli migrated to Medan. The Mandailing and Minangkabau migrated to Medan in early twentieth century, soon

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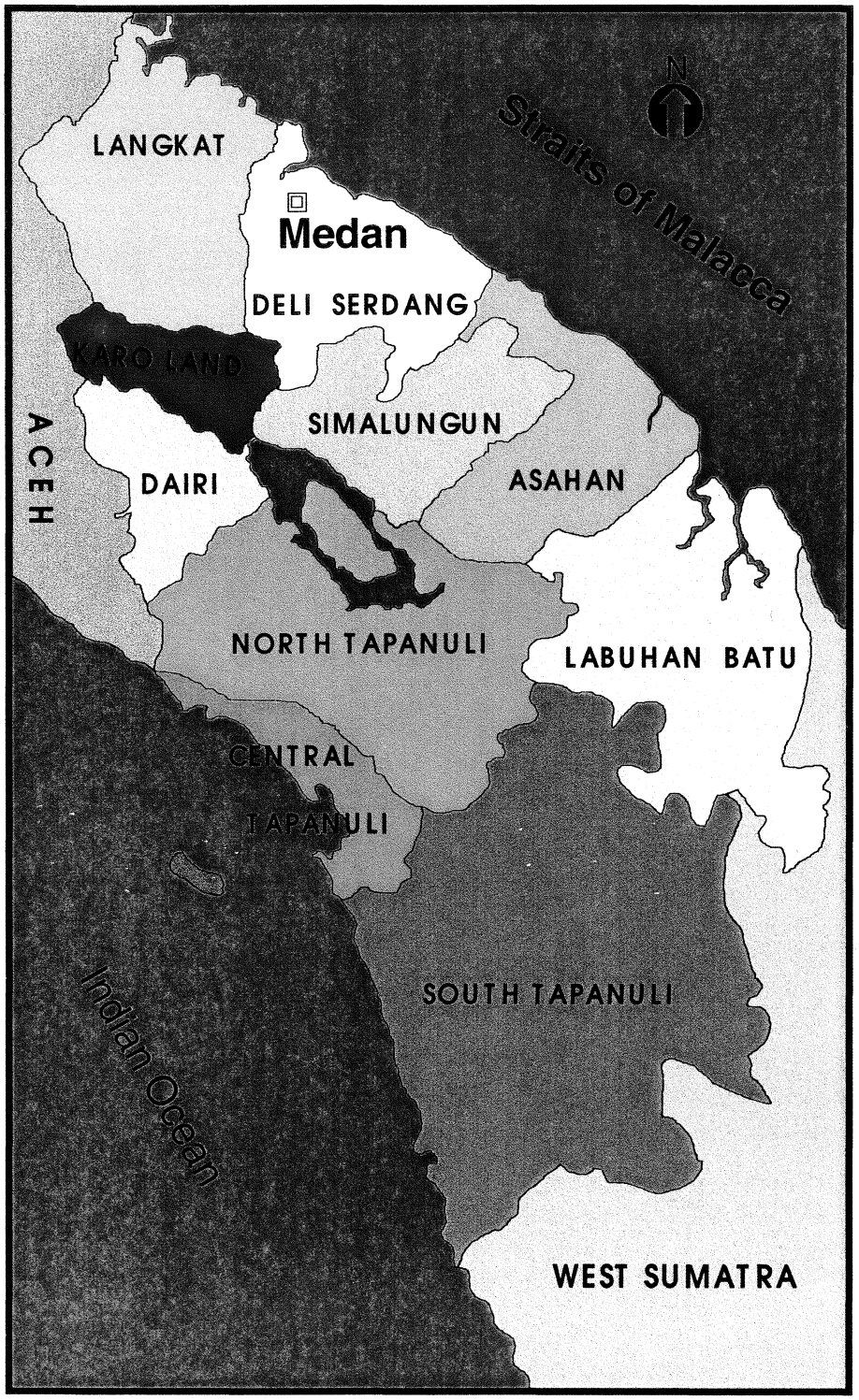
[2] Like the similarly named Canberra (meeting place in local Aboriginal dialects) the word Medan no longer carries the original meaning in the daily conversation of the citizenry. Instead it has stereotypical connotation related to the nature of its inhabitants and their activities in the nation state.

Figure 2.2 Map of North Sumatra



Source: BPS, 1990: x

after the introduction of plantations. The Toba Batak started intensively migrating to Medan in the 1950s after independence[3].

In the earliest available official census of the area, in 1930, the population of Medan was 76, 586 consisting of 54 per cent indigenous Indonesian, 36 per cent Chinese, six per cent European and five per cent 'other foreign Asiatic' (Bovill, 1986:85). As shown in Table 2.1, among the native Indonesians, in 1930, the Javanese was the most numerous ethnic group, comprising a quarter of all Medan's population, while the Minangkabau, the Malays and the Mandailing Batak shared 20 per cent of the whole population. Unfortunately, since then there have been no available official data on ethnic composition in the area; because of political considerations, the Indonesian government decided not to include ethnic affiliation in the census after that time[4]. However, in 1981, Pelly, by contacting each of the 11 districts of Medan individually, was able to gain access to the 'family card' (*kartu keluarga*) which is filled in by the head of each household in the district every year, and which does list the ethnic affiliation of all household members (Pelly, 1983:100).

Table 2.1 Ethnic composition of Medan in 1930 and 1981(percentages)

Ethnicity	1930 N=76,584	1981 N=1,249,132
Javanese	25	29
Toba Batak	1	14
Chinese	35	13
Mandailing Batak	6	12
Minangkabau	7	11
Malay	7	9
Karo Batak	0	4
Acehnese	0	2
Sundanese	2	2
Simalungun Batak	0	1
Dairi Batak	2	0
Other[a]	15	3
Total	100	100

Source: Adapted from Pelly, 1983:103

Note: [a] In the 1930 census, this included Europeans six per cent and 'Foreign Asiatics' five per cent.

[3] During the Dutch colonial rule, the Toba Batak, who are mostly Christian, were not accepted in Medan. The Malay Sultans, who were given authority by the Dutch government, opposed any large-scale influx of the Christian Toba Batak into their kingdoms (Cunningham, 1958, Pelzer, 1977, Langeberg, 1977 cited in Pelly, 1983:130). But after independence, when the authority of the Malay Sultans was lessened by the Indonesian government, many Toba Batak migrated to Medan and bought land from the Javanese and Malays.

[4] The Indonesian government recently changed this policy. Ethnic affiliation is included in the Population Census for 2000, however these data were not available at the time of writing.

As Pelly used different methods and definitions (the national census was conducted by door-to-door enumeration), there is a slight discrepancy between Pelly's figure and the 1980 national census[5]. Nevertheless, Pelly's tables are invaluable for their inclusion of the ethnic composition in Medan, down to the *kampung* (village) level.

Table 2.1 indicates that ethnic composition in Medan changed substantially over the half-century between the colonial census and Pelly's estimates. In 1981 the proportion of the Toba Batak increased dramatically from two per cent in 1930 to 14 per cent in 1981. In 1980, the Javanese were a higher proportion of the total than in 1930, but the Chinese were only a third their proportion in 1930. Nevertheless, in both years, the Javanese were the most numerous ethnic group in Medan.

As the most developed regional centre, Medan remains a major destination for migrants, especially young people from surrounding areas for study or work. Over a five years, the population of Medan increased from 1.7 million in 1990 to 1.9 million in 1995.

2.2.2 Cultural and traditional views regarding puberty and sexuality

The people of Medan are known as competitive and straightforward. It is apparent from the ethnic composition of Medan that this city is a heterogeneous society, with no ethnic group in a majority position. Bruner (1974:255) noted that Medan is a city of minorities with no dominant culture. Nowadays, it is believed that the daily life of Medan is influenced by a mixed culture of at least four influential ethnic groups; the Malays, the Batak, the Javanese and the Chinese. Thus, to understand the cultural backgrounds of Medan's young people and their parents it is necessary to discuss these four groups, especially on issues related to cultural views regarding puberty and sexuality.

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[5] According to the 1980 Indonesian census of North Sumatra, the population of Medan was 1,373,747, while based on Pelly's calculation it was 1,294,132.

2.2.2.1 Malays

Nagata (1974:335) defined the Malays as a group of people who united themselves through intra-ethnic marriage and who, in daily life, practise tradition (*adat*) and speak the Malay language. It means that the Malays are not necessarily based on genealogical relationship, but are more a melting pot of people from various ethnic groups who adopt Malay culture. In the past, as long as they were Moslem, people from a variety of geographic and genealogical sources were considered to be Malays (Husny, 1986:53). Many Malays can trace their lineage to Karo Batak, Acehnese, Toba Batak, Mandailing Batak or Minangkabau (Pelly, 1983:76), but they nonetheless consider themselves distinct from these origins.

The Malays consider their culture a 'Moslem culture'. Nevertheless, given the fact that Hinduism influenced the Malays before the coming of Islam to the area, most elements of Malay ceremonies and rituals are of Hindu origin. Among today's Malays, *adat* is only practised for the major life-cycle ceremonies such as birth, circumcision, engagement, marriage and death.

Traditionally, the Malays regard puberty as the sign of maturity. A girl is considered mature after she reaches menarche, while for a boy maturity is indicated by the change of voice (*gahong*) (Husny, 1977:2-3). Circumcision is considered an obligation for boys and girls. Traditionally, *adat* restricted a young girl from meeting or talking with a young man without other people present (Husny, 1986:83). To avoid adverse consequences, once a girl or a boy is considered mature, she or he is expected to get married; so in the past teenage marriage was common. Information regarding sexual matters is usually given by the mother to her daughter when the girl reaches menarche, but after that there is no discussion in the family regarding sex. For boys, knowledge about sex is mostly gained from informal sources such as peers, pornography and the press (Hassan, 1980:57). Another source of such knowledge for adolescents is religious teachers (see Chapter 4). There is almost no communication between father and son or mother and son on these matters.

2.2.2.2 Batak

The Batak are a group of people who speak similar languages and share a general concept of *adat*. The Batak consist of six groups (and numerous clans - *marga*) - Toba, Mandailing, Karo, Angkola-Sipirok, Dairi-Pakpak and Simalungun - inhabiting a contiguous area of North Sumatra. The Toba Batak believe that all the Batak groups are descendants of a divine ancestor namely *Si Radja Batak* (The King of Batak), who lived on the slopes of Mt. Pusuk Buhit, Samosir Island[6] (Vergouwen, 1964:21). Although the groups are related, each has its own customs and language and they consider themselves as separate units.

The Batak are known to be conservative about religion, especially the Mandailing Batak and the Toba Batak. The Mandailing are mostly Moslem while the Toba Batak are mostly Christian. Other Batak have almost equal numbers of Moslems and Christians in their groups. Islam and Christianity significantly influenced the traditions and cultures of the Batak people (Pardede, 1987:239). Nowadays, almost all Batak subgroups build their own ethnic churches in Medan, such as 'Huria Kristen Batak Protestan' (Toba Batak Protestant Church), 'Gereja Kristen Protestan Simalungun' (Simalungun Batak Protestant Church), 'Gereja Batak Karo Protestan' (Karo Batak Protestant Church), and 'Gereja Kristen Protestan Angkola' (Angkola Batak Protestant Church); these churches usually use their own language in the services. In the city, ethnic churches become a 'magnet' for migrants, a place where they speak their own languages and where one can count on finding friends and kin. For many young people, since they are expected to marry a Batak, the ethnic church is also used as a place to find future spouses.

Among Toba Batak, when they reach puberty girls are considered to be *namarbaju* (young women) and boys are considered to be *doli-doli* (young men). However, regardless of age, a never-married person remains considered as *namarbaju* or *doli-doli;* she or he has no significant role in any *adat* activities. Only those who are married are counted in *adat*.

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[6] According to Singarimbun (1975:70) the Karo Batak do not share this myth.

Discussion of sexual matters with those who are unmarried is taboo. Traditionally, among Karo Batak, it is inappropriate for a father and a son to be together at any discussion regarding sex (Singarimbun, 1975:48). The formal provision of information about sex to boys and girls, other than that on menstruation from a mother to her daughter, does not exist in the Batak family. Traditionally, social relations between a man and a woman including between siblings, a father and a daughter or a mother and a son are characterized by some restraint and avoidance (Singarimbun, 1975:53). It is considered inappropriate for a woman and a man to be alone in a room. In the past the grown-up siblings of the opposite sex would not joke and oral communication between them is limited.

2.2.2.3 Javanese

The Javanese in Medan are mostly the descendants of those who were brought by Dutch colonists as plantation workers; they were commonly labelled *Jawa kontrak* (contract Javanese) by other ethnic groups. When their contract expired, many of the workers remained to live around plantation areas as subsistence farmers or moved to nearby towns, including Medan, and became unskilled workers for the city (Pelly, 1983:128). After independence, many Javanese migrated to Medan as white-collar workers. There are significant social and economic gaps between the Javanese elite and the Javanese former plantation workers; in Medan, the latter form an ethnic organization called *Pujakesuma,* an acronym that stands for *Putra Jawa Kelahiran Sumatera* (Sumatra-born Javanese).

In their homeland, the Javanese consider that their culture does not constitute one of homogeneous unity, and they recognize a regional diversity over the central and East Java Island. Koentjaraningrat (1985:21) observed that Javanese cultural diversity roughly coincides with the areas of the Javanese dialects, and appears clearly in food, household rituals, folk art and music. The culture of Javanese in Medan is a mixture of various Javanese subcultures, because most plantation workers came from several regions in Central, East and West Java. Javanese in Medan consider themselves to be different from those who live in Java. Since most of them originally come from the lower classes (*wong cilik*) in their homeland, the Javanese in Medan are more egalitarian. Nevertheless, most Javanese, especially

the adults, speak the common Javanese language (*ngoko*) at home and practise Javanese traditions such as *slamatan* and circumcision.

Among Javanese societies, puberty is indicated by circumcision (*sunatan*) for a boy and menarche for a girl; then a boy is considered to be *perjaka* (virgin man) and a girl to be *perawan* (virgin woman). *Sunatan* usually involves a great public celebration, while menarche is received without public note or ritual (Carpenter, 1987). In Javanese culture, puberty is closely connected with the process of achieving sexual maturity; nevertheless, sex is never discussed openly in the Javanese family or seriously in Javanese society in general (Koenjaraningrat, 1985:120). Girls receive very little information about married life from their mother or married older sisters, while boys have to find out such things for themselves. Relationships of a boy with his father and brothers are tense, and a boy would never turn to his father or his brother for information about private matters (Magnis-Suseno, 1997:174). Young people usually learn about sex from their equals and close friends. In Javanese peasant society, it is generally believed that boys obtain most of their early sexual experience from prostitutes. A man is expected to be sexually experienced when he enters a marriage; this is necessary in order to introduce his wife to married life (Magnis-Suseno, 1997:175). Since young people have hardly any opportunity to get to know each other, most marriages were arranged by parents.

2.2.2.4 Chinese

The Chinese who migrated to Indonesia came from various areas of China. The important ethnic groups on the east coast of Sumatra were the Puntis or Cantonese and the Hakkas or Kheks from Guandung Province, the Hokkloes from Swatow, the Hailams from Hainan Island, the Hokkians from the District of Shiang Shou Fu and other small ethnic groups from Luitsiu and Kaotsiu Peninsula (Sinar, 1980:37); and because of the proximity of Medan to what is now Peninsular Malaysia, many of these groups went there as well. Most of these ethnic groups have distinct cultures and languages but share a common script. On the east coast of North Sumatra they also worked in different sectors of the economy: most Cantonese worked as goldsmiths, cabinet makers, tailors and traders, the majority of the

Hakkas worked as shoemakers, rattan traders and tinplate makers, the Hokkloes mostly worked as coolies in the plantations while the Hokkian were well known as traders. Indonesian Chinese also are known as tough workers. Traditionally most of the Chinese were Kong Fu Chu believers, but because Kong Fu Chu is not recognized by the Indonesian government, most Chinese converted to Buddhism, some converted to Christianity (Catholic and Protestant) and very few converted to Islam.

In Chinese culture, maturity was indicated by marriage. The unmarried, regardless of their age were considered children (Nio, 1961:170). On the basis of study in Singapore, Hassan (1980: 15) stated that in the Chinese family, no formal information about sex is given to young people; this knowledge is obtained from peers, especially those who are better informed. Even among adults, there is a basic conservatism about discussing sex. Soon after puberty the division between the sexes is maintained more firmly: boys and girls do not play together (Freedman, 1970 cited in Hassan, 1980:15). While premarital sex is condemned for women, sexual adventures including premarital or extramarital intercourse for men are accepted as part of the male prerogative.

2.3 Young people today: the changing socio-demographic context

Young people of today live in a very different social environment from their parents' generation. They are more likely to be single, and freer to mix with the opposite sex, than young people a generation ago. As an effect of the global expansion of formalized educational institutions, the proportion of young people enrolled in school is higher than in the previous generation. In schools they are not only taught basic academic and occupational skills but also introduced to a variety of ideas that may conflict with the ideas and values held by their parents; as a consequence, young people become more selective and critical of their own traditions. Nowadays, among Medan young people, regardless of ethnicity and social status, it is common to find a single woman and man socializing without a chaperon. For these young people, traditional norms that restricted young people from being alone with the opposite sex in a room are no longer significant.

Xenos and Kabamalan's (1998:11) study among youth aged 15-24 years in 17 Asian countries over the period from 1950 to 1990 pointed out the 'youth transition' in the region. According to Xenos and Kabamalan, youth transition comprises certain core changes 'youth demographic transition', 'core social transition' and other social transitions. The elements of youth transition are depicted by three circles. At the centre of the circle is 'the youth demographic transition' indicated by the transition from high to low fertility which then gives rise to a transitional, temporary 'youth bulge'. The next circle outward is the 'core social transition', indicated by transition in marriage and education, which occur in every population once and in a similar fashion. Then the outer circle is 'other social transition', indicated by the changes in economic activity, which are more varied across populations than the core social transition. It may not occur in some populations or may occur differently in different settings. At the outside of the circles are the sexual system (percentage of premarital sex and commercial sex) and the biological system (age at menarche).

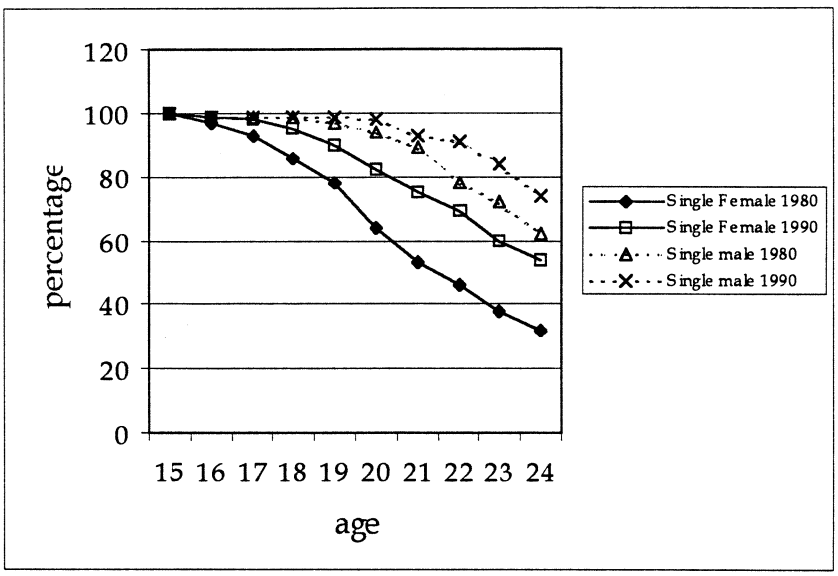
Like young people in other Asian countries, those in Medan have undergone a tremendous socio-demographic change. Young people constitute a large proportion of Medan's population. In the Indonesian Population Censuses of 1980 and 1990, young people aged 15-24 years constituted 24 per cent of the total population of Medan. The age at first marriage, school enrolments and labour force participation among Medan young people increased over the decade.

2.3.1 Change in the age of marriage

Over a decade, the proportion of Medan young single people increased significantly for both sexes. As indicated in Figure 2.1, in 1980, the proportion of unmarried women started to fall sharply at age 17, while in 1990 the proportion of unmarried women started to decrease significantly at age 18 and the reduction was not as sharp as the previous decade. In 1980 the proportion of unmarried women aged 24 was 32 per cent, compared to 54 per cent in 1990. For males, as expected the figures were higher. In 1980, 62 per cent of men aged 24 were single; this increased to 74 per cent in 1990.

In general the rises in the proportion of young single women are larger those of young single men. Figure 2.1 shows gender gaps in the proportion of young single people. These proportions were beginning to diverge at about age 16 in 1980; this increased to about age 17 in 1990. Virtually, there is no gender gap among young people age 15 to 16. The gender gaps are wider among young people at age 20 to 24 than among those at earlier ages. The traditional two or three years' gender difference in age at marriage is evident from the graph. In 1990, by age 18 as women started to get married, the proportion of single women decreased significantly, while among men, the proportion of single persons started to fall by age 21.

Figure 2.3 Proportion of Medan young single people by sex, in 1980 and 1990.



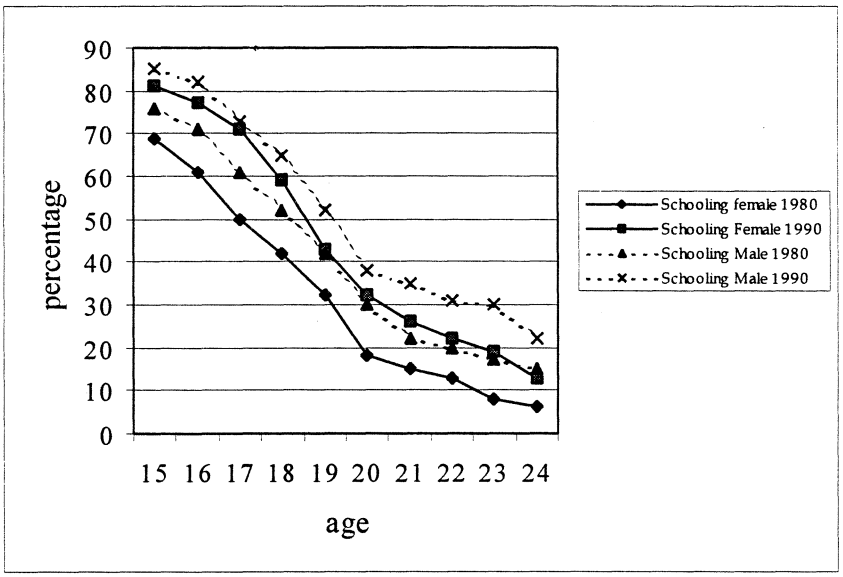
Source: Indonesian 1980 & 1990 sample census data

2.3.2 Change in school enrolment

The improvement in school facilities in most cities in Indonesia has affected the young people of Medan, resulting in a rising proportion in school. As indicated in Figure 2.2, the proportion of Medan young people enrolled in school for both sexes increased over the decade 1980 to 1990. In 1990, 43 per cent of women aged 19 were still in school, compared to only 32 per cent in 1980. The pattern among males was similar, but the figures were higher.

The gaps between males and females in schooling have started by the age of 15. In 1990, the gender gaps in school participation were narrower than the gaps in 1980, especially at the earlier ages, 15 to 17 years. This is understandable, as during this period most young people are still in high school. By age 18 they are expected to finish high school. Girls are less likely than boys to continue studying to the higher level, either because of lack of opportunity or because they get married.

Figure 2.4 The proportion of Medan young people in school by sex, in 1980 and 1990



Source: Indonesian 1980 & 1990 sample census data

Figure 2.2 shows that the proportion of young people in school continues to decrease as age increases. The proportion of school enrolment starts to fall dramatically by age 18-19. This is not surprising though, because by the age of 18-19 they are likely to have finished high school, and given the fact that studying in university or academy is relatively expensive, many young people may not have access to enrolment. In addition, given the increasing unemployment rates among those completing college education, some young people may be reluctant to enrol in academy or university.

For those who were in high school, there are various activities provided by the school: most high schools in Medan provide extracurricular activities. Every student has to choose at least one each year. According to an informant, the

principal of a public high school in Medan, extracurricular activities were designed to encourage the students to use their leisure time in positive activities. The number of extracurricular activities provided depends on the schools' conditions. The 'elite' schools usually provide more of such activities than less favoured schools; or the schools with many extracurricular activities become favoured. Types of extracurricular activities vary: journalism, computers, music, sport, home industry and Scouts (*pramuka*). One relatively new activity provided in many high schools was '*dokter remaja*' ('adolescent doctor'). In this program, the students are given training related to *Pertolongan Pertama Pada Kecelakaan/P3K* (First Aid) and reproductive health information including STDs and HIV/AIDs.

There is no requirement to be involved in extracurricular activities provided by the college or university; such involvement is voluntary. Some college students are involved in student organizations that may not be related to their study, for example, organizations based on ethnic groups or area of origin. Most students' ethnic organizations have branches at the public universities such as *Universitas Sumatera Utara/USU* (North Sumatra University).

According to information and observation during my study, ethnic segregation can also be seen in some high schools and universities in Medan, especially in the private high schools and universities. Most of the students in Moslem religious schools[7] were Malays and Mandailing Batak. According to Malay informants, there is a tendency among the Malay to send their children, especially daughters, to the Moslem religious schools such as *Madrasah,* because some parents believe that religious knowledge is more important than other knowledge. There is a belief that sending children to religious school can prevent young people from being involved in unsuitable activities, including premarital sex. Most of the Catholic private school students were Chinese and the students of Protestant private schools were mostly Toba Batak.

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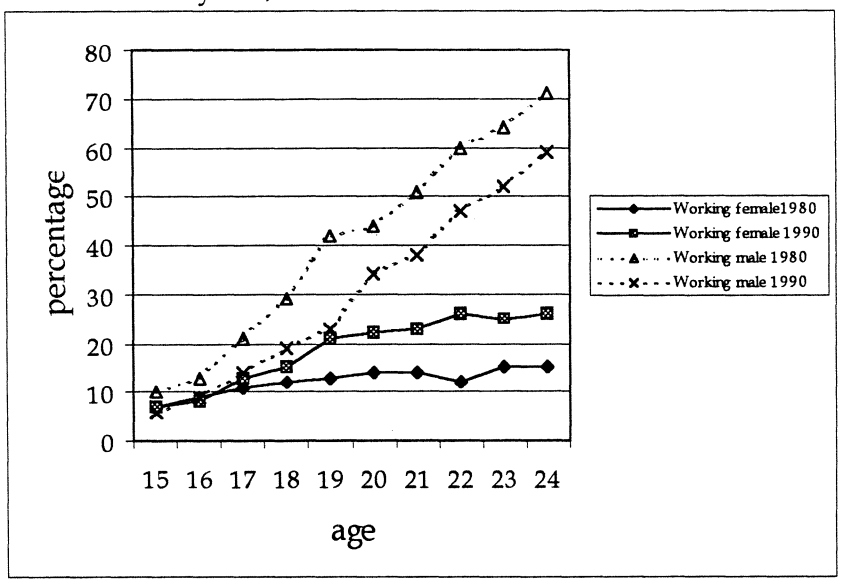
[7] Religious schools, mostly Islamic, are schools under the responsibility of the Ministry of Religious Affairs. A religious school is allowed to devote up to 40 per cent of its curriculum to religious teaching (Oey-Gardiner, 1997:137).

2.3.3 Change in labour force participation

Figure 2.3 showed that over a decade, the proportion of young people in the labour force increased steadily for both sexes. The graph indicates strong gender differentials in the pattern of young people's labour force participation. Young men are more likely than young women to be in the labour force. Among young men, the proportion of those in the labour force continued to increase sharply, starting at age 20 in 1980 and 18 in 1990 to age 24. In 1990, 70 per cent of young men at age 24 were in the labour force, compared to only 20 per cent at age 17. Among young women of each age, the increase in the proportion in the labour force is slower than the increase among young men.

Figure 2.5 Proportion of Medan young people in the labour force by sex, in 1980 and 1990



Source: Indonesian 1980 & 1990 sample census data

As they were young, and according to Indonesia's education system supposed to be in school, most of the people under age in the labour force were likely to have little education. Therefore, it is not surprising to find that many young men have unskilled jobs such as *becak* drivers, street vendors or construction workers or hold the low-level positions in companies. The young women worked as shop assistants in the shopping malls that increased dramatically over the decade in Medan.

In Medan, there were other activities commonly regarded as young people's jobs: *preman* and *mocok-mocok*. *Preman*, originally from a Dutch word *vrjiman* (freeman), is a person who considers himself a 'guard' in a certain area. As his reward he demands payment from other people in 'his area' or from those who come to 'his area'. Usually a *preman* works in the bus terminals and public parking areas. *Mocok-mocok* is a term specific to Medan. *Mocok-mocok* is used to define a person who is willing to do any job available including *'calo/makelar'* (broker). Those who were *mocok-mocok* were often between jobs. Interestingly, these activities were commonly known as men's jobs.

As indicated in Figures 2.1 to 2.3, there are gender differentials in the proportion of unmarried young people, school participation and labour force participation among Medan young people. Compared to young men, young women have less opportunity both in schooling and work.

2.3.4 Characteristics of young women in Medan

Table 2.2 presents the characteristics of Medan young women by age group over a decade. Compared to those of a decade ago, young women in 1990 were more likely to be single, more educated, more in the labour force and less likely to live with their parents.

2.3.4.1 Young single women

In 1990, almost all young women aged 15-17 years were single. The proportion of single women aged 20-21 years increased dramatically from 59 per cent in 1980 to 78 per cent in 1990 and of those 22-24 years, from 39 per cent to 61 per cent. Among the many social and economic reason for the increase in age at first marriage, education is considered the most important. In 1990, more than three quarters of single young women aged 15-17 and more than half of single women aged 18-19 were still in school. Despite the increase over a decade, compared to men, the proportion of Medan young women enrolled in higher education (academy or university) is relatively low. In 1990, only 37 per cent of single women aged 20-21 and 29 per cent of single women aged 22-24 were being educated.

The proportion of single women who were working increased, especially among those aged 22-24 years. In 1980 only a quarter of single women aged 22-24 entered the labour force; in 1990 this increased to 36 per cent. By age 22-24, the proportion of young single women in the labour force is higher than the proportion in school.

Table 2.2 Characteristics of females aged 15-24 in Medan, 1980 and 1990

Age	15-17 years %	18-19years %	20-21 years %	22-24 years %
Single				
1980	97	82	59	39
1990	99	92	78	61
Schooling (% of those single)				
1980	61	45	27	21
1990	77	55	37	29
Schooling (% of those married)				
1980	6	2	2	2
1990	0	0	1	1
Working (% of those single)				
1980	9	15	20	25
1990	9	18	26	36
Working (% of those married)				
1980	7	4	7	7
1990	12	8	7	10
Living with parent/s (% of those single)				
1980	81	72	67	70
1990	79	70	65	64
Living with parent/s (% of those married)				
1980	43	30	24	16
1990	33	30	17	15

Source: Indonesian 1980 & 1990 sample census data .

The majority of young single women were living with one or both parents. This is not surprising, since culturally in most Indonesian societies, single persons regardless of their age are expected to remain living with their parents if they live in the same city. However, compared with unmarried young women in 1980, single women in 1990 were slightly more independent. In 1990 more than a third of unmarried women aged 20-21 and aged 22-24 were living apart from their parents compared to 33 per cent and 30 per cent in 1980 respectively.

2.3.4.2 Young married women

Almost all young married women were out of school and not in the labour force. Most of them were unemployed or as house-keepers. As shown in Table 2.2, in 1990 none of the young married women aged 15-19 were in school, while only one per cent of those aged 20-24 were still being educated. This is partly because Indonesian education policy forbids students in secondary school (usually aged 15-18) to marry. Those who marry are expelled from school.

Few young married women were working; many of them were categorized as housekeeping or housewives; because most young married women were likely to have children less than five years old, which would tend to restrict them to household duties. Traditionally among most Medan social groups, a mother, especially a young one, is not expected to work outside the home.

Since young women tend to marry men older than themselves, who are economically more independent, they are likely to leave their parents' house once they marry. This is true especially among young women aged 20-24. In 1990, only 17 per cent of married women aged 20-21 and 15 per cent of married women aged 22-24 lived with their parents. However, of women aged under 20 a significant proportion still lived with parents, even after marriage.

2.3.5 Characteristics of young men in Medan

Table 2.3 presents the characteristic of Medan young men in 1980 and 1990. As with the young women, Medan young men in 1990 were more likely to be single and more likely to be in school compared with young men in 1980. However, unlike the girls, the proportions of young men in the labour force were smaller in 1990 than in 1980, especially among young single men.

2.3.5.1 Young single men

Almost all young men aged 15 to 21 are single. As discussed in Section 2.3.1, the proportion of young men entering marital unions started to increase sharply at age 21. Although the proportions in school among men are much larger, the pattern of

young single men in school is the same as the pattern among young single women. The participation in education falls with increase in age.

Young single men's participation in the labour force is relatively slight. Interestingly, in contrast with young single women, in 1990, the proportion of young single men in the labour force decreased sharply among all age groups. This can be explained by the dramatic increase in the proportion of young single men in school. As part-time schooling and part-time work are not common in Medan, one has to be either studying or working.

Table 2.3 Characteristics of males aged 15-24 in Medan, 1980 and 1990

Age	15-17 years %	18-19years %	20-21 years %	22-24 years %
Single				
1980	99	98	91	71
1990	99	99	96	84
Schooling (% of those single)				
1980	70	48	29	23
1990	80	59	37	31
Schooling (% of those married)				
1980	61	9	4	3
1990	63	27	4	3
Working (% of those single)				
1980	14	30	43	54
1990	9	21	34	44
Working (% of those married)				
1980	32	71	88	91
1990	21	56	85	91
Living with parent/s (% of those single)				
1980	81	72	65	61
1990	82	75	64	62
Living with parent/s (% of those married)				
1980	84	59	37	24
1990	75	74	26	23

Source: Indonesian 1980 & 1990 sample census data tapes

Most young single men were living with one or both parents; there was no significant change in young single men's living arrangements between 1980 and 1990. As expected, as they grow older, young men are likely to leave their parents' house, either for work or study.

2.3.5.2 Young married men

Despite Indonesian education policy that forbids married people from studying in general secondary school or lower, for many boys, being married does not necessarily mean leaving school. Table 2.2 showed that 61 per cent in 1980 and 63 per cent in 1990 of married youths aged 15-17 were enrolled in school. This may be because there is no physical evidence of being married, such as pregnancy, for boys; thus they may continue their study without reporting their marital status. The proportion of married youths in school drops sharply by age 18.

The majority of married men aged 20-24 were working: in most Medan ethno-linguistic groups, men are considered the breadwinners. Most of these working young people are unskilled workers with relatively low wages.

Since most married youths aged 15-17 were still at school, they are likely to live with their parents. In 1990, three quarters married males aged 15-19 were living with their parents. Among most Medan ethnic groups, parents are expected to support their children until the children are economically independent; as a consequence, parents may have a strong influence on their married children.

2.4 Conclusion

Young people aged 15-24 constituted 24 per cent of the total population of Medan in 1980 and 1990. These young people are experiencing dramatic socio-demographic change. They are more likely to be single and freer to express themselves. In 1980, 90 per cent of young men were single; in 1990, 94 per cent. Among the population of young women in 1980, 71 per cent were single, rising to 82 per cent in 1990. The proportion of unmarried young people in school also increased. In 1980, 45 per cent of unmarried young people were in school, compared to 53 per cent in 1990. The proportion of single young men in the labour force decreased from 32 per cent in 1980 to 26 per cent in 1990, while the figure for girls rose from 15 per cent in 1980 to 20 per cent in 1990.

As expected, there are gender gaps in the participation in school and in the labour force. Young women were less likely than young men to go to school, and also less likely to participate in the labour force. The gender gaps are wider among older age groups and among young married people.

It is evident from the cultural backgrounds and main activities of Medan's single young people that they are not a homogeneous group. The cultural heterogeneity of the city may influence the beliefs of these young people in their traditional culture and make them critical of their parents' norms and values. At the same time, the strong competitiveness of Medan people, may increase their felt need to cling to their ethnic-linguistic groups.

Considering the socio-cultural changes in Medan's society over time, there may be gaps between the old and young generation, especially in relation to sexuality. For today's young people, conservative norms may not be significant in their daily life, while their parents may still hold these values. Parents may tend to educate their children on the basis of their own norms, values and experience. As a consequence, many parents feel uncomfortable about discussing sexual issues with their unmarried children.

Single young people in Medan may face great pressure from the society to behave according to the conservative norms. On the other hand, the city's growth, including education and 'adult entertainment', gives them access to information that might run counter to their parents' values. Since most of these young people are in their teens, they may seek help from any sources available. Cultural traditions hamper them in obtaining information about sex from their parents, while the Indonesian government is still reluctant to provide the information for unmarried people. Given these facts, these young people are more likely to seek information from friends and from the media including pornographic materials. Therefore, it is not surprising to find that many of Medan's young people have little knowledge about sexual matters.

3 Doing research on a sensitive issue: a methodological approach

3.1 Introduction

Conducting research on single young people's sexuality is fraught with difficulties. Asking single young people about sexual matters, especially their own sexual attitudes and experiences, requires treading on very personal ground and involves a high risk of offending and alienating respondents. Young people may be unwilling to participate or prohibited from doing so by concerned parents. Others may exaggerate or under-report their sexual behaviour and attitudes. Others may not really be sure what they do, because of either engaging in denial or simply not having the conceptual skills to provide precise and accurate observations of their own behaviour and motivation (Moore and Rosenthal, 1993:185). To make matters worse, issues regarding single young people's sexual behaviour are often considered politically sensitive. Attempts to gain research permission from the authorities may encounter problems (Utomo, 1997:90). Therefore to avoid unnecessary obstacles, besides selecting the appropriate method of data collection, knowing the right procedure for research permission is very important.

This chapter discusses the strategy for collecting and analyzing the information used in this study. It covers the data sources, research setting, obtaining research permission and the approach to data collection employed in the study, as well as the characteristics of the young people being studied.

3.2 Data sources

Because of the sensitivity of the issues in Indonesia, there are no large-scale data on the fertility and reproductive health of unmarried people. The Indonesian Demographic and Health Survey involved only married women, while in the Population Census, questions related to fertility have only been asked of those who were ever married. As a result of those problems, the main data source for my study was information collected during the field study within a period of seven months, from July 1997 to January 1998. A literature review on issues related to single young people's sexual and reproductive health was undertaken before the field study. This review was important in identifying the research topic and questions for field research. To obtain information on the pattern and trend of socio-demographic characteristics and activities of young people in Medan (see Chapter 2) I also used the data tapes of the Indonesian Censuses of 1980 and 1990.

3.3 The research setting

The area of my study is Medan, the capital city of North Sumatra. As the capital city and the center of development of North Sumatra, Medan is the most developed region and has much better facilities than other regions of North Sumatra. According to the 1998 city statistics, Medan has 283 public and private high schools, three public universities and 100 private universities, including academies and institutes (BPS, 1999:67-71). This city also has many facilities for youth entertainment such as movies, discotheques, nightclubs, shopping malls, sport centres, parks and other interesting places. Many young people from surrounding areas come to Medan for study or work. They live in boarding houses, rent a house with friends or siblings or stay with their relatives. Located close to Singapore and Malaysia, Medan has an international airport as well as a harbour. These facilities, especially the harbour, give the city easy access to illegal goods such as drugs, alcohol and pornographic materials.

3.4 Obtaining research permission

Conducting research in Medan, I needed to obtain a range of research permits from the highest authority, the Department of Internal Affairs, through the Social-Political Bureau in Jakarta to the local authorities, the Social-Political Bureau and Regional Development Planning Board at both provincial and district levels in Medan. To apply for the permission, I provided a research proposal translated into the Indonesian language, the questionnaire and a letter from my office, the Center for Population and Manpower Studies, the Indonesian Institute of Sciences.

With the letter from the Social-Political Bureau and the Official Letter of Introduction from my research institute, I went to the authorized offices at both provincial and district levels in Medan. Then, with the letters of permission from all levels and the Official Letter of Introduction from my research institute, I asked for a letter of permission from the provincial Education and Cultural Affairs Department to conduct the survey in Medan high schools. With these letters I went to eight high schools, and all were willing to co-operate and facilitate my survey. Most of the school directors were also willing to be interviewed.

Despite the experiences of other researchers in obtaining research permission to conduct research covering sensitive issues, such as sexuality, abortion, pregnancy and contraception among Indonesian single young people (Utomo, 1997:80), I did not experience any substantial problem from any institution either in Jakarta and Medan. Research permission in Jakarta was processed through my office. While in Medan I applied for the permission myself. Nevertheless, to anticipate unnecessary problems I contacted two colleagues who work in the Department of Internal Affairs and Department of Education and Cultural Affairs to accompany me. This enabled me to meet the persons who were directly in charge. I was told that processing research permission in Medan, needs 'a strategy'. It involves either money or 'a boom'. Money is needed to

make the lower-level staff pass the letter on to higher-level staff, or 'a boom', someone with authority, is needed to bypass the lower-level staff to deal directly with the higher-level staff. With these strategies, research permission can be obtained within two or three days. Otherwise, it may take weeks or even months. Officially, there is no charge to process a research permission. However, it seems that everybody should understand that 'thank you money' or a so-called 'administration fee' (without receipt) is essential.

3.5 Research methodology

Considering the type of research questions and the study objective, combining both quantitative and qualitative methods was seen as the most appropriate approach. Information obtained from each approach was used as complementary to the other. Employing a relatively large-scale survey, the quantitative approach provides numerical results that can be used to see the pattern of issues being studied. On the other hand, the qualitative approach using selective informants allows the researcher to probe into sensitive issues as well as attitudes, values and beliefs (Scrimshaw, 1991:7) and the collection of information on issues that are difficult to obtain from a quantitative survey. As noted by Berg (1989) "qualitative procedures provide a means of accessing unquantifiable facts about the actual people researchers observe and talk to". Furthermore, while the quantitative data analysis methods test the significance of the relation between the dependent and the independent variables, the qualitative data are used to understand how and why the observed relationship among the interrelated independent variables occurred (Bogue 1993:2).

3.5.1 Quantitative approach

The main quantitative data source used in this study is the 1997 Medan Single Young People's Reproductive Health Survey conducted from July to December 1997. During the field study, I carried out the pretest of the survey instruments, and conducted the interviews. A total of 875 unmarried young people aged 15-24 were completed self-administered questionnaires. Respondents were chosen

purposively, including those who were at school and those who were out of school. The school respondents were high school and university students; the out-of-school respondents were those who were working, including young people working on the street and unemployed.

3.5.1.1 Recruitment of high school student respondents

High school student respondents came from eight high schools in Medan. To cover all the main ethnic groups as well as social classes in Medan, I chose two public high schools (one prestigious and one non-prestigious), three prestigious private high schools (Catholic and Moslem), and three non-prestigious private high schools on the outskirts of Medan. The majority of the students in the prestigious high schools came from well educated and financially better-off families, while most of who studied in non-prestigious private high schools came from relatively poor socio-economic backgrounds. From each school I used one or two classes, depending on the number of students in each class.

The survey took place in the classroom after the necessary permission had been obtained. I worked with two research assistants (a man and a woman), both of them students of the Anthropology Department, Faculty of Social and Political Science, North Sumatra University. Before the survey, I introduced my assistants and myself and the objectives of my study to the students. I informed them that all questionnaires would be sealed and put together with others from several high schools, universities and other young people.

Because of the nature of the questions, I asked the teachers to leave the class and not to be involved; this was in anticipation that the students might be afraid that their teacher would read their answers. And even though I had permission from the school director, I also sought the students' willingness to participate in the study. If they were not willing to participate, students were offered the option either to leave the class or to remain and place a blank questionnaire in the envelope. Given these options, all students were willing to participate.

Most of the high school students were keen to learn more about issues related to sexual and reproductive health. When the survey was completed, the students asked several questions related to puberty, virginity, conception and contraception. Some of them asked me to give a talk regarding adolescent reproductive health in the class; however, since it might have influenced my study and I had no permission to do so, I refused. But I appreciated the need of students to learn more about such issues. Later on I discussed these needs with the principals and encourage them to give lectures about sex and reproductive health issues to the students.

3.5.1.2 Recruitment of university student respondents

For university students it was not possible to give the questionnaire in a classroom. To gain access to the university student respondents I worked with four interviewers (all of them university students) and two research assistants. Most university student respondents were from seven universities comprising two public and five private universities. The students were approached individually in their campus during a class break, before or after class. At these times students were usually chatting together in-group in the canteen or in the campus quadrangle. The are grouped according to the year of entering the university, faculty and department or according to the organization in which they are involved.

When asked to participate in my study, the university students asked several questions on confidentiality. Some students preferred to complete the questionnaire at home, but most of them were willing to complete it straight away. It was interesting to observe how some students answered the questions. At first they sat close to each other, when answering the first and the second pages of the questionnaire, but when answering the next pages where the questions are more 'sensitive', they moved away from each other to complete the questionnaire privately. They did not want their friends to read their answers

and they sealed the envelopes as soon as possible but returned the questionnaire together with others. They did not want to be identified with their answers.

3.5.1.3 Recruitment of working respondents

Those who were working were also approached individually by visiting their working places or through youth organizations. Those who were working in the 'formal sector' including public and private service institutions were interviewed mostly in their own homes after making appointments in their working places or in youth organizations. Most of them preferred to complete the questionnaire in their own time and asked the interviewers to collect them later. However, to make sure they understood the questions, I asked them to read the questionnaire before bringing it home.

Finding working young people was hard, especially those who were working on the street. Most of these young people were suspicious when talking to strangers. Questions such as 'Why don't you ask the students? (*kenapa enggak nanyak anak sekolahan aja?)* or 'Why do you ask such questions?' were often raised before the interview. It needed two or three days to observe their work and to talk with them before they were willing to participate. In many cases knowing 'the leader' was very helpful. However, several of them refused to participate, stating that the questions were too personal, or they were not interested in the study or matters related to academic research.

At first I did not plan to cover young people on the street in the study. However, when I visited NGOs interested in street kids and talked with some of the street kids myself, I became interested. There are at least three NGOs in Medan interested in street kids; none of them covers reproductive health issues. At the same time the NGOs interested in adolescent reproductive health did not cover those out of school. At that time their main target groups were young people at school.

Young people who worked in the informal sector, including those who worked on the street, were interviewed in their work places, such as bus stations, at traffic lights, in the streets, malls and parking areas. About 100 respondents were interviewed or completed self-administered questionnaires. Many of these respondents considered themselves employed as street vendors, shoe shiners, *preman* ('informal security'), informal parking person, *becak* or city bus drivers, city bus co-driver (*kenek*) and odd jobs (*mocok-mocok*). Others said they were unemployed[1]. They preferred to be interviewed after work or when they were not busy. Most of them preferred to be interviewed in person. However, for the 'sensitive' questions such as experience with sexual intercourse, some of them preferred to write the answer by themselves and returned the questionnaire in the sealed envelope. However, since almost all the respondents answered all the questions, it did not cause any problem in the analysis.

3.5.1.4 Recruitment of unemployed respondents

Young people who were not studying and not working were categorized as 'unemployed'. This included those who were freshly graduated from high school but had not been accepted in public universities and were willing to try the next year. These young people were mainly obtained by visiting youth organizations such as 'Youth Church Organizations' (*muda-mudi gereja*), 'Mosque Adolescents Groups' (*remaja mesjid*) or youth ethnic-group/area of origin organizations (*ikatan muda-mudi kesukuan/kedaerahan*). Most of them were willing to participate.

Unemployed young people also included those who were just hanging around doing nothing in shopping malls, parking areas, food stalls or other public places. Similar with those who worked on the street it needs extra efforts to persuade them to participate in the study. Those who were unemployed were

[1] In the questionnaire I did not provide a technical definition of working, so the respondents' answers to these questions are based on their own definition. Some respondents may consider activity such as odd jobs, informal parking person and *preman* as occupations, while others do not think so.

interviewed in several places including at youth meetings, at their homes, in shopping malls, parking areas and food stalls.

3.5.1.5 Questionnaire and confidentiality

To prevent the respondents getting tired or bored when answering the questions, I designed the questionnaire to be as short as possible (see Appendix). It took about 30 to 45 minutes to complete the questionnaire. Within that time the respondents still had time to ask questions about the study, if they so desired.

The questions are classified into seven categories:
Characteristics of respondents, including age, sex, religion, ethnicity, education completed, main activity, level of education, occupation, living arrangement and involvement in youth organizations.
Family background including parents' occupation, parents' education, parents' religions, parents' marital status and the number of siblings.
Knowledge related to human reproduction, including the fertile age for women and men, fertile periods for women and respondents' age of menarche or first emission ('wet dreams').
Knowledge and attitudes about contraception including method of contraception and the availability of contraception for single young people.
Attitudes toward marriage and relationships before marriage including ideal age of marriage, having the first child, the ideal number of children, the most important factor in choosing a future spouse, virginity, premarital sex, premarital pregnancy and abortion.
Knowledge on and experience of health related to reproductive health including whether they had ever heard of and knew the symptoms of STDs, AIDS, vaginal discharge and their experience of vaginal discharge symptoms.
Source of information regarding reproductive health issues including contraception, menstruation, wet dreams, conception, abortion, STDs and HIV/AIDS.

To ensure confidentiality, the respondent's name, address and school or work were not asked. Before completing the questionnaire, respondents were asked to read all the questions briefly, and asked whether they were willing to answer all the questions honestly. Most of the respondents were willing to co-operate; only a few refused to participate (mostly university students and those who were out of school), stating that some questions were too personal. Because of the nature of the questions, in most cases the questionnaire was self-completed and returned in an envelope. When they had finished, the respondents were asked to seal the envelope themselves. To identify the cases, all the questionnaires were numbered. But the numbered were not related to particular individuals

3.5.1.6 Data processing and analysis

As soon as the completed questionnaires were returned, I edited and coded the data personally. This was necessary to make sure that all the questions were completed properly. I had to exclude five of the 880 respondents because they did not meet the study criteria, either because they were married (two respondents) or did not answer more than one-third of the questionnaire (three respondents). Then all the completed questionnaires were brought to Jakarta for data entry. The data entry was done by three computer services staff of the Center for Population and Manpower Studies, the Indonesian Institute of Sciences.

Data obtained from the survey were entered and analyzed using SPSS 9.0 for Windows. For the analysis of the data, I employed descriptive statistics, including frequencies and percentage distribution, bivariate analysis, including cross-tabulations and the chi-square test, and logistic multivariate regression analysis. The bivariate analysis was used to examine the relation between independent and dependent variables individually. Logistic multivariate analysis was used to examine the relative contribution of variables found to be individually significant in the bivariate analysis to dependent variables.

Dependent variables examined were knowledge of a woman's fertile period, attitude toward virginity, attitude toward premarital sex, reported experience of premarital sex, attitude toward abortion, knowledge on STDs and HIV/AIDS, and opinion about contraceptive information for single young people.

Socio-demographic variables treated as independent variables are age, sex, main activity, religion, ethnicity, living arrangement, and parental background including father's occupation, mother's occupation, father's education and mother's education. Because of the small number of respondents, some of these variables were grouped into several categories.

Age of respondents was grouped into three categories: 15-17, 18-20 and 21-24 years. This corresponded roughly to respondents' level of education and main activity. Of those who were students, all respondents aged 15-17 were at high school; of student aged 18-20 some were at high school and some at university; and all student respondents aged 21-24 were university students. According to the Indonesian school system, in which the age for entering primary school is six years, by age 17 most of the students were expected to have finished high school[2].

Respondents' religion was grouped into three categories: Moslem, Christian and Buddhist/Hindu. Protestants and Catholics were grouped into one category, Christian by far with the larger group being Protestant. Because of the small number of Hindu respondents (four), they were grouped into one category with Buddhists. In the survey, I did not ask questions related to religiosity, because religion is a sensitive issue for most Medan people. Most local researchers that I interviewed in the preliminary visit suggested that adding questions related to religiosity in the questionnaire might influence young people's responses to issues related to sexual behaviour and premarital sex. However, I raised

[2] In Indonesia's education system, primary school lasts six years, secondary school three years, high school three years, academy/diploma three years and university four to five years.

questions related to religiosity at the end of personal interviews or in focus group discussions.

Ethnic groups were divided into seven categories: Toba Batak, Mandailing Batak, Karo and other Batak (Simalungun and Dairi/Pak-Pak Batak), Javanese, Malay, Chinese and Others. The Batak were divided into three groups because, despite sharing similar traditions, the Medan Batak believe that each sub-ethnic group is different (see Chapter 2). In addition the proportions of Toba Batak, Mandailing Batak and Karo Batak respondents were sufficiently large to be examined separately.

3.5.2 Qualitative approach

The qualitative data collection involved in-depth interview and focus group discussions. In-depth interviews elicit information that people is too private to talk about in a group (Bernard, 1988), while focus groups are a suitable approach for getting people to express a range of different opinion about an issue (Murphy *et al.*, 1992). For my study, the combination of both methods is particularly good because it allows me to obtain information on group norms as well as information about the more private aspects of sexual and reproductive health.

A total of 33 in-depth interviews and eight focus group discussions were carried out. I also interviewed six representatives of NGOs interested in adolescent problems, five local researchers from the North Sumatra University (*Universitas Sumatera Utara/USU*) and the State Institute of Moslem Religion (*Institute Agama Islam Negeri/IAIN*), two of the local staff of the Ministry of Health, one local staff member of the Ministry of Social Affairs and one local staff member of the National Family Planning Coordinating Board (BKKBN). Both in-depth interviews and focus groups were guided by an interview guide, which was developed during the fieldwork.

The respondents for in-depth interviews and focus group discussions were selected in various ways: mostly from recommendations of other respondents, my research assistants, interviewers, local researchers, NGOs and other people that I met during my field work. I found that some young people were reluctant to participate without an introduction from someone that they knew. However, I also interviewed some young people whom I met accidentally in public places around Medan.

3.5.2.1 In-depth interviews

To obtain views from all Medan's main ethnic groups as well as all social classes, I conducted 24 in-depth interviews with unmarried youth from various backgrounds, including high school students, university students, workers in the formal and informal sectors and those who were unemployed (see section 3.6.2). In addition, to obtain information about married young people's knowledge and attitudes toward issues being explored, I interviewed four married young people (two females and two males). Furthermore, to have some ideas about young people in the past and how parents communicated the issues related to sex and reproductive health to their teenage children, I also interviewed five parents (three mothers and two fathers).

In-depth interviews with unmarried young people were mostly conducted in places chosen by respondents. Most of them preferred to be interviewed outside in public places such as parks or canteens around the campus, in the food stalls or in shopping malls. In contrast, the married young people and parents preferred to be interviewed in their own houses. Almost all the single young people (22 respondents) refused to be taped during the interview, but most married young people and parents did not object to being taped. Nevertheless, in some cases I decided to stop the recording in the middle of the interview when the respondents looked uncomfortable. Some respondents were more communicative when the tape was off.

Interviewing young people who spend most of their time on the street was a challenge. Despite their low level of education, I found that street young people were more curious about my study than the students. Even though I had explained the objective of my study, whenever I asked personal questions they often questioned the importance of the issue for my study. Questions such as *'Untuk apa pertanyaan seperti itu* (What's the importance of such questions?)' were often raised. However, most of them were willing to answer the questions after necessary explanation. Some of them wanted to know what I was writing in my notes. Given this situation, I only wrote the key sentences during the interview and completed the field notes after the interviews were finished.

To build rapport with the respondents, after my introduction, I started the interview with general questions, then after both of us felt more comfortable, I asked more sensitive questions. Since most in-depth interviews were not recorded, I revised the field notes as soon as I had a chance. I decided not to interview other respondents before I completed the field notes for the previous interviews.

3.5.2.2 Focus group discussions

To elicit young people's opinions about sensitive issues such as premarital sex, contraception and abortion, I conducted eight focus group discussions. It has been suggested that the stimulating nature of the focus group discussion yields more and richer information than do individual interviews with the same number of participants (Folch-Lyon, 1981). A focus group discussion also helps to resolve ambiguous findings which might be detected from a survey which has covered the issue in a more superficial way (Murphy *et al.*, 1992:37).

Given the sensitivity of the issues, I believed that participants would feel more comfortable in expressing their views openly if they perceived other members of the group sharing similar experiences. Therefore, I grouped the FGDs with respect to gender, activity and marital status (see section 5.6.3). Eight FGDs were

conducted: two groups of high school students (males and females), two groups of university students (males and females), one group of working adolescents (mixed males and females), one group of youth on the streets (males) and two groups of married young people (males and females).

Inviting young people to participate in what they might perceive as an academic discussion was not easy; most young people were not familiar with focus group discussions. At first when I invited them for a discussion about adolescent reproductive health, most of them were not interested. I was informed that many young people were not interested in a formal or academic discussion. I also found that the term 'reproductive health' was strange to them. Given this situation I changed my strategy; instead of using formal terms, I invited young people for an informal chat about 'today's adolescents' lives' (*ngobrol-ngobrol mengenai kehidupan remaja masakini*). I deliberately stressed that the chat would be very informal and relaxed; then some of them became interested. However, to ensure that all participants attended the discussions on time, all participants were picked up and taken to and from the place. The duration for each group was about 90 minutes.

The location of a focus group discussion may also influence the participants' opinions, especially in talking about sensitive issues. For example, talking about premarital sex and abortion in a school, church or mosque may cause the young people to feel uncomfortable about expressing their opinion freely. To avoid this problem, the FGDs were conducted at my place, in a room that I used as an office during my fieldwork. Before the discussion, I asked the participants where they preferred to sit, on the chairs or on the floor; all of them preferred to sit on the floor, saying that it would be more relaxed. I also sought the participants' permission to record the discussion. All of them agreed.

Because of the sensitivity of the issues, at first I did not plan to moderate the male focus group discussions myself. However, after talking with several male

respondents and talking with my research assistants, I decided to moderate all the focus group discussions. For female focus group discussions, I asked a female assistant to be an observer and note taker, and for male focus group discussions, I asked a male assistant to do the same job. I found that the male participants were more open to talking about sensitive issues than the females. Under my supervision, the full transcriptions of the focus group discussions were done mostly by the note taker.

The first five to ten minute of focus group discussions were used to introduce the topic, the note taker, the moderator and the participants. Then I started to raise the general issues that were familiar to each group. Then, after the participants felt more relaxed, I asked about the more sensitive issues. Nevertheless, most of the time the participants raised the sensitive issues such as young people's experiences in using contraception, abortion and premarital sex before I raised them. This made it easier for me to explore the issues without causing the participants to feel uncomfortable.

The issues discussed in each group were essentially the same. However, because the backgrounds of participants in each group differed, each group had a specific topic. For example, when conducting the focus group discussion among adolescents working in the street, a great deal of time was spent discussing their experiences using drugs, getting drunk and visiting prostitutes. In focus group discussions among female high school students a large amount of time was spent talking about their experiences during their first menstruation, reproductive health information given in schools, and their relationships with boys.

3.6 The characteristics of Medan's young study population

3.6.1 Respondents in the survey

Table 3.1 presents the socio-demographic characteristics of respondents in the survey. Of the 875 respondents, 41 per cent were 15-17 years old, 27 per cent

were 18-20 and 32 per cent were 21-24. The proportion of males and females was similar (53 per cent and 47 per cent respectively).

The majority (76 per cent) of respondents were students, 18 per cent were working and six per cent were unemployed. Among those who were students, 62 per cent were in high school and 38 per cent were at the academy or university. Of the 153 respondents in the labour force, 44 per cent had completed high school and 15 per cent had graduated from the academy or university. Among the 56 unemployed respondents, 62 per cent had completed high school and 13 per cent had completed academy or university (not shown). Most working young people in the study held unskilled jobs such as labourer, trader, street vendor, shoe shiner, parking person, bus or *becak* driver, and 'private' security guard (*preman*).

The young people in the study represented the four major ethnic groups (Javanese, Batak[3], Malay and Chinese) in Medan and all religions recognized by the government. More than half (57 per cent) of respondents were Moslem, 24 per cent Protestant, 12 per cent Buddhist, six per cent Catholic and only one per cent Hindu. This reflected the composition of the religious affiliation of Medan's single young people based on the 1990 Indonesian census.

The majority of respondents (65 per cent) were living with both parents, eight per cent with one parent, 12 per cent were living with a sibling or other relative, including grandparents, and 16 per cent were living in boarding houses. Most respondents (85 per cent) still had both parents and only two per cent had divorced parents.

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[3] Since Islam and Christianity have significantly influenced the traditions and culture of the Batak people (see Chapter 2), the Bataks were divided into three groups; the Mandailing, who are mostly Moslem, the Toba Batak who are mostly Protestant, and other Bataks, a group which has an almost equal number of Moslems and Christians.

Table 3.1 Characteristics of respondents in the survey

	Number of respondents N=875	Percentage
Age		
15-17	362	41
18-20	232	27
21-24	281	32
Sex		
Male	463	53
Female	412	47
Religion		
Moslem	502	57
Protestant	210	24
Catholic	57	6
Hindu	4	1
Buddhist	102	12
Ethnicity		
Javanese	168	19
Toba Batak	166	19
Mandailing Batak	114	13
Karo and other Bataks	88	10
Malay	109	13
Chinese	150	17
Others	88	9
Education completed		
Primary school	19	2
Junior high school	471	54
Senior high School	355	41
Academy/university	30	3
Respondents' main activity		
Study	666	76
Working	153	18
Unemployed	56	6
Level of students' education	N=666	
High school	410	62
Academy/university	256	38
Occupations of respondents	N=153	
Labourer	34	22
Public service	4	3
Employee	58	37
Trader	10	7
Street vendors, shoe shiners	26	17
Preman ('informal security')	3	2
Informal parking person, becak driver, city bus driver, city bus co-driver (*kenek*)	18	12
Odd jobs (*mocok-mocok*)	2	1
Living arrangement		
With parents	569	65
With either mother or father	67	8
With sibling	60	7
Other relative	43	5
Boarding house	136	16
Parental marital status		
Parents 'complete'	737	85
Father dead	97	11
Mother dead	19	2
Parent dead	3	0
Parents divorced	19	2

Source: Medan Adolescent Reproductive Health Survey, 1997-98

As presented in Table 3.2, respondents came from families with low and middle income and education level. More than two thirds (70 per cent) of respondents' fathers had high school or higher education, while more than half (58 per cent) of respondents' mothers had high school or higher education. Despite the relatively high level of education, almost half (46 per cent) of respondents' mothers were unemployed. The majority of those who were working had unskilled jobs such as trader (23 per cent) and labourer. The majority of respondents' fathers were in the labour force; only three per cent were not employed and 11 per cent were retired. The distribution of parental religious affiliation was almost the same as the distribution of respondents' religious affiliation.

Table 3.2 Backgrounds of respondents' parents

	Father		Mother	
	number	percentage	number	percentage
Occupation				
Labourer	52	6	18	2
Trader	176	20	205	23
Public servant	267	31	115	13
Employee	136	15	22	3
Retiree	100	11	15	2
Not employed	22	3	406	46
Other	122	14	94	11
Education completed				
Some primary	18	2	44	5
Primary	86	10	127	15
Secondary	137	16	173	20
High school	332	38	370	42
Academy	70	8	77	9
University	209	24	65	7
Other	23	2	19	2
Religion				
Moslem	497	57	502	57
Protestant	210	24	215	25
Catholic	47	5	43	5
Hindu	7	1	3	0
Buddhist	114	13	112	13

Source: Medan Adolescent Reproductive Health Survey, 1997-98

3.6.2 Respondents interviewed in depth

The respondents interviewed personally and in depth were also from various backgrounds, namely single and married young people and parents (Table 3.4). Those single included 16 males aged16-24 years and eight females aged 16-26 years. Seven of the male respondents were young people who were spending most of their time hanging around or working on the street, except one who said he was a student at a private university. I could not find any young females spending most of their time on the street who were willing to be interviewed personally.

Table 3.3 Characteristics of respondents interviewed in depth

No.	Pseudonym	Sex	Age	Education	Occupation	Ethnicity	Religion
Unmarried Youth							
1	Edi	Male	24	SHS	Broker	Javanese	Moslem
2	Deny	Male	20	Univ. student	-	Malay	Moslem
3	Tarigan	Male	18	SHS dropout	Street vendor	Toba Batak	Christian
4	Iyan	Male	19	SHS drop out	*Preman*	Javaneses	Moslem
5	David	Male	20	JHS	*Togel*	Mandailing	Moslem
6	Oman	Male	23	Univ. dropout	*Preman*	Karo Batak	Christian
7	Roni	Male	16	JHS dropout	Street vendor	Toba Batak	Christian
8	Gulo	Male	24	University	Reporter	Nias	Christian
9	Jhony	Male	23	Univ. student	-	Chinese	Moslem
10	Apo	Male	24	University	Unemployed	Sundanese	Moslem
11	Ciko	Male	23	University	Unemployed	Toba Batak	Christian
12	Lina	Female	16	SHS student	-	Malay	Moslem
13	Inong	Female	22	SHS	Labourer	Javanese	Moslem
14	Von	Female	16	SHS student	-	Mandailing	Moslem
15	Ratih	Female	17	SHS student	-	Javanese	Moslem
16	Sofi	Female	17	SHS student	-	Malay	Moslem
17	Lin	Female	17	SHS student	-	Javanese	Moslem
18	Esti	Female	21	Univ. student	-	Toba Batak	Christian
19	Cc	Female	26	Academy	Secretary	Karo Batak	Christian
20	Iwan	Male	17	SHS student	-	Malay	Moslem
21	Santo	Male	22	Univ. student	-	Javanese	Christian
22	Martin	Male	20	Univ. student	-	Toba Batak	Christian
23	Luther	Male	20	Univ. student	-	Toba Batak	Christian
24	Jojon	Male	21	Univ. student	-	Malay	Moslem
Married youth							
1	Anggi	Female	20	SHS dropout	Housewife	Malay	Moslem
2	Eka	Female	21	SHS dropout	Housewife	Karo Batak	Christian
3	Dono	Male	23	SHS	Driver	Javanese	Moslem
4	Kasino	Male	22	SHS	Trader	Javanese	Moslem
Parents							
1	Aini	Female	64	Primary	Trader	Javanese	Moslem
2	Uwak	Female	67	No school	House-keeper	Javanese	Moslem
3	Uli	Female	70	Primary	Housewife	Toba Batak	Christian
4	D	Male	49	University	Public servant	Javanese	Moslem
5	HS	Male	50	Academy	Self employed	Toba Batak	Christian

Notes: JHS = Junior High School SHS = Senior High School

The two married young men that I interviewed had a relatively high level of education (high school graduates), and both were working. But like many other working young people in Medan, they held unskilled jobs; whereas both married young women interviewed were high school dropouts and not in the labour force.

3.6.3 Participants in focus group discussions

As Tables 3.4a-d show, the participants in focus group discussions came from different schools, universities, jobs and areas. Therefore, most of them did not know one another. Research shows that this is necessary to reduce the likelihood of pre-existing patterns of leadership among participants (Murphy *et al.*, 1992:38). Each group consisted of five to six participants. To cover the ethnic heterogeneity, when it was possible, each group had members of the four main ethnic groups in Medan (Batak, Chinese, Javanese and Malay); however, it was difficult to find Chinese who were willing to participate in discussion. Only three groups (male and female high school students and working adolescents) had Chinese as participants. In Medan it was common knowledge that Chinese were unwilling to mix with the non-Chinese, especially those they do not know well. Although one of my assistants was Chinese, he also found it quite difficult to persuade Chinese to participate in a meeting with non-Chinese.

Table 3.4a Characteristics of single high school students participating in focus group discussions

Number	Pseudonym	Age	Ethnicity	Religion
FEMALES				
1	Indri	18	Malay	Moslem
2	Yuni	17	Javanese	Moslem
3	Lina	17	Chinese	Buddhist
4	Ana	17	Toba Batak	Christian
5	Yopin	17	Toba Batak	Christian
6	Gusnita	16	Javanese	Moslem
MALES				
1	Edi	16	Javanese	Moslem
2	Faisal	17	Malay	Moslem
3	Heri	17	Chinese	Christian
4	Roni	17	Chinese	Buddhist
5	Fakul	17	Javanese	Moslem
6	Amru	16	Mandaling Batak	Moslem

Note: Dates of interview: 2 November 1997 for females; 18 October 1997 for males

Table 3.4b Characteristics of single university students participating in focus group discussions

Number	Pseudonym	Age	Ethnicity	Religion
FEMALES				
1	Tetty	21	Malay	Moslem
2	Erna	23	Javanese	Moslem
3	Masdiana	23	Toba Batak	Christian
4	Silvi	22	Toba batak	Christian
5	Esther	22	Toba Batak	Christian
MALES				
1	Sakri	22	Javanese	Moslem
2	Ramos	24	Toba Batak	Christian
3	Marto	23	Karo Batak	Christian
4	Joni	21	Malay	Moslem
5	Maksud	23	Toba Batak	Christian

Note: Dates of interview: 11 October 1997 for females; 25 October 1997 for males

Table 3.4c Characteristics of single out-of-school young people participating in focus group discussions

Number	Pseudonym	Age	Education	Occupation	Ethnicity	Religion
WORKING (mixed)						
1	Amin (male)	20	JHS	Labourer	Javanese	Moslem
2	Ahau (male)	20	SHS	Trader	Chinese	Buddhist
3	Ijul (male)	24	University	Tutor	Malay	Moslem
4	Eva (female)	19	SHS	Karate instructor	Sundanese/Mandailing	Moslem
5	Ina (female)	22	SHS	Shop keeper	Javanese/ Minang	Moslem
6	Nida(female)	23	Academy	Secretary	Toba Batak	Christian
YOUTH ON THE STREET (males)						
1	Koko	20	Primary dropout	'Security'	Acehnese	Moslem
2	Hendy	19	SHS dropout	Broker	Toba Batak	Christian
3	Adi	18	JHS dropout	Parking person	Javanese	Moslem
4	Ano	17	JHS dropout	Unemployed	Malay	Moslem
5	Edy	16	Primary school	Street vendor	Javanese	Moslem

Note: Dates of interview: 19 October 1997 for working youth; 18 January 1998 for youth on the street

Table 3.4d Characteristics of married young people participating in focus group discussions

Number	Pseudonym	Age	Education	Occupation	Ethnicity	Religion
FEMALES						
1	Tari	20	SHS	Housewife	Javanese	Moslem
2	Zariah	24	JHS	Housewife	Javanese	Moslem
3	Iyus	24	SHS	Housewife	Javanese	Moslem
4	Puspa	24	SHS dropout	Housewife	Malay	Moslem
5	Adek	23	SHS dropout	Housewife	Minangkabau	Moslem
6	Rima	23	SHS	Housewife	Javanese	Moslem
MALES						
1	Anto	23	SHS	Labourer	Javanese	Moslem
2	Izul	24	SHS	Becak driver	Javanese	Moslem
3	Didik	24	SHS	Company driver	Batak/Javanese	Christian
4	Bambang	23	Univ. dropout	Trader	Mandailing Batak	Moslem
5	Hery	21	SHS	Motorcycle garage	Malay	Moslem

Note: Dates of interview: 15 January 1998 for females; 13 January 1998 for males

3.7 Conclusion

Looking at their socio-demographic characteristics, the respondents in this study reflected the heterogeneity of young people in Medan. However, because the number is too small and respondents were chosen purposively, they cannot represent young people in Medan. Therefore the data cannot be generalized to be regarded as representative of Medan's young people views and experiences.

Getting young people, especially unmarried, to talk about their opinions and experiences regarding sex was not easy. It requires special interpersonal communication skills to encourage young people to talk comfortably about very private issues. The interviewer should be open minded, not be biased by personal beliefs and standards and more importantly he/she should have non-judgmental attitudes towards other people's specific values and behaviours.

To open a discussion often was difficult, but when good rapport was reached, the participants in this study have been remarkably open about their opinions and experiences regarding sex and reproductive health. In the next four chapters the results of the survey, in-depth interviews and focus groups are discussed.

4 Entering adulthood: knowledge, attitudes and experiences of young people at puberty

4.1 Introduction

Adolescence indicates the psychological processes of adaptation to the condition of pubescence (Blos, 1962). Previous studies have suggested that the rapid biological changes during this period may cause embarrassment even stress for many girls and boys (Golub, 1983:26; Koff and Rierdan, 1995:796; Martin, 1996:20; King, 1999:250-253). These negative attitudes are mostly due to inadequate knowledge of the event. Boys and girls are often confused or unsure about the change and growth they are experiencing (Gaddis and Brooks-Gunn, 1985; Beyene, 1989:104-107; Adegoke, 1992). In addition, social reactions to these changes also place pressure on young people that may cause then more difficulty in adapting (Mensch *et al.*, 1998:44). In many societies including Indonesian society, puberty is culturally very important and is often marked by special rituals, commonly called initiation rites or rites of passage (Geertz, 1960:51; van Gennep, 1960:69; Hotvedt, 1990:164). One activity that is often performed as a rite of passage is circumcision (WHO, 1998). Despite the importance of puberty, very few studies focus on the attitudes and experiences of young people regarding this issue in Indonesia.

This chapter explores the knowledge, attitudes and experiences of Medan's young people at puberty, especially in relation to the onset of reproductive maturity. The questions raised in this chapter are: how do boys and girls experience the social and biological changes that occur as they become reproductively mature? What does this experience mean to them and to others? And what they know about human reproduction and ovulation?.

4.2 International perspectives on puberty

Biologically, puberty is universal. All human beings, regardless of their social and cultural backgrounds experience puberty. However its effect on young people's lives varies between cultures, subcultures and social groups, because the process of growing up is one of biological development that may be viewed as a cultural event (Brooks-Gunn and Reiter, 1990:35; Kiem, 1993:16). Every society may interpret these changes differently. As a consequence, attitudes and experiences of puberty may differ between girls and boys, as well as between ethnic groups.

The onset of puberty is marked by the initiation of secondary sexual characteristic development. The time and sequence of these physical changes is different between girls and boys; girls experience puberty about two years earlier. In girls the first sign of puberty begins with breast development, followed within a year or so by the growth of pubic and axillary hair, height spurt and changes in general physique. In boys, the onset of puberty begins with testicular enlargement, followed by growth in pubic hair, spurts in height and growth in penis size. The appearance of facial, axillary and other body hair starts about two years after pubic hair growth has started.

Reproductive maturity starts when a girl experiences menarche (the first menstruation) and a boy has a seminal emission or 'wet dream' (the first ejaculation). These usually occur two or three years after the first sign of adolescence (Hopwood *et al.*, 1990:48; Tanner, 1990). Most traditional societies define menarche and *spermarche* as indicators of an individual's maturity and readiness to enter adult life including marriage and sexual activities (Geertz, 1961:119; Paige and Paige, 1981:80; Muhaimin, 1995:201; Mensch *et al.*, 1998:44).

Adolescent girls receive more pressure from society than boys, especially in matters related to reproductive maturity. Menarche for girls is often a stressful event: they are unsure about the changes and growth they are experiencing.

Even those who have been informed about menarche and are excited about the impending event may find menarche mildly stressful. When it occurs they may greet it with mixed feelings including some negativity (Golub, 1983:26; Doan and Morse, 1985:15; Koff and Rierdan, 1995:796; Martin, 1996:20). For girls in traditional societies menarche may be even more stressful and depressing. Girls are often taught to believe that menstruation is a dirty thing and something to be ashamed of and hidden from others (Moore and Rosenthal, 1993:57; Humble, 1995:271). In addition at menarche girls' activities are often restricted, mainly to maintain virginity. Citing several studies in developing countries, Mensch *et al.* (1998:44) indicated that at menarche, girls' activities were restricted in many aspects including food preparation and consumption, socializing, religious practises, bathing, mobility, school attendance and sexual activity. In some societies where virginity is valued highly, several traditions are practised to preserve a woman's chastity. One of the most common of these is circumcision; in societies where this is practised, it is believed that a woman's sexual drive needs to be physically moderated to avoid promiscuity.

Compared to girls, aspects of puberty in boys are still relatively unknown. There is little information about the sociological and psychological meaning of pubertal changes in boys. Martin's (1996) study indicated that boys are less stressed during puberty than girls. She noted that 'girls' feelings of shame, objectification, and fear that are created by menstruation and breast development more negatively affect their self-worth than boys' feelings of pubertal uncertainty affect theirs" (Martin, 1996:58). For boys, puberty may be joyful. Boys obtain more benefit than girls from their physical changes: socially, they gain more independence and more recognition and from their parents and society (Martin, 1996:6).

Studies on the psychological effect of first emission for boys indicates that boys have a more positive reaction to it than girls have to menarche (Gaddis and Brooks-Gunn, 1985; Adegoke, 1992). Nevertheless, boys are more reluctant than girls to discuss their experiences with other people. Interviewing 13 boys aged

13.5 years and 15.5 years, Gaddis and Brooks-Gunn (1985) found that only a few of them had told other people, mostly their father, about their experiences. Not one of the respondents reported discussing their experiences with peers (Gaddis and Brooks-Gunn, 1985:66). This is slightly different from Adegoke's (1992) study among adolescent boys in Nigeria, which found that 57 per cent out of 188 respondents aged 12-18 years talked about their experiences with others, especially with their peers (Adegoke, 1992:205). Furthermore, King (1999:252) noted that fewer boys were prepared by their father for first ejaculation, than girls were prepared by their mothers for menstruation.

4.3 Medan young people's experiences of puberty

Previous studies have noted that age at menarche among girls in developed countries has declined over time (Wysack and Frish, 1982 cited in Bongaarts and Cohen, 1998:99). Considering the substantial improvement in nutritional status, a similar trend can be expected in developing countries for both males and females.

In this study, all respondents in the survey (463 males and 412 females) and in personal interviews reported having experienced menarche or wet dreams[1]. The mean reported age at menarche was 13.1 years, and the mean reported age at first ejaculation was 14.3. The earliest age at menarche reported was nine years (one respondent) and the latest was 17 years (four respondents); the earliest age at first ejaculation was 10 years (five respondents) and the latest was 18 years (six respondents).

Although there has been no study yet on the trend of age at menarche and first emission among Indonesian adolescents, most mothers interviewed in this study stated that their daughters reached menarche earlier than they had. None of the

[1] It is necessary to note that in the questionnaire, respondents were asked about their own experience with menarche for the girls only and wet dreams for the boys only. All respondents answered the question, nevertheless some respondents answered both. This may be because they interpreted the questions as knowledge on menarche and wet dreams.

parents interviewed reported knowing the age at which their son experienced his first ejaculation.

4.3.1 Attitudes and experiences of menarche and menstruation: the young women's story

The Medan women in FGDs and personal interviews all stated that they had been informed about menstruation before the first menses. Mothers are commonly reported as the first and the main source of information. Nevertheless most respondents said the information they received was not comprehensive. When asked whether they had heard about menstruation before they experienced it, most respondents answered 'yes, but not much'. The account below, from a personal interview, is a typical response from the women in this study:

> Before I got my first period my mother told me about it. I was told that when a girl gets big she will produce dirty blood, once a month, but at that time I did not really care and had no idea. I got my first period when I was in the fifth grade of primary school. I was going to take a shower at that time and I saw blood in my panties. I was a bit worried. At first I did not know why I was bleeding then I told my mother and she told me that was menstruation blood. My mother taught me how to use pads and how to wash my panties (Lina, 16 year-old, high school student, Malay).

Because of the insufficient information they received, some girls said they were slightly afraid and surprised the first time they menstruated. Others said they felt nothing special (*biasa aja*). Most of them were aware that menstruation is a normal and inevitable thing that a woman has to experience. This positive attitude may be because most of the women in this study had been menstruating for at least three or four years by the time of the interviews. By this time their attitude towards menstruation may be more positive than when they first experienced it (Wood *et al.*, 1983:96; Koff and Rierdan, 1995:797).

Unlike what was suggested by previous research in other countries (Golub, 1983:26; Doan and Morse, 1985:15; Koff and Rierdan, 1995:796; Martin, 1996:20)

most young women in Medan said menarche is not considered a stressful event, perhaps because of the help they received when they experienced it. Most girls said their mother provided a great deal of assistance the first time they experienced menstruation. Their mothers taught them how to use and when to change pads and how to wash their underwear. In the first three or four months, most girls said their mother always prepared disposable pads for them. None of the respondents reported use of cloths for menstruation. Many girls, especially Javanese, said their mother suggested regularly drinking traditional herbs (*jamu*) during menstruation. They believed that *jamu* could make the menstruation flow heavy smooth and painless[2]. Some participants in focus groups said their mothers often made the *jamu* for them during menstruation. Nevertheless very few young women said they regularly drink *jamu:* they do not like the bitter taste.

Many young women said they experienced some physical discomfort during menstruation; but none of them claimed to take it seriously enough to seek treatment. Nevertheless some girls said sometimes they needed to use pills to relieve the pain. The pills can be bought easily in supermarkets, drugstores or other places, without a doctor's prescription. The most common brand mentioned by the respondents for relieving menstrual pain was Feminax. Others said they preferred to take traditional herbs such as *jamu kunir asam, jamu pelancar haid, jamu datang bulan* or *jamu putri remaja.* These can be made or bought in many shapes including pills, capsules, powder or herbs that must be boiled with water.

Although culturally menarche is often associated with sexual maturity, none of the young women in this study said they received any information about sex when they experienced menarche. Most young women said the first time they menstruated, their mother or other older women in the family warned them to be careful with boys (*hati-hati sama anak laki*). A respondent said:

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[2] There is a belief among some people in Indonesia that heavy menstruation is a sign of health.

> When I just had my first menstruation, I was eleven, my mother warned me to be careful with boys. She said 'now you are a woman (*udah gadis*), so you have to be careful with boys'. At that time I was not sure what it meant (Ing, working, 22 year-old, Javanese).

For most young people in Medan, the reason for menstrual blood is still puzzling. Most respondents could not explain why a woman had a period once a month. Some women said menstrual blood is the unfertilised ovum (*sel telur yang tidak dibuahi*) while others said it is a woman's 'fate' (*kodrat wanita*). One female non-student respondent associated menstruation with Eve's sin. She believed that it is 'a burden' that must be faced by a woman because of Eve's sin for disobeying God. Menstrual blood is often considered dirty, therefore when a woman has her period, she is regarded as dirty (*sedang kotor*). Many local terms are used by respondents to refer to menstruation such as *datang bulan* ('monthly visit'), *berhalangan* ('unavailable'), *sedang kotor* ('being dirty') and *haid* or *mens* ('menstruation').

Some taboos associated with menstruation were also mentioned by young women. A participant in a focus group discussion among married women said that her mother forbade her to eat green bananas and pineapples after she reached menarche: she was told those fruits are also not good for a mature woman because they can cause the vagina to become too wet (*becek*). Others said they can cause vaginal discharge (*keputihan*). Another respondent, a 47-year-old Javanese woman, said that when she was young she was told not to eat fish during menstruation because it can cause the menstruation blood to smell (*bau amis*). Other taboos mentioned by young women were cooking rice, baking a cake and washing your hair during menstruation. Some of them said they believed in these taboos but most said they did not believe in them.

Talking about menstruation with those of the same sex is common, but talking about it with the opposite sex, especially fathers or brothers is considered very embarrassing. One focus group participant among female high school students said her mother told her that a good girl would not to let anyone, especially a

male, notice when she is having her period. Something dirty must be hidden. Another participant said she does not like the boys to notice because she believes they could make fun of her. Nevertheless some girls said that it is all right to talk about menstruation with their boyfriends or with their male best friends, especially if it is discussed in an academic manner.

Most young men in this study have general knowledge about menstruation. All men in the focus group and personal interviews said they knew that once a month a woman menstruates for about three to seven days. The young men also considered menstruation blood as dirty blood. An expression such as 'once a month a girl produces dirty blood' often appeared in the discussions. Boys' information about menstruation was received mostly from school, religious teachers and from friends including female friends.

Young women in this study receive better information and less restriction regarding menarche and menstruation than their mothers did; nevertheless, misinformation is still evident. Many girls are unsure what is happening to them when they menstruate. In addition, as menstrual blood is considered dirty blood, menstruating girls are often perceived as unclean. This negative attitude may discourage girls from learning more about the health aspects of this natural bodily function.

4.3.2 Attitudes and experience of first emission and masturbation: the young men's story

Unlike young women, most young men said they never talked about wet dreams in the family. None of the male focus group participants or respondents in personal interviews (10 respondents) had ever talked about wet dreams with their parents or their brothers; talking about wet dreams with the family is considered very embarrassing. Below are reactions given by focus group participants and respondents in personal interviews when asked 'Have you ever talked about wet dreams in your family?':

> No, in fact I cannot imagine talking about such things in my family. It is too embarrassing. I do not have any brothers and I rarely talk with my father (Ciko, 23-year-old, Toba Batak, university student).

> Never, I do not know why. We talk about a lot of things in the family, but never talk about such things. Maybe that is why I don't feel comfortable to talk about it even with my brother, let alone with my father (Apo, 24-year-old, Javanese, university graduate).

> No. I don't think anyone will talk about it within the family. I think it's taboo (Ano, 17-year-old, Malay, unemployed, junior high school dropout).

Similar answers also appeared in personal interviews with fathers (five respondents). One respondent, a 50 year-old father of two sons (22 and 25 years old) and two daughters said:

> I never talked about it with my sons. Actually, I never even thought that I needed to but then since you asked, yes I think it is important for parents to inform their sons about it. But I don't think I can do it. It would be very embarrassing. How could I tell them? (HS, Toba Batak).

Another respondent, father of two teenage sons (19 and 18 years old) said:

> I never talked about it with my sons because they never asked. If they ask me, I will tell them. However my sons never talk about personal things with me, they prefer to talk about those things with their mother (D, 49-year-old, Javanese).

The main sources of information for most boys before puberty are religious teachers (especially among Moslems), school teachers and teenage magazines. Almost all young men said they had heard about wet dreams before they experienced their first ejaculation. Nevertheless, according to some respondents, the information they received from peers, religious teachers (*guru ngaji*) and school teachers was not clear. A Moslem respondent said:

> I knew about wet dreams first from my religious teacher (*guru ngaji*). It wasn't clear. My teacher told me when a boy was entering *akil- balig* (maturity), he will have wet dreams and then be able to have children. At that time I had not had my *spermarche* and I was too shy to ask [what he meant] (Iwan, 17-year-old, Malay, high school student)

According to young people, information from magazines is more comprehensive than information from school or religious teachers. Those who reported reading articles about wet dreams in teenage magazines were more knowledgeable than those who had never read any article about it. In a personal interview, Apo said:

> I've heard about wet dream from school and my religious teacher (*guru ngaji*). But the information was unclear. I learned a lot about wet dream from '*Hai*' magazine. I read an article about it several months before I had a wet dream. So, when the first time came, I did not have any negative feelings such as worry or being scared. I did not tell anybody, because I don't think it is necessary, what for? I already knew all about it. From the magazine I knew that it was very natural and there was nothing to worry about (22-year-old, Javanese, university graduate).

Most respondents reported experiencing their first ejaculation when they were in junior high school. None of the respondents said they were afraid or worried the first time they had a wet dream. Some of them said at first they felt guilty for having such dreams[3], then they felt fine when they noticed they had ejaculated.

> At first I felt a bit guilty for having such dreams (*mimpi masalah 'gituan'*). But then when I realized that it was a wet dream, I felt fine (Jojon, 21 year-old, Malay, university student).

Most respondents interviewed personally said they did not tell anybody about their first experience. Some said they told only their close friends who had had ejaculations but not those who had not yet experienced it. One respondent in a personal interview said:

> I had my first wet dream when I was in the first year of junior high school. I did not tell anybody about it, including my friends. At that time I was afraid that they might tease me if they noticed. Because as far as I knew not many of my friends had had it, so I was a bit shy. You know, being different from your friends at that age was very embarrassing (Luther, 20-year-old, Toba Batak, university student).

According to most respondents, talks about wet dreams among junior high school students were not as open as those in senior high school and university, among whom sharing experiences about wet dreams was no longer embarrassing. This is because they believe that almost all of their peers have had

similar experiences by that time. One respondent, a university student, said that when he was still in high school it was common to share one's 'dreams' and some people even shared their sexual experiences. In university there was less talk about wet dreams than in high school, but more about actual sexual activities. All young men interviewed in this study reported experiencing first ejaculation by a wet dream. However many respondents said they had friends who had first ejaculation by masturbation.

Information obtained from focus groups indicates that after the first ejaculation, most young men often masturbated. When asked in focus group and personal interviews whether they ever masturbate, most respondents answered spontaneously *'udahlah kak, sering kali pun* (off course we have, in fact very often)'. Most young men believe that masturbation is unavoidable for unmarried people. It is necessary to avoid premarital sex. Nevertheless most focus group participants and respondents, especially Moslems, agreed that according to religion, masturbation is wrong. Some respondents said that the first time they masturbated, they felt guilty and as if they had sinned; but after doing it several times (*setelah biasa*) they did not feel guilty or sinful any more. One respondent said that nowadays among some young people, instead of feeling sinful or guilty about masturbation, there is a tendency to seek justification for this activity. Arguments such as *'dari pada nge-sex lebih baik 'ngocok'* (it is better to masturbate than have premarital sex)' are often raised in discussion among young unmarried men. They believe masturbation to be less sinful than premarital sex.

Some myths about masturbation were raised in focus groups and personal interviews. Myths such as that masturbation may weaken a man, reduction in the amount of sperm can cause infertility (*mani encer*) and a man may not be able to enjoy actual sexual intercourse were known by most respondents. Most young people were not sure whether or not these myths were based on facts.

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[3] Many people believe that having a sex dream is a sin.

For most young women, knowledge about men's experiences of reproductive maturity is very limited. The concept of a wet dream (*mimpi basah*) is a mystery for most young women. When asked what they know about wet dreams, most women said 'not much'. However, most women said they know that wet dreams are an indication of reproductive maturity for men. The boys seldom talked to girls about their experiences, and girls feel too shy to ask them about it. According to respondents, the information given in school is vague. There is no explanation of why, when and how often a man has wet dreams. One focus group participant among female high school students said:

> I do not know anything about wet dreams. I don't know how, when and why it happens. I just know that if a girl has menstruation, a boy has wet dreams. But do men have wet dreams once a month and how long does it take, I mean how many times does it happen in a month? Is it the same as with us women? I wonder (Gusnita, 16 year-old, high school student, Javanese).

When she raised those issues, none of participants in the focus group could explain the matter to her satisfaction. Then when I asked the same questions in other female focus groups (college students and married women), many of them said they had no idea.

However, some respondents in personal interviews said they learned about wet dreams from their male best friends (*teman akrab cowok*), whom they usually asked anything they wanted to know about a man. Sensitive issues such as menstruation and wet dreams were sometimes discussed in a group of close friends from both sexes. Female Moslem respondents said they knew about wet dreams from their religious teacher (*guru ngaji*).

4.4 Circumcision

In his book published in 1885, Wilken concluded that circumcision in Indonesia was originally a cultural event and had been practised before the advent of Islam to this region. It was practised among people in Java and some parts of Eastern Indonesia (Wilken, 1885 cited in Kaptein, 1995). Nowadays circumcision is

considered to be a religious obligation, and is widely practised by Indonesian Moslems regardless of ethnicity. In some provinces it is applied to both males and females, while in other areas it is largely practised by males.

There are many forms of circumcision for both males and females. Citing Bryk's 1931 study on circumcision, Kaptein (1995:285) noted there are at least 18 forms of male circumcision including 'the *amputatio* penis, the *castratio*, the *extirpatio testiculi sinistri*, the *perforatio glandis* (a pin or a bar is pierced crosswise through the penis) and the *implantatio* (bells, balls or all kinds of other objects were inserted under the skin of the glans or the shaft of the penis)'.

In Indonesia, the practice of male circumcision involves the cutting of some part of the foreskin of the penis or according to Bryk's classification, it can be categorized as *circumcisio partialis* (Kaptein, 1995). Male circumcision is a religious obligation and a sign that one is a Moslem. Therefore those who convert to Islam are encouraged to be circumcised. It is usually performed when the boys are entering puberty at ages of about nine to fourteen (Geertz, 1960:51; Wessing, 1978:133).

Female circumcision can be classified into at least four types. There is 'excision of the prepuce, excision of the clitoris, excision of part or all of the external genitalia and unclassified including pricking, piercing or incising of the clitoris and/or labia or any other procedures included in the definition' (WHO, 1998). Traditionally, in Africa where female circumcision is commonly practised, it is mostly performed as part of the activities in initiation rites (Koso-Thomas, 1987; Delaney *et al.*, 1988; Dorkenoo & Elworthy, 1992; Hosken, 1993; WHO, 1998). Koso-Tomas (1987) noted there are many reasons given for adopting this practice. Among those are 'maintenance of cleanliness, pursuance of aesthetics, prevention of still-birth in primigravida, promotion of social and political cohesion, prevention of promiscuity, improvement of male sexual performance and pleasure, an increase in matrimonial opportunities, maintenance of good

health, preservation of virginity and enhancement of fertility' (Koso-Thomas, 1987:5-9).

Unlike male circumcision, female circumcision is only practised by some Indonesian Moslems. Nevertheless it is widely practised among Moslems in Medan regardless of ethnicity. The practise in Medan, as well as in other places in Indonesia, is very different from that in Africa or in some countries in the Middle East. In Indonesia, female circumcision is mostly performed at a very early age, about two weeks to three months after birth (Hosken, 1993; Adrina *et al.*, 1998) although in the past apparently it was commonly done when a girl reached the age of eight or nine (Geertz, 1960:20; Wessing, 1978:133). Female circumcision in Indonesia usually does not involve the removal of the clitoris or other parts of the vagina. In Java, some people only practise it symbolically (Hosken, 1993:280), others usually only prick the skin around the clitoris with a needle, cutting a bit of the skin around the clitoris or removing a 'small white thing on the tip of the clitoris' (the clitoral hood). Interestingly, although it is mostly done in infancy or during childhood, many people believe that female circumcision is necessary to lessen a woman's sexual drive in order to avoid promiscuity (Adrina *et al.*, 1998:4-5). This belief is also found in the Arab world (Hosken, 1993:130).

Many Indonesians, including researchers, consider that circumcision is not a significant issue for reproductive health in Indonesia. Few studies discuss the issues of circumcision (mainly female circumcision) from a reproductive health perspective (Hosken, 1993:1-5; Adrina *et al.*, 1998:2-7). In the past most studies focused on the religious and ceremonial activity of circumcision (Geertz, 1960; Wessing, 1978; Kaptein, 1995; Muhaimin, 1995). As a result there is very little information about the health issues of this activity. Nevertheless, in accordance with the heated debate over circumcision in international forums, there has been a growing awareness of the need to explore the health aspects of this practice in Indonesia.

4.4.1 Female circumcision: attitudes and experiences of young women

There is a range of opinions regarding female circumcision among young people in this study. Many of them said it is a religious obligation, some said it is not obligatory (*kewajiban*) but a preference (*keharusan*) (permitted by religion, neither sinful nor meritorious) while others were not sure whether it is a religious obligation or a tradition. Nevertheless almost all Moslem women interviewed reported being circumcised when they were a baby or a child. Reasons given by respondents for the need to circumcise a woman included to lessen sexual drive, to clean a woman's body from dirt and to avoid genital diseases. Of those who believed that circumcision is obligatory in Islam, the most common reason given was that a woman must be cleaned from all dirt.

Unlike in Java, where some people practised female circumcision symbolically by rubbing or cutting turmeric around the vagina, none of the respondents agreed that it could be done symbolically. According to respondents, female circumcision has to involve the removal or the cutting of the tiny white thing ('the size just like a grain of rice') on the tip of the clitoris. It is believed that this part contains disease and is possessed by a devil and can cause a woman to become promiscuous. Below are the opinions given by some female respondents when asked why a woman needs to be circumcised:

> All Moslems have to be circumcised. When I asked my *ustaz* (religious teacher), he told me that on the tip of female the genital there are diseases (*kuman penyakit*), and it also lessens a woman's sexual drive, because there is a devil there (Von, 16- year-old high school student, Mandailing Batak).
>
> A Moslem girl has to be circumcised in order to clean her genitals from dirt (*najis)* (Lin, 17- year-old high school student, Javanese).
>
> In Islam, a girl has to be circumcised to clean her genitals, so she would not be easily contaminated by genital diseases. Circumcision is performed in order to throw the dirt away from a woman's genital. It can be done by a midwife, a doctor, a nurse or a *dukun* (traditional healer) or an old woman (Sofi, high school student, 17 year-old Malay).

But not all respondents were sure about why a woman has to be circumcised. They believed that female circumcision is compulsory in Islam, but could not really explain why. One respondent said:

> I think circumcision is compulsory for Moslems. I was told it would make us clean. But clean from what, I am not sure (Ratih, senior high school student, 17-year-old Javanese).

Other respondents were not even sure whether it is a religious obligation or a tradition. A focus group participant among young working people said:

> I don't really know why a woman has to be circumcised, maybe it is a tradition. I never asked my parents about it. I just obeyed what my parents told me. Also I don't feel comfortable to question what old people say. It's a tradition (*namanya tradisi*). I was in my second year of primary school (about 8 years old) when I was circumcised. It really hurt, especially when urinating. But it was only for two or three days. I was circumcised at home, my parents called a midwife to circumcise me. There was no ceremony or party, not like a boy's circumcision (Ina, working, 22-year-old Javanese).

A male respondent, graduated from the National Institute of Religion of Islam (IAIN) said that in Islam female circumcision is not an obligation but a preference. This means that if a girl is circumcised, she will not receive a *pahala* (reward for moral conduct), and if she is not circumcised it does not mean she is sinful. He said female circumcision was a tradition during the prophet era (*jaman nabi*) which was then converted into religious doctrine.

Uncertainty about female circumcision also appeared among parents, especially those relatively uneducated. The educated argued that it is a religious obligation. An interview with an old Javanese lady, 67 years old, mother of three daughters and grandmother of seven granddaughters, who worked as a housekeeper said:

> I don't know why a woman has to be circumcised, but I circumcised all my daughters and grand daughters. It is a tradition that has been practised since a long time ago. I think everybody practises it, so I just follow. I didn't dare to disobey. All my daughters were circumcised by traditional birth attendants when they were around two or three months old. I never saw when they were circumcised, I didn't have the heart to see it (*enggak sampai hati*). I really pity them, but what can I do (*kek mana lagi*) it is a tradition that has to be done.

4.4.2 Male circumcision: attitudes and experiences of young men

All Moslem men in this study reported having been circumcised. Although in some places in Eastern Indonesia male circumcision is also practised by non-Moslems, none of the non-Moslem respondents in this study reported having experienced it. The circumcision was generally performed when they were in the fourth or fifth grade of primary school or when they were 10 to 12 years old. According to respondents, a Moslem male has to be circumcised soon after puberty (*akil-balig*). A respondent said that when he was a child, he was told that if a boy is circumcised too early (before puberty) he might not grow up (*tidak bisa besar*), while if it is done too late he will be teased and accused as a coward and 'not yet a man'. Owing to peer and social pressure, usually it is the boys who asked to be circumcised. Nevertheless decisions on when and where the circumcision takes place are taken by the parents.

The main reason for circumcision given by all Moslem respondents and focus group participants was religious obligation. They believed that to be considered 'an adult Moslem', one has to be circumcised. Some young people, especially those in college, said male circumcision is also good for a man's health, to keep his genitals clean. None of the respondents and focus groups linked male circumcision with tradition or *adat*. Nevertheless, all respondents said their family celebrated the occasion with a traditional ceremony (*slamatan* or *kenduri).*

Although male circumcision is considered a religious obligation, in most Indonesian societies it is an occasion for a great traditional celebration (Geertz, 1960; Wessing, 1978; Muhaimin, 1995). Among Moslem Javanese in Cirebon, West Java, a newly circumcised boy is treated as 'a king for a day' (*raja sehari)* or as a 'circumcised groom' (*penganten sunat*) (Muhaimin, 1995). Usually he will be dressed like a groom or dressed in a 'Moslem fancy cloth' with a *sarung* (a sarong) and a *kopiah* (a special hat). The celebration usually takes place immediately after the operation. If the operation is done in the morning, then the celebration takes place in the evening, or if it is done in the afternoon, the

celebration takes place the next day. However, one respondent said his circumcision celebration was held several weeks after he was circumcised, when the wound had healed.

For most young people in Indonesia, circumcision is not regarded as a traumatic event. In fact, many of them considered it a time for holding a big party and receiving a lot of money. Therefore, according to respondents most boys were looking forward to this occasion. Although some of them said they were a bit afraid before the operation, it did not last long. When asked 'What is the thing that you remember when you were circumcised?' many respondents spontaneously said 'party and receiving a lot of money and gifts'. In a personal interview, one respondent said:

> I was circumcised a bit young compared to my friends at that time. At first I was reluctant, because I was afraid it might hurt. Then my parents persuaded me (*di iming-imingi*) by telling there will be a big celebration for me and they will invite a lot of guests. I was told that all the guests would give me money or presents. Then after being circumcised, I felt proud, I felt like an adult although it was painful (Santo, university student, 22- year-old Javanese).

In the past, circumcision was performed by a traditional circumcisor called a *calak, bong, paraji sunat* or *dukun sunat,* who usually had no medical training. However, nowadays many people, especially in urban areas, prefer to go to a hospital or clinic where circumcision is performed by a male nurse or a male doctor. Most young men in this study reported being circumcised in a hospital or clinic; others reported going to a *dukun sunat.* Information from personal interviews with some parents revealed that in Medan the place where a boy is circumcised may indicate the social status of the family in society. The more expensive the place, the higher the status. This attitude was also found among Moslem Javanese in Cirebon, West Java (Muhaimin, 1995: 200).

According to most respondents, the healing process was more painful than the circumcision itself, especially when urinating. During that time they usually received special treatment from their family. It takes one to two weeks to heal the

wound. After the operation the wound is dressed. Some respondents said the bandage was changed every day or once in two days, some said only once in a week and others said it was not changed until the wound was healed. None of the young people in this study reported having problems after being circumcised. Nevertheless, a focus-group participant among out-of-school youth mentioned that his friend's brother had had an infection after circumcision and had to be hospitalized.

4.5 Human reproduction: what do young people know and think about it?

The most common indicator to measure young people's knowledge of human reproduction is to ask whether they know when the fertile period for a woman is or the days of the cycle when pregnancy is most likely to occur (Nichols *et al.*, 1986:102; Ajayi *et al.*, 1991:207). Usually it is between 12 and 17 days after menstruation. In this study the respondents in the survey were asked similar questions. The questionnaire is a mixture of closed and open questions. The respondents were asked 'Have you ever heard of a woman's fertile period, if yes please explain'. Then those who said they had heard it were asked a further question: 'Could you identify the fertile period of a woman's menstrual cycle, if yes please explain?'

Table 4. 1 shows the percentage of male and female respondents who reported having heard about a woman's fertile period, and claimed to be able to explain and to identify the fertile period of a woman's menstrual cycle, according to socio-demographic characteristics. The figures indicate that respondents' knowledge about a woman's fertile period is very poor. Although 60 per cent of male and 77 per cent of female respondents stated they had heard about a woman's fertile period, few of them were able to explain the concept.

Table 4.1 Percentage of male and female respondents who have heard of, and claimed ability to explain and to identify the fertile period of a woman's menstrual cycle, by socio-demographic characteristics

	Have heard		Claimed able to explain[a]		Claimed able to identify[a]	
	Males N=463	Females N=412	Males N=288	Females N=323	Males N=288	Females N=323
ALL	60	78	55	64	24	37
Age group						
15-17 years	56	73	51	69	23	29
18-20 years	61	78	53	59	18	40
21-24 years	63	80	61	63	29	43
Activity	**		*			
Study	67	77	54	67	25	38
Working	37	80	68	55	25	33
Unemployment	64	65	31	43	6	29
Religion						
Moslem	61	73	55	60	20	36
Christian	58	82	56	64	31	41
Buddhist/Hindu	59	77	50	77	21	31
Ethnicity						
Javanese	56	71	62	51	19	46
Toba Batak	62	77	52	61	31	38
Mandailing Batak	55	64	53	56	24	24
other Batak	58	89	58	72	27	34
Malay	68	81	63	69	17	36
Chinese	57	80	57	71	27	35
Other	66	74	38	70	21	43
Living arrangement					*	
With one or both parents	59	76	52	63	26	36
With sibling or other relative	61	76	53	75	8	41
Boarding house	64	81	70	62	30	40
Mother's education	**					
Part/finished elementary	39	74	60	67	27	29
Finished JHS	57	71	53	53	18	35
Finished SHS	65	79	56	68	24	39
University/academy	78	79	53	64	27	39
Father's education	**					
Part/finished elementary	45	80	63	81	23	28
Finished JHS	45	76	45	49	23	28
Finished SHS	61	71	53	65	18	41
University/academy	74	82	58	64	30	39
Mother's occupation						
Public servant/retired	65	76	64	60	25	33
Employee/laborer	57	65	64	82	29	27
Trader	60	77	59	68	21	38
Not employed	61	77	49	59	24	37
Others	54	80	59	76	27	40
Father's occupation						
Public servant/retired	64	78	55	65	22	43
Employee/laborer	58	78	56	57	28	28
Trader	53	73	60	71	24	29
Not employed	39	78	50	63	17	63
Others	64	74	51	62	27	40

Notes : * = Significant at $p < 0.05$ ** = Significant at $p < 0.001$

[a] These questions are only applicable for those who reported having heard about a woman's fertile period

Source : Medan Adolescent Reproductive Health Survey, 1997-98

Of those who said they had heard of a woman's fertile period, 60 per cent (55 per cent of males and 64 per cent of females) claimed to be able to explain, while only 31 per cent (24 per cent of males and 37 per cent of females) claimed to be able to identify the event. Furthermore, of those who claimed to be able to explain the period, only a few could explain it correctly, and even fewer could identify the event correctly.

The majority of respondents who claimed to understand a woman's fertile period answered incorrectly. The typical incorrect answers were 'during menstruation', 'soon after menstruating', and 'when a woman is very sensitive emotionally'. Further, the majority of those who thought they could identify the fertile period said that it is a week before and a week after menstruation.

As expected, women have better knowledge than men. There is no significant difference among female respondents in their knowledge about a woman's fertile period according to socio-demographic characteristics. On the other hand, differences by main activity and parents' education were related to whether men had heard of a woman's fertile period. Young men who are in school and who had educated parents are more likely to report having heard about a woman's fertile period than are those who dropped out of school and had less educated parents. Activity was significantly related with claimed ability to explain a woman's fertile period; main activity was also significantly related with this claim and only among men was living arrangement significantly associated with claimed ability to identify the period.

However considering the high number of those who claimed to be able to explain and to identify, but did so incorrectly, these findings need to be interpreted carefully. For example, for both sexes there is no significant difference between young people in school and out of school who claimed to be able to identify a woman's fertile period but this does not necessarily mean that the knowledge of those in school and out of school is similar. Students may

prefer to answer 'do not know' to the question when they are unsure or do not remember, rather than give an incorrect answer.

The poor knowledge of young people about the fertile period of a woman also relates to their limited knowledge on the menstrual cycle. Most respondents did not know that the average length of an adult menstrual cycle is about 28 days. Therefore many young women believed they have an irregular period if it does not appear at the same date each month. According to a female respondent,

> My period is irregular. I seldom have it at the same date each month. Most of the time it appears two or three days earlier than the previous month. But I don't worry about it, because many of my friends also have the same problem. So I think it is normal (Sofi, 17-year-old high school student).

Focus group discussions among students revealed that information about human reproduction is taught in biology class in the second year of high school. Nevertheless, most participants reported that the information they received was not practical and not interesting. They thought it was very technical. According to a focus group participant among male university students:

> The information I received in high school was very technical, honestly, I found it a little boring. For example, when we learned about ovulation there was no information about when it occurs. Whether it occurs soon after intercourse or in a day, week or month was not clear. And when we were taught about the fertile period, we were not taught about the safe period. I knew about those things from magazines and friends (Joni, 21 years old, Malay).

The reluctance of some teachers to discuss human reproduction in class was also mentioned by some respondents in personal interviews and the focus groups. Some teachers, especially young women, were often embarrassed when explaining issues related to sex. A focus group participant among female high school students reported:

> My biology teacher is a single young woman. When she was teaching us about ovulation, one of the male students asked her a 'naughty' question. He pretended to be 'innocent' and asked the teacher to explain more about how to make a sperm meet an ovum. At that time everybody laughed and the teacher went red (*gurunya*

> *merah*), she just ignored the question and finished the subject quickly (Lina, 17 years old, Chinese).

Many female respondents especially those who studied in mixed gender schools, also felt shy about asking many questions about human reproduction in the class. They were afraid that the teacher and their friends would became suspicious.

In focus groups when the participants were asked 'Is it possible for woman to be pregnant from a single sexual intercourse?', some respondents said no, but the majority said it was possible provided the woman is very fertile. However, when they were asked further what they meant by fertile, most respondents said it could be seen from a woman's appearance and her healthiness. Very few of them referred to a woman's menstrual cycle.

4.6 Conclusion

Despite the importance of puberty in many cultures, most young people do not receive sufficient information or are dangerously ignorant regarding this event. Misunderstandings are evident among young people on issues related to menstruation, ejaculation, masturbation and the fertile period. Most young people are not aware of the importance of understanding the changes they experience during puberty. The information they receive from friends and religious teachers is not sufficient. Most parents, especially fathers, are uncomfortable to talk about problems related to reproductive maturity with their own children. Nevertheless both young people and the fathers, when asked whether it is necessary for parents, especially fathers, to provide such information for their children, mostly agreed.

Among Moslems in Medan, circumcision is widely practised for both sexes. Nevertheless, they tend to be still uncertain about this activity, especially female circumcision. There are three main opinions regarding female circumcision: that female circumcision is not a religious activity, that it is a religious obligation and

that it is a religious activity but not an obligation (*sunnah*). Regardless of their reasons for being circumcised, most Moslems in Medan practise it. Although nowadays more people prefer to go to medical personnel to perform the operation, some people, especially the uneducated, still practise it traditionally. Very few young people are aware of the health consequences of this activity.

As they have limited knowledge about a woman's fertile period, young people in Medan are ignorant of the menstrual cycle. Although most young people in this study reported having been taught about human reproduction in high school, many of them did not know that the average length of an adult menstrual cycle is about 28 days. This ignorance obviously puts young people at greater risk of unwanted pregnancy, particularly if they are relying on traditional methods which focus on abstinence during ovulation.

With this limited knowledge, young people in Medan then enter adulthood and are exposed to adult life including pornography and sexual activities. The majority of young unmarried Indonesians may not yet be involved in sexual activities, but some of them have had unprotected sex without knowing the risks they face. There is evidence that the proportion of young Indonesians living with this risk is increasing. In the next three chapters, these issues are explored.

5 Chastity and curiosity: tensions in premarital sex

5.1 Introduction

Young people today confront demands and expectations as well as risks and temptations that seem more numerous and more complex than any facing youth in their parents' generation. They often face a dilemma between conservative norms, which value chastity highly, and modern norms, which are more tolerant toward premarital sex. By nature, they are eager to experiment with new things, especially related to 'adult lives', including premarital sex and pornography in the belief that this will take them effectively into adulthood. The transition from a traditional to a modern society has raised concern about changes in Indonesian young people's lives and values, in particular regarding premarital sex.

Based on information obtained from both the survey and in-depth interviews including focus group discussions, this chapter examines young people's attitudes and experiences related to virginity and premarital sex. The questions raised in this chapter are: what does virginity mean to young people? What are the factors affecting young people's attitudes and behaviour regarding premarital sex? What are the differences between women and men regarding virginity and premarital sex?

5.2 Chastity: maintaining 'purity'

Previous studies indicated that socio-cultural factors play a major role in how young people express sexual arousal (Serbin and Sprafkin, 1987:184; Brooks-Gunn and Reiter, 1990:45). One indicator of the strength of societal control on sexual behaviour, especially for women is virginity (Carael, 1995:93; Silva *et al.*, 1998:383-385). Traditionally the concept of virginity is an ethical matter arising from the assumption that a woman's hymen possesses a quality of peculiar high moral value (Ploss *et al.*, 1935: 37). The intact hymen was commonly believed to be the sole and definitive mark of virginity. It is considered as a symbol of purity, family honour and also fertility (Ploss *et al.*, 1935; Schneider, 1971; Schlegel, 1991; Renne, 1993). Women are expected to be 'pure' and remain chaste until marriage; and an intact hymen is evidence of this. Men in contrast were commonly given more sexual freedom than women (Hassan, 1980; Silva *et al.*, 1998:391,) and were not burdened by any physical evidence of sexual experience.

In Indonesia, the high value of virginity was introduced after the coming of modern religions such as Islam and Christianity (Nemecek, 1958:67; Reid, 1988:153; Utomo, 1997). Reid (1988: 153) noted that before Islam was introduced to the Malays and the Javanese, premarital sex was regarded indulgently and virginity at marriage was not expected. Nemecek (1958:67) wrote that, about the year 1840, premarital sexual activity for both sexes among the Batak in North Sumatra was generally accepted. Reviewing the literature and historical studies on sexual behaviour in Indonesia, Utomo (1997:57-66) reported that sexuality was open among many societies, then it changed after the coming of Islam and the influence of Dutch-formulated marriage regulations.

Since the introduction of Islam and Christianity, most Indonesian societies have come to value virginity highly. Studies of the Malays and Chinese in the early 1900s indicated that some Malay and Chinese families practised a virginity test at the time of marriage consummation (Alwi, 1962; Yusuf 1966; Hassan, 1980). Virginity was very important in a marriage. Failure to prove virginity (usually by the traces of blood on the marital bed) could cause the breakup of the marriage. Vergouwen's (1964) study in Samosir Island in the 1930s found that the

Toba Batak girls were very sensitive about their virginity status. He wrote: 'should people talk about a girl, she will not hesitate to be examined by a doctor and, armed with a declaration of her virginity, will turn to authority complaining of slander' (Vergouwen, 1964:166). More recently Bovill's study among the Toba Batak in Medan indicated that apart from religion and ethnicity, virginity was the most important consideration for a woman to be a potential spouse (Bovill, 1986:303).

However, recent studies indicate that for many Indonesian young people, virginity is no longer seen as an important factor in arranging a marriage (YKB, 1993; Singarimbun, 1996:118). Virginity tests are no longer practised. A study among never married young people aged 15-24 years in Medan in 1993 revealed that more than half of respondents (60 per cent of 301) disagreed that virginity is something important or special. The study also reported that only 18 per cent of all respondents agreed that virginity was an indicator of being a respectable woman (*citra wanita baik-baik*) (YKB, 1993). Another study among unmarried men aged 17-24 years in Yogyakarta and Bali reported that 48 per cent out of 181 respondents in urban Bali and 50 per cent of 185 respondent in urban Yogyakarta disagreed that a woman has to preserve her virginity until married (Singarimbun, 1996:118).

5.2.1 Concept of virginity for young people: is it a biological or social matter?

For today's young people, female virginity was not necessarily indicated by an intact hymen as it was in the past. Information obtained from the focus groups in my study revealed that there were two definitions of female virginity. One opinion argued that regardless of the cause, once a woman's hymen tore, she was no longer a virgin. The other opinion stated that woman's virginity is more about behaviour, whether she has ever had penetrative sexual intercourse. Below are some young people's definitions about female virginity:

> In my opinion a woman is a virgin if her hymen is still intact, that is why she is called *'anak dara'* (a hymen girl) (Inong, 22- year-old, working woman, Javanese).

> If the hymen ruptures because of a fall, in a way (*istilah halusnya*) she is a virgin, but actually I think she is not a virgin (Yopin, female, high school, 17-year-old, Batak).
>
> In my opinion, virginity means never having had sex, because if someone has had sexual intercourse, where a penis (*'itunya' laki-laki*) entered a vagina, but because of the elasticity of her hymen, it did not tear, for me she is no longer a virgin (Lina, female, high school, 17-year-old, Chinese).
>
> I once watched a movie on TV. A woman fell off her bike, then her virginity 'disappeared' (*hilang*), in my opinion, she is still a virgin (Sakri, male, university student, 22-year-old, Java).

The biological and social meanings of virginity also appear in the Indonesian language associated with female virginity namely *anak dara, keperawanan, kegadisan* and *kesucian*. Literally, the meaning of *anak dara, keperawanan, kegadisan* is having a hymen, whereas *kesucian* (purity) is more related to the condition of being 'pure'. Unlike female virginity there is only one term that is usually related to male virginity: *perjaka or keperjakaan.* The definition of male virginity is also simple: never having had vaginal intercourse. In my study, all the respondents that I interviewed personally and the focus group participants agreed to this definition.

In the past when people were referring to unmarried people in general they used the terms *perjaka* for men and *gadis, perawan,* or *anak dara* for women. However, nowadays these terms are rarely used, especially among young people. One respondent, a university student, stated that those were old-fashioned words and no one used those terms any more. He noted that if one of his friends used those expressions, the others would tease him or her: 'Are you sure? How do you know?'. According to him, this is because premarital sex is so common among young people that a virgin bride or groom might be difficult to find.

5.2.2 Young people's opinions of virginity

To explore values and attitudes of young people related to virginity, the respondents in my study were asked several questions, such as: 'Do you think a woman needs to preserve her virginity until marriage? And a man? What do you think is the most important factor for choosing a future spouse? What would you do if you found out that your future spouse was no longer a virgin?[1].

Table 5.1 Respondents' opinions and attitudes about virginity

	Male % N=463	Female % N=412	Male+Female % N=875
Chastity is necessary for a woman	92	92	92
Chastity is necessary for a man	65	85	74
Most important factor in choosing spouse			
Virginity	38	26	32
Personality regardless of virginity	44	47	45
Family background	18	27	23
Attitude if future spouse is no longer a virgin			
Break the engagement	28	27	28
No problem	59	59	59
Reconsider the engagement	12	14	13
Other	1	1	1

Source: Medan Adolescent Reproductive Health Survey, 1997-98

Most young people in my study agreed that chastity is 'necessary'. As seen in Table 5.1 almost all respondents (92 per cent) said that a woman needs to preserve her virginity until marriage but fewer respondents (74 per cent) agreed it is 'necessary' for a man. A clear double standard regarding virginity is evident, among young people, but this is stronger among men. Almost all men (92 per cent) agreed that a woman must remain chaste, while only 65 per cent believed that chastity is necessary for a man.

Despite respondents' general opinions about the need for chastity, when asked what is the most important factor in choosing a future spouse, only 32 per cent of all respondents said virginity. Many respondents (47 per cent female and 44 per

[1] In the questionnaire I did not provide a technical definition of virginity, so the respondents' answers to these questions are based on their own concepts and definitions.

cent male) believed that personality was more important than virginity. Interestingly, family background including ethnicity and religious affiliation seem to be more important for young women than for young men. More than a quarter (27 per cent) of female respondents said family background was the most important factor in choosing a future spouse while only 18 per cent of male respondents gave a similar answer.

The patterns of respondents' opinions on the most important factor for choosing a future spouse were consistent with the pattern of respondents' attitudes if they found out later that their future spouse was no longer a virgin. Many respondents (59 per cent) said they would not mind, while 28 per cent stated they would break up, and 13 per cent stated they would reconsider their plans. There was no significant difference between men's and women's attitudes if they found out later that their intended spouse was no longer virgin. Some of those who answered that they would reconsider their plan said it depended on how the future spouse lost his or her virginity. They mentioned that if it was not because of sexual relationship or if it was because of rape, they would not object. This reasoning was also given by some females. One of the female respondents in high school answered that she would not mind if her boy friend 'had lost his virginity because of accidents such as fall or riding a bike'. This raises a lot of questions about her understanding of the term.

Table 5.2 shows the percentage of men and women who said that virginity was the most important factor in choosing future spouses according to socio-demographic characteristics. The differences by age and main activity were statistically significant for both sexes. The patterns for both sexes are also similar. As expected, those in the older group (aged 21-24 years) and out of school (working and unemployed) are more likely to accept non-virgin spouses than those students aged 18-20 years and those aged 15-17 years. Differences were not statistically significant by living arrangement, or ethnic, religious and parental backgrounds of respondents, though these might have been expected to be important determinants of sexual attitudes.

Table 5.2 Percentage of male and female respondents who said that virginity was the most important factor in choosing a spouse by socio demographic characteristics

	Males (N=463)		Females (N=412)	
	Number	%	Number	%
Age group		*		**
15-17 years	196	45	166	36
18-20 years	98	37	134	19
21-24 years	169	31	112	19
Main activity		*		*
Study	335	43	331	28
Working	103	27	50	12
Unemployment	25	20	31	19
Religion				
Moslem	278	39	224	26
Christian	144	40	123	26
Buddhist/Hindu	41	32	65	23
Ethnicity				
Javanese	91	36	77	27
Toba Batak	102	46	64	33
Mandailing Batak	67	46	47	26
Other Batak	52	31	36	25
Malay	57	39	52	25
Chinese	53	28	97	22
Other	41	32	39	23
Living arrangement				
With both or one parent	329	40	307	26
With sibling or other relative	61	39	42	21
Boarding house	73	32	63	27
Mother's education				
Part/finished elementary	105	42	66	26
Finished JHS	89	33	84	20
Finished SHS	189	37	181	24
University/academy	80	35	81	35
Father's education				
Part/finished elementary	64	34	40	35
Finished JHS	78	35	59	19
Finished SHS	165	38	167	22
University/academy	156	42	146	30
Mother's occupation				
Public servant/retired	68	28	62	26
Employee/labourer	23	5	17	6
Trader	123	53	82	24
Not employed	210	79	196	28
Others	39	31	55	27
Father's occupation				
Public servant/retired	206	41	161	26
Employee/labourer	101	38	87	29
Trader	87	37	89	26
Not employed	13	15	9	11
Others	56	38	66	23

Notes : * = Significant at $p < 0.05$ ** = Significant at $p < 0.001$
Source : Medan Adolescent Reproductive Health Survey, 1997-1998.

In-depth interviews with young men revealed that there were many reasons why they might accept non-virgin girls as wives. Among these were the way young people defined virginity and the chance to know their future spouses more closely. Those who defined virginity as an intact hymen said that virginity was not important in choosing a spouse because they believed that the rupture of the hymen was not necessarily resulting from sexual intercourse. According to Adri, a Javanese 21- year-old man, who was unemployed:

> For me it does not matter whether she is still a virgin or not, because non-virgin does not always mean no longer 'pure' (*enggak suci lagi*). For example, she might have lost her virginity not because she has done something negative but because of an accident when she was a child, for me it does not matter, the important thing is she loves me.

Other young people argued that the chance to know their future spouses closely before marriage caused virginity status to become less important. Unlike in parentally arranged marriage as practised in the past, most young people have time to know their partner personally before they decide to get married. As a consequence in many cases personality is more important than virginity. In in-depth interviews, Martin, a Toba Batak 20 year-old who was studying at university, said:

> Virginity is an important thing, however before marriage, there was a dating period, wasn't there? (*kan ada proses berpacaran*), if during this period my girlfriend confessed that she was no longer a virgin, then that depends, if we do like each other, it won't matter too much (*tidak masalah sekali*), if she has everything I like. But if I don't really like her, why would I put up with her? *(untuk apa perempuan yang kayak gitu*?).

5.2.3 Why is virginity important for a woman but not for a man?

As revealed from the survey, in-depth interviews and focus group discussions, a woman's virginity was more important than a man's virginity. While an unmarried woman is expected to be 'pure' and preserve her virginity for her husband, some young men believed that a man is expected to have premarital sex experience. In addition, the fact that there is no physical proof of males' virginity also affects young people's attitudes toward it.

Many young men in my study believed that a man needed 'an experience' before marriage. In contrast, a woman has to keep her 'purity' intact. Although many respondents said that virginity was not important in a marriage, all male focus group participants said they preferred to have a virgin woman for a wife. Below are arguments given by focus group participants among male university students when asked if a man needs to be a virgin before marriage:

Jojon: In my opinion, it is better for a man not to be a virgin (*perjaka*), because if he is still a virgin when married, there is a possibility that he would not know how to do 'it', and would be very embarrassing.

Martin: In my opinion, like me, if I want a virgin wife, I think a woman wants a virgin man as well but, how can I say, for men it's rare, most of my friends were no longer virgins when they married. Personally, I want to be still a virgin when I marry, but if one day when I am dating, I am tempted, well *mana ada buaya nolak bangkai* (there is no crocodile refuses a carcase).

Rony : Ehm, my opinion is the same as Jojon's [a man] needs an experience isn't it Jon? A man needs to learn from experiences to know how to do it so he won't feel gauche (*canggung).*

Sukir: I prefer both to be the same, the woman is a virgin and so is the man. I agree a man needs to know how to do it, but I don't think we have to experience it. I believe we would find it out eventually (*tu pengalaman nggak dapat dari siapa-siapa, tahu sendiri*), I reckon the way to do it is just the same.

Mahmud: Well, how can I say? Basically I agree with Jojon, but premarital sex is commonly associated with sin. For me it's fine to be afraid to have sin, but sometime you just cannot avoid it. As many people said they did not plan to have it. But it happened accidentally.

Similar arguments were also raised by other young people in my study. The need for sexual experience before marriage was often expressed by young men. An informant, a lecturer at North Sumatra University, mentioned that in the past, there was a common rumour among the Malays that a groom usually 'practised' sexual intercourse before his wedding with his *mak andam*[2] (usually a middle-aged woman). Culturally a man is expected to know about sexual intercourse before marriage. A study by Kim (1993: 150) among young people in a Moluccan town found that premarital sex among young men is encouraged and considered necessary for success in the male sex role.

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[2] A *mak andam* is a person who helps a bride or groom for the wedding ceremonies.

Young women in my study also regarded male virginity as unimportant. Most of them stated they preferred to have a virgin husband, but they would not mind having a non-virgin. They believed that in these days a virgin male is rare, so they have to accept a non-virgin. Moreover, the fact that it is very difficult to tell whether a man is a virgin or not influences their attitude. One female respondent stated her opinion clearly:

> Actually in my opinion male virginity is also important, because if a woman has to be virgin, why not a man? But the problem is we do not know how to tell whether a man is virgin or not. There is no mark of it. So I think it is better not to think about it too much. Just accept it (*pasrah aja*) (Esti, single, university student, 21- year-old, Toba Batak).

The reasons for the importance of female virginity were different between young men and young women in my study. For women, keeping their virginity was more related to morality and purity and also as a 'gift' for their husbands. Many of them believed that their husband might blame them if they have had sex with another man. Two respondents, one single and one married, stated:

> It is very important for a woman to keep her virginity, because it means she keeps her purity for her husband, and I believe it is the most important gift for him (Esti, single, university student, 21-year-old, Batak).

> It is very important for a woman to keep her virginity, because when she marries, and her husband gets 'nothing', then one day when they have an argument, he will bring that up, there will always be a regret for him! Even if he said it was OK. Later on the wife will have no say in her husband's behaviour (Anggi, married, housewife, 23-year-old, Minangkabau).

These suggest that women's views on female virginity are more conservative than men's views. Among men virginity is not always related to morality or purity. Some young men in my study stated they would not mind having a non-virgin wife, as long as she told him before they married. Those who said they would mind having a non-virgin wife believed that a woman would never forget a man who took her virginity. The reasons for refusing a non-virgin woman are more related to jealousy and lack of self-confidence. Below are some answers of male respondents when I asked 'What would you do if you found out that your future wife was no longer a virgin (had had sex with another man) before she had a

relationship with you?':

> I would break off the engagement. I don't want to marry such a woman. I don't want 'second-hand goods' (*barang bekas*), there is a possibility that she will compare me with the man who took her virginity. A woman can't forget that (Iwan, 17-year-old, high school student, Malay).

> I need to know the status of her former boyfriend, how long their relationship lasted. If her virginity was taken by someone who is richer and more handsome than me, I would back off, because she might still have some feeling for her former boyfriend, but if I am better than him, it is all right, she might regret her past (Jojon, 21-year-old, university student, Malay).

> Maybe for most men, virginity is vital, but in this era, for me virginity is number two, because I have already tasted a virgin, so for me now virginity is number two, the most important thing is that she can understand me (Luther, 20 year-old, university student, Toba Batak).

Those who did not mind if they found out that their future spouse was no longer a virgin argued that trust and honesty is very important in a marriage. As long as their future spouse was honest and told them about it before they married and expressed regret for her past, it would be fine. Men would not feel cheated. Nevertheless, most men said it was not necessary for a man to tell his future wife about his sexual life in the past. They argued that a woman would not notice it, so why make her upset?

5.2.4 Myths related to virginity

The importance of female virginity is also indicated by many myths related to the signs of a woman's virginity. Most young people in Medan have heard that signs of virginity are apparent in a woman's hips, breasts, calves, knees or the way she walks. Some young people believed such notions; some did not but most were unsure about these stories. When asked how to tell whether a woman was still a virgin, the issue of whether it can be detected from the body was always raised by young people in my study. Below are some of their arguments:

> You can tell it from her face and from her body. People told me about that, my friend herself told me about it, she told me that a woman who has had sex, her breasts will droop a bit then her hips will be a bit flabby, also the way she walks will be different (Izul, working man in a mixed FGD).
>
> I heard from a friend of mine who often has relationships with *bondon*[3], that he can differentiate. He told me, this *bondon* is still a virgin, is still good or that *bondon* had ever had 'that' (sex). According to him if a woman has had sex, her body will be flabby. But I know some women because of their work might have flabby posture but still be virgins. My mother told me virginity can be seen from a woman's calves, they will be flabby if she is not virgin. But I know a *bondon* who had sex and still has a tight calf. So I am not sure how to tell whether a woman is a virgin or not. Because I also was told that some women will bleed at the first sexual intercourse but some will not, especially if they are fully aroused (Jony, unmarried, university male FGD).
>
> I don't really believe that virginity can be indicated from the body appearance, we can't be sure about that. But because I have had sex with several women, I know the difference. Usually a virgin woman cries [at the first sexual intercourse] and I also can tell from her expression and the way she acts. To be honest, in the past I've 'used' not only one woman (*bukan hanya satu perempuan aja yang saya pakai dulu*) (Bambang, married male FGD).

The issue of whether virginity can be detected by body appearances was also raised in a seminar for adolescents I attended during my fieldwork in November 1997. The seminar topic was '*Bebas bergaul tanpa sex* (Free mixing without sex)', organized by the local Indonesian Planned Parenthood Association (PKBI) youth centre, Citra Mita Remaja, an NGO interested in adolescent reproductive health. Many participants asked questions related to virginity, such as what can cause a hymen to tear, how to tell whether a man is a virgin or not, and whether it is true that virginity can be detected by body appearances. Whatever people might say about the 'necessity' of premarital chastity, it is clear that they are curious (and confused) about the meaning of virginity.

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[3] *Bondon* is a term used among young people in Medan for an adolescent girl who is willing to accompany a man just to have fun. Usually aged between 14 and 19 years, most are still in high school or junior high school. A *bondon* service does not always culminate in sexual intercourse. Sometimes she is only willing to go to a movie, discotheque or restaurant.

Although many women in my study did not believe the myths about virginity, nevertheless because many of their male friends believe the myths the women could not be completely sure of what they should think. One female respondent expressed her worries about this situation:

> It is very difficult for us as women, especially for a woman like me. I am a karate instructor. Because of my activities my breasts might be a bit droopy, and because of heredity, my hips are big. Many people believe those are the signs of a person who has already lost her virginity. That is not fair. Although I know these ideas are not true, because a lot of men still believe them, I am a bit concerned.

This suggests that virginity is still a significant issue for some young adults in Medan. However the intact hymen was no longer seen as the sole symbol of morality. Contemporary young people understand that rupture of a hymen does not necessarily mean the loss of 'purity'.

5.3 Curiosity: young people's attitudes and experiences of premarital sex and pornography

One commonly held belief about puberty is that 'raging hormones' increase sexual arousal and behaviour. Biologically, this is true. Sexual arousal is significant with raised levels of testosterone during puberty, for both boys and girls (Moore and Rosenthal, 1993:46). Sexual behaviour, however, as well as sexual arousal is socially mediated (Katchadourian, 1990:330-51). The decline in age at puberty and the increase in the age at first marriage are often associated with the increased risk of premarital sex (Udry, 1979; Zabin *et al.*, 1981:140, Morris, 1993; Bongaarts and Cohen, 1998:101; Zabin and Kiragu, 1998:213). Furthermore, the socio-cultural changes in many developing countries, including education, urbanization and telecommunication, create an environment conducive to young people mixing freely with the opposite sex, which in turn increases the opportunities to engage in premarital sex (Kiem, 1993:150; Carael, 1995:86; Silva *et al.*, 1998:7).

Like other young people in most cities in developing countries, young people in Medan also are experiencing rapid socio-cultural and demographic changes. As indicated in Chapter 2, the proportion of Medan's young people who are unmarried as well as the proportion of those who are in school increased over a

decade. The exposure toward global information including Western liberal sexual norms to some extent influences young people's sexual attitudes and behaviour. Previous studies indicated that despite the strict traditional and religious values regarding virginity in the society, premarital sex among Medan's young people is not uncommon (YKB, 1993; Saifuddin and Hidayana, 1999:111-114).

Many newspapers reported the sexual life of young girls who might have sex just for fun (*Media Indonesia, Suara Pembaruan, Kompas, Republika*). One of Indonesia's newspapers, Media Indonesia, published special reports regarding teenagers involved in sexual activities for fun or for money in several cities in Indonesia including Medan (*Media Indonesia Online*, 2-26 August 1999). Although the percentage of young girls engaging in this activity may be very small and would not represent the image of the majority of Indonesian young people, these reports suggested that teenage prostitution is not only a big-city phenomenon but may also be found in small towns such as Tasikmalaya and Tegal. Each place, however has a local term to refer to the girls involved in this activity. In Jakarta they are commonly called *perek* (experimental women), in Medan and Bandung they are called *bondon*, in Surabaya, *cilik'an*, and in Tasikmalaya, *anyanyah.*

To investigate the views and practices related to premarital sexual intercourse[4] of Medan's young people, in the survey respondents were asked questions such as: what is your opinion about premarital sex? Have you ever had sex? With whom did you have sex? What was your reason for having sex? and what were your reactions when you had sex for the first time?

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[4] In the questionnaire I used the term *'hubungan kelamin/bersenggama'* for sex, which has sole meaning of vaginal penetration.

Table 5.3 Respondents' attitudes and reported experiences regarding premarital sex and pornographic materials by gender

	Male N=463 %	Female N=412 %	Male+female N=875 %
Ever had premarital sex	27	9	18
Ever had a steady relationship (*pacaran*)	76	73	74
Attitude toward premarital sex			
Agree if it is based on mutual willingness	20	9	14
Agree if it is in a steady relationship	12	7	10
Agree to obtain an experience	13	2	8
Do not agree	55	82	68
Attitude if best friend involved in premarital sex			
Advised him/her to stop	47	64	55
No problem, not my business	42	24	33
Keep some distance from her/him	8	9	9
Other	3	3	3
Partner in sexual intercourse [a]	N=123	N=36	N=159
Steady boy/girl friend (*pacar*)	16	76	30
Casual friend (including *bondon*)	10	3	8
Prostitute	39	0	30
Combination of regular partner, Casual friend and prostitute	35	21	32
Feeling after the first intercourse	N=123	N=36	N=159
Nothing special	47	14	40
Sinful and then stop	16	44	22
Sinful but still continue	30	36	31
Other (satisfied and 'become addicted ')	7	6	7
Reason for sexual intercourse[a]	N=123	N=36	N=159
Mutual attraction	17	43	23
Curiosity (*ingin coba-coba*)	22	3	18
Stimulation from pornography	10	0	8
Combination of mutual willingness, Curiosity and pornography	51	54	51
Exposure to printed pornographic materials			
Have read	88	45	67
Never read	12	55	33
Exposure toward visual pornographic materials			
Have watched	89	39	66
Never watch	11	61	34

Note : [a] = Multiple responses possible
Source : Medan Adolescent Reproductive Health Survey, 1997-98

Table 5.4 shows that in contrast to common conservative beliefs, young people in Medan were relatively tolerant toward premarital sex. Eighteen per cent of all respondents (nine per cent among females and 27 per cent among males) reported ever having sex. The proportions of those who conditionally agreed with premarital sex, such as if it is based on mutual attraction (*suka sama suka*), within a steady relationship (*pacar*) or to get experience (*pengalaman*), were even higher (18 per cent among females and 45 per cent among males).

Women seem more involved emotionally than men when having sexual relationships. Seventy six per cent of sexually active women reported only having sex with a steady partner, compared with only 16 per cent of sexually active men. The majority of young men have sex with more than one partner as indicated by the type of partner for sexual intercourse: casual friends including *bondon* (10 per cent), prostitutes (39 per cent) and combination of regular partner, casual friends and prostitutes (35 per cent).

Data from focus groups and in-depth interviews confirmed these patterns. Many male participants stated they preferred to go to a *bondon* or prostitute when they wanted to have sex. The reason for this is because they believe having sex with a girl friend (*pacar*) demands more responsibility. Some of them expressed their opinions as follows:

> It's better to have sex with prostitute, because with a girl friend if later on you break up [before marriage], it means you 'destroy' some-one's daughter (*merusak anak gadis orang*) (Ahau, working, male, Chinese).
>
> I prefer to have 'an experience' with a *bondon*. Because with a *bondon* it is more fun, no responsibility; a *bondon* does not demand a lot. They just want to have fun, be happy for today. It is different with a girl friend. If I have taken her virginity, automatically I have to take responsibility, if not her family may be after me, it is hard (Joni, university student, male, Malay)

The reasons to engage in premarital sex were also different for men and women. Of those women who reported having had sex, 43 per cent stated they had it solely because of mutual attraction, while only 16 per cent of men claimed this reason. In contrast, the percentages of men who reported having had sex because

of curiosity and stimulation from pornography were much higher than those of women. Twenty two per cent of men stated they had sex solely because of curiosity and 10 per cent said because of stimulation of pornography, whereas only three per cent of women reported having sex solely because of curiosity and none of them said it was solely because of stimulation from pornography. A majority of both sexually active young men and girls said that they had more than one reason for being involved in premarital sex.

Men and women also report different reactions to their first experience of sexual intercourse. Compared to the men, the young women in Medan were more conservative. Eighty per cent of sexually active women reported feeling sinful the first time they had sex and 44 per cent of them reported stopping afterward. Less than half of sexually active men reported a feeling of sinfulness the first time they had sex and few of them reported being dissuaded from repeating the experience.

5.3.1 Respondents' exposure to pornographic materials

Despite Indonesian laws (Article 282 Section three of the Criminal Code/*KUHP*) banning all pornographic materials, the majority of young people in my study were exposed to pornographic[5] material which, as is common knowledge, can be found easily in most big cities in Indonesia. All the men in my study knew where and how to obtain them. Many video and book rental shops provide pornographic materials. Since it is illegal, the rental shops do not display them openly. Only those who know how to 'ask', with special codes, are able to borrow them. Those who want to purchase the books, videos or VCDs can buy them on the black market. There are two types of pornographic books, stencilled and printed: stencilled books are cheaper than the printed. The price for stencilled books is around Rp. 2,000-Rp. 7,500; for printed books Rp. 5,000 - Rp. 15,000. Videos and VCDs are more expensive. The prices range from Rp. 10,000 to Rp. 25,000[6].

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[5] In the questionnaire I specified pornographic materials as 'blue film/movie' and pornographic books/stencilled. These terms are well known among young people in Medan to indicate X- rated or hard- core pornographic materials.

Some cinemas in Medan often screen pornographic movies. These cinemas are mostly classified as second-class; usually they are much cheaper than first class cinemas. Most of them are located close to traditional markets and settlement areas. Although there are no advertisements for when the cinemas will show pornographic movies, most young people know when. One respondent said one way to tell when a cinema is showing a pornographic movie is from the ticket price. The price for blue films is more expensive than for the ordinary films. A ticket for a pornographic movie was around Rp. 3,000-Rp. 5,000 while for an ordinary movie it was Rp. 2,000-Rp. 3,500.

Those who do not have enough money to buy pornographic videos or go to cinemas usually watch pornographic videos in a certain *warung kopi* (coffee shop). People who watch these videos mostly come from poor socio-economic backgrounds such as *becak* driver, *preman* and street kids. According to some informants, by paying Rp. 1,000- Rp. 2,000 they can watch videos and have coffee or tea.

Many local people, especially parents, complain about the existence of such shops in their area. Nevertheless, they cannot do much. The police often said they had no proof of the activities. Most people believe this is because these shop owners have 'backing' in the army; as a consequence, police often close their eyes to this illegal activity. When I was in the field, a local newspaper reported that several coffee shops were raided by the police for their activities showing pornographic videos. When I raised this issue in the focus groups, most participants responded spontaneously 'That must be because the owner did not 'give' enough money to the police (*itu karena sogokannya kurang aja*)'.

As would be expected, men have more experience of pornographic materials than women. Most men reported having read printed pornography or watched pornographic videos or movies. Only 45 per cent of all women reported having read printed pornographic materials and 39 per cent reported having watched pornographic movies.

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[6] At that time US $1= Rp.2,500 or A $ 1= Rp. 1,800.

In male focus group discussions, when the participants were asked whether they had watched or read pornographic materials, most participants spontaneously answered *'Ya udah lah kak! Udah biasa kali itu* (of course we have, that's really common)'. Observing their expressions when I was asking them, I could feel that for them my question was 'strange'. Among young men reading or watching pornography was not something that needed to be hidden. They talked about it openly without indication of shame or guilt. Below are some of the expressions given in male focus groups:

> I have read and watched it, I guess all adolescents must have had similar experiences, in the video or cinema! (Adri, informal sector FGD).

> I have watched it when I gathered with friends, then we shared the rental of videocassettes. We watched it in one of my friend's house when none of his family was in (Anto, informal sector FGD).

The discussions with women were not as open as with men. It required more effort to encourage them to talk openly. In the focus group with female high school students, none of the participants said they had read or watched pornographic materials. Nevertheless, some of them said they often heard their male classmates talking in class about their experiences with pornography. In other female focus groups (university students and married women) most participants reported having read pornographic books and only a few of them said that they had watched pornographic movies. Those who claimed to have had experiences of pornographic materials tended to stress that they did it by accident. The young women commented as follows:

> I have read it, because my friend often shows it to me (*sering nunjuk-nunjukin*) (Iyus, married women FGD).

> I read it by accident. One day when my brother cleaned his room, I saw a book on his bed. When I read it, it was very 'dirty' (Eva, working, mixed sexes FGD).

> I have read and watched pornographic materials. My friend lent the books to me. In fact last week I just watched a pornographic video with some friends of mine. They simply asked me to join them (*Saya sih cuma diajak aja)* (Masdiana, female university students FGD).

Most focus group participants and respondents in in-depth interviews stated that watching or reading pornography might encourage young people to have sex. They believed that those who were exposed to pornographic materials would be tempted to try and practise the activities in such books or movies.

5.3.2 Factors affecting young people's attitudes toward premarital sex

Table 5.5 shows the socio-demographic factors associated with respondents' acceptance of premarital sex. For both sexes, significant differences were observed by main activity and religious affiliation, while differences by age, ethnicity, parents' education and father's occupation were only significant among men. In contrast, the differences by mother's occupation were only significant for young women. Differences by living arrangement were statistically insignificant for both sexes.

The out- of- school respondents were much more tolerant toward premarital sex than were students. More than three-quarters of working men and 44 per cent of unemployed men agreed with premarital sex, compared to only 34 per cent of young male students. The pattern was slightly different among women, with 30 per cent of working women and 36 per cent of unemployed women agreeing with premarital sex, compared to 14 per cent of those who were students.

Respondents' religious affiliation was also found to be significant in affecting attitudes toward premarital sex for both genders. Compared to young people from other religious affiliations, those who were Buddhists or Hindus were more likely to agree with premarital sex, followed by Christians and Moslems. Fifty nine per cent of all Buddhist and Hindu young men and 54 per cent of Christian young men agreed with premarital sex, compared to 37 per cent of Moslem young men. Although the proportions for all religious groups were much lower, the pattern of differentials was the same among young women.

Table 5.4 Percentage of male and female respondents who agreed with premarital sexual intercourse, by socio-demographic characteristics

	Males (N=463)		Females (N=412)	
	Number	%	Number	%
Age group		**		
15-17 years	196	34	166	13
18-20 years	98	49	134	20
21-24 years	169	54	112	21
Main activity		**		**
Study	335	34	331	14
Working	103	80	50	30
Unemployment	25	40	31	36
Religion		*		*
Moslem	278	37	224	14
Christian	144	54	123	18
Buddhism/Hindu	41	59	65	29
Ethnicity		*		
Javanese	91	33	77	18
Toba Batak	102	53	64	14
Mandailing Batak	67	40	47	13
Other Batak	52	52	36	22
Malay	57	42	52	15
Chinese	53	55	97	25
Other	41	37	39	8
Living arrangement				
With both or one parent	329	44	307	17
With sibling or other relative	61	43	42	17
Boarding house	73	47	63	19
Mother's education		**		
Part/finished elementary	105	60	66	24
Finished JHS	89	51	84	20
Finished SHS	189	41	181	16
University/academy	80	26	81	12
Father's education		*		
Part/finished elementary	64	55	40	18
Finished JHS	78	56	59	24
Finished SHS	165	44	167	20
University/academy	156	35	146	12
Mother's occupation				*
Public servant/retired	68	35	62	13
Employee/labourer	23	52	17	41
Trader	123	53	82	21
Not employed	210	44	196	15
Others	39	33	55	20
Father's occupation		*		
Public servant/retired	206	41	161	17
Employee/labourer	101	39	87	15
Trader	87	53	89	24
Not employed	13	85	9	11
Others	56	45	66	15

Notes : * = Significant at $p < 0.05$ ** = Significant at $p < 0.001$
Source : Medan Adolescent Reproductive Health Survey, 1997-1998.

Interestingly, while respondents' age and mother's education are strongly significantly related to young men's attitudes toward premarital sex, they appeared to be statistically insignificant in explaining young women's attitudes. Among male respondents, those aged 21-24 years whose mothers had only primary education were more likely to agree to premarital sex than the men of younger age groups whose mothers had a higher level of education. Of all men aged 21-24 years, over half agreed with premarital sex, while a third of young men aged 15-17 years agreed with it. More than a half of men whose mothers had only primary education agreed with premarital sex, compared to only about a quarter per cent of men whose mothers had academy or university education.

The backgrounds of respondents' fathers were more related to young men's premarital sex attitudes than they were for young women. Both fathers' education and occupation were significantly associated with young men's attitudes toward premarital sex but they were insignificant in explaining girls' attitudes. Among young men, those whose fathers had less than senior high school education and those whose fathers were not employed were more likely to agree with premarital sex than those whose fathers had higher education and whose fathers were in the labour force. Among young women, only mother's occupation appeared to be significantly associated with attitudes toward premarital sex. Young women whose mothers worked as labourers were more tolerant toward premarital sex than those whose mothers worked as public servants, traders or others.

Ethnicity was significantly associated with young men's attitudes toward premarital sex. Compared to other ethnic groups (Javanese, all Bataks, Malay and others), Chinese young men were more likely to agree with premarital sex. However, ethnicity was not a significant determinant of attitudes among women.

In further analysis, I devised a multivariate logistic regression model using a forward stepwise method, to examine the relative contribution of socio-demographic background factors found to be statistically significant in bivariate analysis on attitude toward premarital sex. As indicated in Table 5.6, only

respondents' main activity, religious affiliation and mother's education were significantly related to the men's acceptance of premarital sex, while only respondents' main activity and religious affiliation significantly influenced women's agreement with premarital sex.

For both male and female respondents, main activity was the strongest predictor of reported attitudes toward premarital sex. For young men in the labour force, the odds of agreeing with premarital sex were more than six times (odds 6.54) as large as those for young men who were in school. With odds 1.61 SE 0.43, unemployed young men were more likely to agree with premarital sex than those who were students. However the relationship between students and unemployed was insignificant.

Table 5.5 Logistic regression showing odds ratio and standard error (SE) of the effects of socio-demographic characteristics on the likelihood of premarital sex acceptance, by gender

Backgrounds variable	Males N=463		Females N=412	
	Odds	SE	Odds	SE
Activity				
Study (ref.)	1		1	
Working	6.54*	0.28	2.33*	0.35
Unemployed	1.61	0.43	4.04	0.41
Religion				
Moslem (ref.)	1		1	
Christian	2.32*	0.25	1.32	0.31
Buddhist/Hindu	2.08*	0.38	2.73*	0.34
Mother's education				
Part/finished elementary	1		na	na
Finished JHS	0.88	0.32	na	na
Finished SHS	0.63	0.45	na	na
Finished academy/university	0.37*	0.36	na	na

Notes: Dependent variable coded as 1= Agreed; 0 = Disagreed
* = significant at p<0.05 ** = significant at p <0.001 ref..= reference group.
JHS= Junior High School SHS= Senior High School na = not applicable
Source: Medan Adolescent Reproductive Health Survey, 1997-1998

The trend was slightly different for women, where the odds ratio of those who were unemployed was higher than the odds ratio of those who were working. The odds for unemployed female respondents to agree with premarital sex was four times (odds 4.04) as large as the odds for those who were in school, while the odds of agreeing with premarital sex for those who were in the labour force were twice as large as those for female students.

Buddhist or Hindu young people were more likely (odds 2.1 for men and 2.7 for women) to agree with premarital sex than were Moslem young people. The odds for Christian young men to agree with premarital sex were also more than twice as large (odds 2.3) as those for Moslem young men, while with odds of 1.3, Christian young women were slightly more tolerant toward premarital sex than were Moslem young women; the difference, however, was not significant.

Mother's education appeared to be important in predicting the likelihood of male respondents agreeing with premarital sex. With odds of 0.37 and SE 0.36, male respondents whose mothers have academy or university level of education were significantly less likely to agree with premarital sex than those whose mother had only an elementary level of education.

In addition, data from focus groups and in-depth interviews revealed that young people's attitudes toward premarital sex were also influenced by their peers' sexual experiences. The fact that many of their friends had a premarital pregnancy affected their attitude toward premarital sex. These attitudes were shown from answers given by women when asked whether they agreed with premarital sex or not:

> For me, it's better to avoid sex [before marriage]. But nowadays it's like that, it's common. Sometime after seven or six months pregnancy they get married, it's acceptable now (*udah lumrah gitu).* Often today's young people say dating without sex is not enjoyable (*kalau pacaran enggak 'gituan' enggak enak*) (Rima, 23 years, married, house wife)
>
> Maybe it [premarital sex] is the trend. Most married people already had it (Tari, 20 years, married, housewife).
>
> For men I think it's OK, because most men have done 'it' (Silvi, female, 20 years, single, university student).
>
> Actually it's wrong, but what can we do, many people have done 'it' (Erna, female, 20 years, single, university student).
>
> Whether I agree or not? Well, basically I think there is no one who would agree with such things. But often in a relationship when the couple has been very close, they can not avoid it (Inong, single, working).

In most focus group discussions especially among young men, issues about religious reasons were rarely raised. When one participant gave a religious reason for not agreeing with premarital sex, others who agreed with premarital sex would say, 'I do not want to be a hypocrite here, I prefer to talk about reality (*saya enggak mau munafik, kita bicara fakta ajalah*)'. This suggests that many respondents in my study believed that religious teaching is not always applicable or relevant in the daily life.

5.3.3 Factors affecting young people's behaviour regarding premarital sex

I also used bivariate and multivariate regression analysis to examine factors affecting young people's reported experience of premarital sex. However, since the number of young women who reported having had sex was very small (36 respondents), and they are to different to be put together, I limit my analysis to men.

Table 5.6 presents variables found to be significantly associated at the bivariate level with male and female respondents' reported sexual intercourse. Factors such as respondents' age, main activity, parents' education were significantly associated with reported sexual experience for both genders. Living arrangement, whether they live with parents or not, was only significantly related to young women's reported sexual experience. Parents' occupation was only significant for young men's reported sexual experience. In contrast with respondents' attitudes toward premarital sex, respondents' religious affiliation was not related to either women's or men's reported sexual experiences. Ethnicity also appeared to be insignificant in explaining young people's premarital sexual behaviour for both genders.

There was a strong positive relationship between the age of respondents and reported premarital sexual intercourse for both genders. As their age increased, respondents' reported experience of premarital sex also increased, as expected. Almost half of young men aged 21-24 and more than a quarter of those aged 18-20 reported having had sex, compared to only 12 per cent of boys aged 15-17 years. The pattern also appeared among young women, though the proportions of those reported having had sex are much lower than the proportions among men.

Respondents' main activity also has a strong relation with reported sexual experience for both genders. Young people who were out of school were significantly more likely to report having sexual intercourse than those who were students. Almost two-thirds of working young men and 48 per cent of those who were unemployed reported having had sex, compared to only 13 per cent of those who were studying. The trend was slightly different among young women. Those who were unemployed were more likely to have had sex than those who were working or studying.

Parents' education was significantly associated with reported experience of sexual intercourse for both genders, but parents' occupation was significantly related to reported sexual experience only among young men. As with attitudes toward premarital sex, respondents who had relatively well educated parents were less likely to report having had sex than those whose parents had less education. Among men, those whose fathers were in the labour force while their mothers were not employed were less likely to report having had sex.

Table 5.6 Per centage of male and female respondents who reported having had premarital sexual intercourse, by socio-demographic characteristics

	Males (N=463)		Females (n=412)	
	Number	%	Number	%
Age group		**		*
15-17 years	196	12	166	3
18-20 years	98	30	134	11
21-24 years	169	42	112	14
Main activity		**		**
Study	335	13	331	6
Working	103	66	50	12
Unemployed	25	48	31	29
Religion				
Moslem	278	25	224	8
Christian	144	30	123	9
Buddhist/Hindu	41	25	65	12
Ethnicity				
Javanese	91	22	77	14
Toba Batak	102	31	64	6
Mandailing Batak	67	25	47	0
Other Batak	52	37	36	14
Malay	57	32	52	8
Chinese	53	21	97	13
Other	41	15	39	3
Living arrangement				*
With both or one parent	329	24	307	7
With sibling or other relative	61	38	42	17
Boarding house	73	30	63	14
Mother's education		**		**
Part/finished elementary	105	40	66	12
Finished JHS	89	28	84	19
Finished SHS	189	24	181	5
University/academy	80	30	81	4
Father's education		*		**
Part/finished elementary	64	27	40	8
Finished JHS	78	36	59	24
Finished SHS	165	30	167	8
University/academy	156	18	146	4
Mother's occupation		*		
Public servant/retired	68	24	62	5
Employee/laborer	23	48	17	24
Trader	123	36	82	10
Not employed	210	22	196	8
Others	39	15	55	11
Father's occupation		*		
Public servant/retired	206	26	161	8
Employee/laborer	101	27	87	12
Trader	87	30	89	9
Not employed	13	62	9	22
Others	56	14	66	6

Notes : * = Significant at $p < 0.05$ ** = Significant at $p < 0.001$

Source : Medan Adolescent Reproductive Health Survey, 1997-1998.

The influence of whether or not they lived with one or both parents on the likelihood of reporting sexual experience was significant among women but insignificant among men. Young women who had left their parents' house were more likely to report sexual experience than those who still lived with their parents. Seventeen per cent of girls who lived with their siblings or other relatives and 14 per cent of those who lived in boarding houses reported having had sex, compared to seven per cent of those who lived with one or both parents. However, this may be related to respondents' age. Women who had left their parents' house were likely to be older than those who still lived with their parents.

Although religious affiliation and ethnicity appeared to be significantly related to respondents' attitudes toward premarital sex, there was no significant relation with reported sexual experience for either male or female respondents. This means that despite the strong link of many Medan young people to their own ethnic-religious societies, there is no significant difference among ethnic groups regarding their reported premarital sex experience. This may be a reflection of the common weakening of ethnic-religious moral control over young people's sexual behaviour.

Table 5.7 shows the odds ratios resulting from stepwise logistic regression analysis of male respondents' reports of sexual experience. Only respondents' age and main activity appeared to be important in predicting the likelihood of young people engaging in premarital sex.

Similar to attitudes towards premarital sex, respondents' main activity was the most important factor in predicting the likelihood of respondents being involved in premarital sex. The odds of reporting having had sex was more than ten times as large for those who were working as for those were students. The odds for those who were unemployed to report having had sexual experience were nearly five times as large as for those students.

Respondents' age was also significantly important in predicting the likelihood of young people being involved in premarital sexual activities. With odds of 2.90, respondents aged 21-24 years were more likely to report having had premarital sexual experiences than respondents aged 15-17 years. And the odds of the likelihood of respondents aged 18-20 reporting having had sex were nearly twice as large as for those aged 15-17 years.

Table 5.7 Logistic regression showing odds and standard error (SE) of the effects of socio-demographic characteristics on the likelihood of male respondents' reported experiences of premarital sex (N=123)

Background variables	Odds ratio	SE
Age		
15-17 years (ref.)	1	
18-20 years	1.76	0.35
21-24 years	2.90*	0.30
Activity		
Study (ref.)	1	
Working	10.7**	0.27
Unemployed	4.56**	0.44

Notes: Dependent variable coded as 1= has had sex; 0 = never had sex
* = significant at p<0.05 ** = significant at p <0.001 ref.= reference group.
Source: Medan Adolescent Reproductive Health Survey, 1997 -1998

Although at both bivariate and multivariate level living arrangement appeared to be insignificant for young men's reporting sexual experiences, qualitative results indicate that premarital sex among young men who were living away from home was quite common. A male respondent, a university graduate who had been living for more than eight years in boarding houses, said:

> As far as I know, among us who live in boarding houses, bringing the girl friends to the bedroom was common. Well, at least in several boarding houses in my neighbourhood. Usually when some one has a partner in his room, he will lock the door and close the window, the others would understand. They no longer felt shame about it, because many people did a similar thing. But if there was a visitor in the house, especially the families, we did not do that (Gulo, university graduated, 26 years, reporter).

Young people who no longer live with their parents might have less parental guidance, and at the same time receive greater pressure from their peers to engage in premarital sexual activities, than those who still live at home.

5. 4 Conclusion

Young people in Medan are increasingly tolerant of premarital sex. Although the majority of them said that chastity was necessary for both men and women, they also believed that for many young people premarital sex is often unavoidable. With this attitude, virginity has become less important in considering a partner for marriage. The demise of the parent-arranged marriage and the opportunity to know their future spouse before marriage mean that a potential spouse's personality is more important than his or her virginity. Furthermore, the concept of female virginity itself varies among young people. Some people associate it with an intact hymen while others associate it with whether a woman has ever had sexual intercourse. However, few young people consider virginity as the sole symbol of morality. Losing virginity does not necessarily mean losing respectability.

Compared to boys, girls were more conservative regarding virginity and premarital sex. And as would be expected, single young men were much more tolerant of premarital sex and more likely to report having had sexual intercourse than were young women. The factors affecting attitudes and reported experience of premarital sex were likely to be the same for both sexes. Main activity, whether they are studying, working or unemployed, was the most important predictor of the likelihood of young people in my study agreeing with premarital sex as well as the likelihood of reporting experience of premarital sexual intercourse.

Although religious affiliation appeared to be significantly related to respondents' attitudes toward premarital sex for both sexes, it was insignificant as a determinant of differences in respondents' reported sexual experience. On the other hand, the age of respondents appeared to be important factors in predicting the likelihood of reporting sexual experience among male respondents, but not significant in predicting the likelihood of respondents for both sexes agreeing with premarital sex. Qualitative results suggested that premarital sex among young people who were not living with their parents was common.

As education increased, more young people left their parents' houses for study or work. This means that the probability of these young people engaging in premarital sexual activity may rise. In addition, the majority of young men have positive reactions to their first sexual intercourse, and are likely to continue seeking such relationships. Regarding at the type of partner in sexual intercourse, most of these young men have sex with more than one partner including prostitutes and *bondon*. The variety of entertainment facilities including night-clubs, discotheques, shopping malls and pornographic materials in Medan may encourage young men to satisfy their natural curiosity and they may ignore moral and religious teaching discouraging such behaviour.

As most young people in this study have little knowledge of reproductive and sexual health (see Chapter 4) they may be trapped in a pattern of risks they do not recognize. The next chapter explores the reproductive health risks that Medan young people are facing. These include premarital pregnancy, abortion and sexually transmitted diseases including HIV-AIDS.

6 Living with risks: premarital pregnancy, abortion, sexually transmitted diseases and HIV/AIDS

6.1 Introduction

As was discussed in Chapter 5, many sexually active unmarried young people reported unprotected sex and multiple sexual partners including prostitutes. These practices place females at high risk of premarital pregnancy, which often leads to forced marriage or abortion; and place both sexes at risk of sexually transmitted diseases including HIV. Young people's risky sexual behaviour is often associated with ignorance of reproduction, contraception and disease prevention as well as lack of access to family planning services (Gorgen *et al.*, 1993; Amazigo *et al.*, 1997; Hillier *et al.*, 1998; Zabin and Kiragu, 1998). In addition, studies in developing countries have reported that many females, especially girls, ignore problems related to menstruation and genital discharge or they practice self-medication which may exacerbate problems (Daili *et al.*, 1994:7; Hull *et al.*, 1996:223-224; Boonmongkon, 1997:4; Mensch *et al.*, 1998:45). For most women, then, reproductive health is a series of risks to be faced rather than a simple matter of 'facts of life'.

This chapter examines the health problems resulting from risky sexual behaviour in young people and describes factors influencing their attitudes and behaviour towards the issues. It raises questions such as: what are the best resolutions for adolescent premarital pregnancy according to young people? What are young people's attitudes towards abortion? Despite various definitions of abortion in Indonesia, how do young people define it? What do they know about STDs including HIV/AIDS? Are they concerned about these contagious diseases?

The information to answer those questions was mostly gained from focus group discussions and personal interviews with young people. The survey data are limited to information on the patterns and general information regarding young people's knowledge and attitudes toward the issues being discussed.

6.2 Premarital pregnancy

In societies where premarital sex is unacceptable, a single girl who becomes pregnant out of wedlock is generally presented with two choices: marry to legitimize the birth, or have an abortion. The adverse societal perceptions of premarital pregnancy and ex-nuptial birth have meant that very few women, especially teenagers, choose to become single mothers. When marriage is not an option, for example because the partner refuses to marry, or in cases of incest or rape, many women turn to abortion. Since abortion is illegal in most countries, it is often performed by unskilled providers in unsafe conditions. As a consequence, the risks of serious health complications and death are great.

Health risks as well as socio-economic problems are also faced by a pregnant girl who marries to legitimize her pregnancy: teenage pregnancy, regardless of marital status, can be dangerous for both mother and infant. Empirical studies have indicated that teenage mothers have higher risks than older mothers of pregnancy-related complications such as hypertension, cephalopelvic disproportion, iron deficiency and anaemia (Zelnik *et al.*, 1981; Senderowitz, 1995:17; Zabin and Kiragu, 1998: 215-217). Other studies suggest socio-economic problems related to teenage marriage (Ajayi *et al.*, 1991; Singh and Samara, 1996:148-175). A young girl is likely to give up her formal education, career and personal growth for her pregnancy. In addition, women who have first births conceived out of wedlock are more likely to experience marriage dissolution than those whos first child is conceived within a marriage (Mc Carthy and Menken, 1981:229).

The resolution of premarital pregnancy is influenced by many factors such as the social milieu including family and societal attitudes and the legalization of

abortion (Moore and Caldwell, 1981; Cooksey, 1990; Moore and Rosenthal, 1993). Moore and Caldwell's (1981) study among girls aged 15-19 in the United States found that in states having relatively generous Aid to Families with Dependent Children (this includes children born out of wedlock), the probability of abortion is significantly lower. The probability of forced marriage because of pregnancy or having an ex-nuptial child is slightly (but statistically not significant) higher. Moore and Caldwell (1981) also suggested that the availability of abortion slightly reduces the probability of forced marriage and has significant effects in reducing the likelihood of an ex-nuptial birth.

Another study (Cooksey, 1990) in the United States revealed that the first premarital pregnancy resolutions were significantly associated with family background factors such as ethnicity, family structure, age at first conception, family size, working mother and parental education. Black young women were more likely than Whites and Hispanics to have their children out of wedlock. The study also suggested that regardless of ethnicity, as parental education increase the likelihood of childbearing, especially ex-nuptial childbearing, decreases, and the likelihood of abortion increases fourfold between the lowest and highest education levels. The effects of family structure, age at first conception, family size and working mothers on premarital pregnancy resolution differ between Blacks, Whites and Hispanics (Cooksey, 1990:213-216).

In Indonesia where abortion and ex-nuptial childbearing are regarded as disgraceful by the society, many premarital pregnancies result in marriage. Nevertheless, it is believed that the number of abortions due to premarital pregnancy is increasing (Kristanti, 1996; Emiyanti *et al.*, 1997; *Media Indonesia Online*, 22 October 2000). A qualitative study in Yogyakarta in 1997, among 44 women age 15-24 who were or had ever been premaritally pregnant, found that 26 respondents reported continuing with the pregnancy and 18 respondents reported terminating the pregnancy (Khisbiyah *et al.*, 1997:43). Of those who continued the pregnancy, 21 respondents married during their pregnancy and only five respondents remained single.

Nevertheless, as the number of premarital pregnancies increases, more unmarried women find the option of abortion preferable to forced marriage. Data from focus groups among medical doctors and midwives in Medan revealed that abortions were mostly requested by unmarried women (Emiyanti *et al.*, 1997:14). Reports from 10 PKBI clinics in various Indonesian cities including Medan showed that the proportion of abortions among females aged 15-24 increased from nine per cent a of total 7683 abortion cases in 1992, to 35 per cent of 4314 cases in 1993 (Kristanti, 1996:204). Recent PKBI reports indicated that for 1998 and 1999, in Indonesia, there were two million abortions each year, and 750,000 (38 per cent) of them were requested by single young women (*Media Indonesia Online*, 22 October 2000).

6.2.1 The resolution of premarital pregnancy: young people's perspectives

To gain information about young people's opinions on premarital pregnancy resolutions, survey respondents were asked what they considered the best solution for adolescent premarital pregnancy, families would solve teenage premarital pregnancy, and the attitudes of people around them toward premarital pregnancy.

Table 6.1 Solutions for adolescents' premarital pregnancy

	Number of respondents N=875	Percentage
Respondents' solutions		
Marriage	721	88
Abortion	55	7
Unwed motherhood	28	3
Other	16	2
Family's solutions		
Marriage	769	94
Abortion	21	3
Unwed motherhood	6	1
Expel from the family	9	1
0ther	15	2
Societal attitudes		
No problem if then married	201	25
Do not care	59	7
Condemn	554	68
Other	6	1

Source : Medan Adolescent Reproductive Health Survey, 1997- 98

Table 6.1 indicates that marriage is considered by young people and parents to be the best solution for adolescent premarital pregnancy. Nevertheless, there is a slight difference of opinion between young people and their families: young people's solutions were not always the same as what they said their family would do. Seven per cent of respondents said abortion is the best solution for teenage premarital pregnancy compared to only three per cent of respondents who said that their family would suggest it. Unwed motherhood is not considered the best solution for most young people. Very few respondents said it is the best solution and fewer respondents said that their family would suggest giving birth outside marriage. Considering the negative reaction of most people in Medan to single mothers and ex-nuptial children, this attitude is understandable. A few respondents suggested spontaneously that their family would expel a premaritally pregnant girl from the family (*diusir dari keluarga*), nevertheless none of respondents regarded this as the best solution[1].

The survey also suggests that if quickly followed by marriage, premarital pregnancy is no longer seen as a problem by many people. A quarter of respondents said that the people around them would have no problem with premarital pregnancy as long as the girl then married. Seven per cent of respondents even said that the people do not care. Data from focus groups and in-depth interviews also support this view. In a personal interview a 70-year-old mother of seven daughters and three sons said:

> Nowadays words such as *'sudahlah yang penting kawin* (the important thing is that they get married)' are common among parents and society. Many marriages occur because of pregnancy. Some parents even told me about it [the pregnancy]. In the past, premarital pregnancy was very rare, and if it happened, the parents would wed them secretly (Uli, housewife, Toba Batak).

Among young people in Medan, a girl who marries because of pregnancy is labeled an 'MBA' (Marriage By Accident, not Master of Business Administration): according to respondents, the increase in such marriages has

[1] Originally, 'expel from the family' was not provided in the questionnaire. However since more than one per cent of respondents mentioned it, instead of putting it into the category Others, I categorized it separately.

inspired young people to create a label for them. Almost all focus group participants said they had friends or relatives who were forced to marry because of pregnancy.

In the focus group discussions among married men, four out of five participants said they got married because of their girlfriends' 'accidental pregnancy'; in focus group discussions among married women, three out of five participants stated they got married because 'they were dating too far' (*pacarannya terlalu seru*). Almost all participants who reported a pregnancy-forced marriage claimed that they were not ready to marry but had no choice.

In-depth interview respondents who married to legitimize their pregnancy said that when they suspected that they were pregnant, most of them attempted to 'regulate their menstruation' by taking traditional herbs (*jamu*), drinking young pineapple juice, or having massages; when they failed to terminate the pregnancy, they had no choice but to tell their parents. According to respondents, once the parents knew, marriage was almost certain. All of them said they married the men who made them pregnant. Most of them reported marrying when three or four months pregnant.

The double standard in society related to premarital pregnancy was mentioned by married women. In a focus group of women, a participant said that when people find out a single woman is pregnant, they automatically blame the woman more than the man. Participants think this is not fair, since usually it is the man who initiates premarital sex. When this issue was raised in a focus group among male university students most of them believed that was normal; one discussant stated that this opinion could be related to biological differences between men and women:

> It is normal for a man to initiate sex. A man, just like sperm (*sperma*) is very active. And a woman is like an ovum (*sel telur*), passive. In other words, it is normal for a man to 'attack' and a woman has to protect (*bertahan*) herself. That is why a woman is often blamed because she did not protect herself properly (Joni, 21 year-old college student, Malay, Moslem).

The different opinions between men and women also appear when the participants are asked: if the man refuses to marry, what is the best solution for adolescent premarital pregnancy? In focus groups among men, three opinions arose: send the girl away until the baby is delivered; terminate the pregnancy; find a man who is willing to marry her. Some male participants said 'If it is necessary, pay a man to marry her. If later on the marriage does not work, they can ask for divorce; the important thing is to legitimize the baby'. Below are some of opinions raised in men's focus groups.

> I think it is better to keep the baby, send the girl to another city to avoid *omongan tetangga* (rumours in the neighbourhood). Raise the child, socially indeed it is very difficult, but that is the risk (Martin, 23 year-old college student, Karo Batak, Christian).

> In my opinion abortion is better, because the child has no status in the society, a bastard (*anak haram*), the child will suffer, and it will become a mental burden (*beban mental*) for her or him (Ramos, 24 year-old college student, Toba Batak, Christian)

> I do not agree with abortion, better to keep the child, and marry the girl to any man who is willing. In my home town [about 6 hours drive from Medan] there was a girl who got pregnant and was dumped (*ditinggal lari*) by her boyfriend. Then her father said that, if there is a man willing to marry his daughter he will give the man millions of rupiahs. Then there was a man who is willing, maybe because of the money, but until now they are still married (Sakri, 23 year-old college student, Javanese, Moslem)

In among women's focus groups, only the first two options arose: abortion or become single motherhood. None of the female participants agreed with the last option. They argued that asking a man to father someone else's child would create more problems than solve them.

Most participants believed that the best solution for an unmarried pregnant girl who could not marry the baby's father was to become a single mother. Those who supported this opinion did not agree with abortion, saying that abortion is a sin and raising a child is a blessing (*karunia*). They argued that there is no bastard child (*anak haram*), all babies are innocent. However, most participants

admitted that an unwed mother is still not accepted in society. Very few participants knew someone who raised her children without being married.

Those who agree with abortion state that raising a child without marriage is very difficult for a teenager. It will ruin the girl's and the child's futures. Those who support this view say giving a child up for adoption is not a good solution, because later on in life the child will feel unwanted and blame the mother.

6.3 Abortion

As a single mother remains a disgrace in many countries, abortion may be the only option for some unmarried girls if marriage is not possible. In developing countries, it is estimated that each year adolescents obtain 1 million to 4.4 million abortions (Senderowitz, 1995:1). Given the fact that abortion is usually illegal, most of these abortions are likely to be performed by unskilled providers in unsafe conditions. According to World Health Organization calculations, in developing countries, excluding China, in 1995 there were 24.9 million abortions a year. Of those abortions it is estimated that more than two third were illegal (WHO, 1998 cited in Henshaw *et al.*, 1999:32).

The Programme of Action of the 1994 ICPD urged governments and other relevant organizations 'to deal with the health impact of unsafe abortion as a major public concern and to reduce the recourse to abortion through expanded and improved family planning services' (UN, 1994). Implementing this recommendation is not easy, especially in countries where abortion is illegal.

According to the Indonesian Criminal Code enacted in 1918 and Indonesian Health Law no 23 of 1992, abortion is a crime against morals and life. Nevertheless, it is known that abortions are widely practised in Indonesia by both medical and non-medical personnel (Utomo *et al.*, 1982; Hull *et al.*, 1993). The chairman of the Indonesian Doctors' Association, Azrul Anwar, has stated that doctors were aware their colleagues conducted abortions but there was an unspoken agreement among them not to report such activities, unless their

actions had adversely affected a patient. According to Anwar, nowadays the demand for abortion is increasing (*Jakarta Post*, 13 November 1998:3).

Traditionally, abortions have been practised among many ethnic groups in Indonesia. They were performed by traditional healers using many techniques such as massage (*pijat*), traditional herbs (*jamu*), or inserting various objects or liquids in the vagina (Utomo *et al.*, 1982; Hull *et al.*, 1993; Singarimbun, 1996, Lubis, 1997). Singarimbun (1996) noted that among the Karo Batak, traditional abortion has been practiced for a long time: during his stay in a Karo village in the early 1960s, *tengkua*, a kind of plant, was commonly used for abortion by inserting it in the vagina. Among Javanese, traditional massage and *jamu* have been used for a long time to 'regulate' delayed menstruation (Rahardjo, 1990).

As indicated above, the number of abortions among unmarried young people is increasing. Despite the law that restricts abortion, many people in Medan believe that an abortion is relatively easy to obtain. In late 1997 a local newspaper reported that in Medan abortions are no secret and are relatively safe from the authorities' investigation (*Mimbar Umum*, 15 December 1997:1). A senior staff member in PKBI Medan said that in a year the clinic itself conducts more than 500 menstrual regulations (*induksi haid/ IH*) and the numbers are increasing each year. These numbers do not including abortions conducted by PKBI doctors in their own private practice[2].

6.3.1 The abortion debate in Indonesia: when is a foetus considered to be a human?

Abortion has been a controversial issue among experts as well as in general society in Indonesia for a long time. The debate is changing over time. During the 1970s and 1980s, the debate among experts was mostly on the status of abortion under the law (Utomo *et al.*, 1982). During these years, abortion was regulated under the Indonesian Criminal Code enacted in 1918 by the Dutch

[2] In Indonesia, it is common that general practitioners and midwives perform abortions in the form of menstrual regulation procedures in their private practices.

colonial government. This law was inspired by conservative Dutch Reform Church pressures and Indonesian customs that were strongly influenced by 'modern' religions such as Islam, Hinduism, Buddhism and Christianity (Hull *et al.*, 1993:242). According to this law, all forms of induced abortions are crimes against morality and against human life. Since in practice many doctors carried out abortions for medical reasons, many attempts were made to reform this law (Soewondo, 1982 cited in Hull *et al.*, 1993).

In the early 1990s, the public debate on abortion centred on the uncertainty arising from the vague meaning of terms used in the new law about abortion, Health Law No. 23 of 1992 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 foetus, it is permissible to carry out certain medical procedures.

Then this paragraph is clarified with the following:

> Medical procedures in the form of 'abortion' (*pengguguran kandungan*), for any reason, are forbidden as they violate legal norms, religious norms, ethical norms, and norms of propriety. Nevertheless, in case of emergency and with the purpose of saving the life of a pregnant woman and/or the foetus in her womb, it is permissible to carry out certain medical procedures.

This paragraph has created public debates among experts (Mohamad, 1992; Sumapraja, 1992; Hull *et al.*, 1993). Hull *et al.* (1993) noted that the explanations of the paragraph contradict the substance of the paragraph itself. Furthermore they argue that the terms used in the explanation have created two uncertainties; linguistic confusion over the term 'certain medical procedures' and the unclear meaning of 'violate legal norms, ethical norms, religious norms and norms of propriety' (Hull *et al.*, 1993:245).

In late 1997, the public debate over abortion heated up in Jakarta, when newspapers reported foetal parts being discovered in a garbage dump in North Jakarta by a group of children. This time the issues debated mostly focused on the time a foetus is considered a human being (*Jakarta Post*, 27 November 1997:3;

Kompas, 30 November 1997:15; *Kompas*, 13 December 1997; *Gatra*, 6 December 1997; Mohamad, 1998:65).

In Indonesia there are many opinions regarding the exact time a foetus is considered alive; most opinions are based on religious belief. Catholics believe a foetus must be treated as a human life from conception. In Islam there are three opinions; some Moslem leaders believe that a foetus is alive after 120 days, others believe after 14 days, and others that life starts at conception (Singarimbun, 1996:131). Hindus believe a foetus is alive from conception (Manuaba, 1995 cited in Dewi, 1997:12). Indonesian law is based on the opinion that from the moment of conception the foetus must be protected. Nursjahbani Katjasungkana, an Indonesian senior lawyer said:

> The exact time when a foetus is considered alive is central to the abortion controversy. That is why government officials, doctors, religious leaders should first reach consensus on it...if they can reach an agreement, then we will talk about making a law to legalize the practice (*Jakarta Post Online*, 17 November 1997)

Nevertheless, until recently debates over abortion issues have still continued (*Media Indonesia Online*, 30 March 2001; *Jakarta Post Online*, 1,3 April 2001). Given the increased number of illegal abortions, many experts, especially medical doctors have demanded that the government solve the confusion over the Health Law No. 23/1992 and suggested it should set up an institution to perform legal abortions. One of Muhammadiyah's[3] leaders told the press that according to Islam, abortion is permitted if it is done before 120 days of pregnancy (*Media Indonesia Online*, 30 March 2001), therefore he believes that Muhamadiyah approves abortion as a family planning method. This opinion is contrary to the view of the State Minister of Women's Empowerment and Head of BKKBN, who strongly opposed abortion as part of the family planning program (*Jakarta Post Online*, 16 February 2000).

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[3] Muhammadiyah is the second biggest Moslem organization in Indonesia.

6.3.2 Young people's definitions of abortion: prevention or termination?

The concepts and definitions of abortion among young people in Medan are also influenced by the public debate over the time when a foetus is considered alive. Data from focus groups revealed that young people's definitions of abortion vary according to their knowledge and beliefs about human conception. Below are some definitions provided by young people in focus groups.

> In my opinion, a woman is considered to have had an abortion when she knows she is pregnant and does something to terminate the pregnancy (Martin, 23-year-old college student, Karo Batak, Christian, male)

> In my opinion abortion is after three months, because it is already a foetus (*sudah jadi janin*), under three month it is still just a clot (*berbentuk gumpalan darah)* (Joni, 21-year-old college student, Malay, Moslem, male)

> Abortion is 'removal' (*menggugurkan*) and it means the foetus already exists (*udah ada janinnya*). In blunt words (*bahasa kasarnya*), killing a foetus. The foetus exists after about one and a half months to two months (Erna, 23-year-old college student Javanese, Moslem, female)

> Abortion is after a foetus is alive, which means when a woman can feel the foetus move (Lina, 17-year-old high school student, Chinese, Buddhist, female).

> In my opinion abortion is intention (*niat*), when a woman intends to terminate her pregnancy, no matter how old it is, for me that is an abortion (Esther, 22-year-old college student, Toba Batak, Christian, female).

Young people's definitions of abortion must be related to their confusion about conception (see Chapter 4). Within a context of confusion, many young people believe that pregnancy can be 'prevented' after having sex by massage or drinking *jamu* (see Chapter 7). Focus group participants were asked what they would say if a sexually active woman who had not menstruated for more than a month, drank *jamu* or a mixture of young pineapple with other herbs to 'regulate her menstruation'. Very few participants considered it a pregnancy termination. Most young people believe drinking *jamu* is 'pregnancy prevention'. Among

married young women in this study, taking it to regulate their menstruation is common.

Originally *jamu* is from Java. Since Javanese have been living in Medan for more than a century (see Chapter 2), *jamu* is well known among Medan people, regardless of ethnicity. Nowadays, *jamu* can be obtained easily at shops, kiosks or supermarkets in the form of pills, powder, leaves and roots. *Jamu* that were often mentioned by young women to regulate menstruation were *jamu terlambat bulan* and *jamu peluntur*. Some respondents believe that *jamu peluntur* is stronger than *jamu terlambat bulan*. A respondent said than *jamu terlambat bulan* is usually used to regulate menstruation, while *jamu peluntur* is used to terminate pregnancy. However, looking at the ingredients, there are no significant differences between these *jamu*.

All focus group participants said that abortion is illegal in Indonesia, but none of them knew the definition of abortion in Indonesian law. These young people are not aware that what they consider pregnancy prevention may be categorized as pregnancy termination under Indonesian laws. Many young people in this study believe that the foetus is exists or alive 6-12 weeks after sexual intercourse. Thus, many believe that any action before that period is legal because it is pregnancy prevention.

6.3.3 Young people's attitudes to abortion

Young people in the survey were asked the question 'What is your attitude to abortion[4]?'. The results indicate that the majority of young people disapproved. Two-thirds of the respondents did not approve abortion for any reason; 24 per cent approved to save the mother's life and eight per cent approved to save the family's reputation. There is no significant difference between men's and women's attitudes toward abortion.

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[4] In the questionnaire I did not provide a technical definition of abortion, so the respondents' answers were based on their own concepts and definitions.

Table 6.2 Percentage of male and female respondents who agreed with abortion, by socio-demographic characteristics

	Males N=463		Females N=412	
	Number	%	Number	%
Age group		*		**
15-17 years	196	28	166	26
18-20 years	98	21	134	27
21-24 years	169	44	112	49
Main activity				*
Study	335	32	331	31
Working	103	30	50	48
Unemployment	25	44	31	29
Religion				
Moslem	278	31	224	30
Christian	144	35	123	34
Buddhism/Hindu	41	37	65	40
Ethnicity				
Javanese	91	26	77	31
Toba Batak	102	35	64	27
Mandailing Batak	67	27	47	21
Other Batak	52	27	36	39
Malay	57	37	52	44
Chinese	53	36	97	39
Other	41	44	39	21
Living arrangement				
With one or both parents	329	31	307	30
With sibling or other relative	61	31	42	31
Boarding house	73	38	63	44
Mother's education				
Part/finished elementary	105	31	66	30
Finished JHS	89	35	84	31
Finished SHS	189	31	181	33
University/academy	80	34	81	36
Father's education				
Part/finished elementary	64	34	40	25
Finished JHS	78	27	59	34
Finished SHS	165	33	167	36
University/academy	156	33	146	30
Mother's occupation				
Public servant/retired	68	38	62	40
Employee/labourer	23	39	17	24
Trader	123	23	82	39
Not employed	210	36	196	31
Other	39	31	55	24
Father's occupation				
Public servant/retired	206	33	161	27
Employee/labourer	101	38	87	37
Trader	87	29	89	40
Not employed	13	23	9	33
Other	56	29	66	29

Note : * = Significant at $p < 0.05$ ** = Significant at $p < 0.001$
Source : Medan Adolescent Reproductive Health Survey, 1997-98

In bivariate analysis, respondents' attitudes were grouped into two categories: those who do not approve of abortion for any reason and those who approve for some reasons including saving the mother's life and family's reputation.

Table 6.2 shows the percentage of men and women who approve of abortion according to socio-demographic characteristics. The results suggest that the differences by age were statistically significant for both males and females. Those aged 21-24 years are more likely to agree with abortion than those who are younger. Differences by main activity are only significant among women; working young women are more likely to approve of abortion than women studying or unemployed. However, given the small number of working and unemployed women in this study (50 and 31 respondents, respectively) this result should be interpreted with caution. Factors that were expected to be significant, such as religious affiliation, ethnicity and parental background, appear not to be linked to attitudes to abortion.

Young people's attitudes to abortion are also associated with their understanding of abortion. In focus group discussions among female college students, when the participants were asked their attitudes to abortion, all said they did not approve. They believed abortion to be both a sin and dangerous. Later, after the discussion about the definition of abortion, I asked what are their attitudes were to a sexually active woman who seeks a doctor to 'regulate her menstruation' because she has missed her period two times. To this question, some participants answered that they disapproved while others approved. Those who believe that the foetus is alive soon after sexual intercourse did not approve. They argued that it is an abortion. Others who believe that pregnancy occurs 6-12 weeks after sexual intercourse approved. They believed that it is pregnancy prevention. Young people's confusion about conception together with the controversy about abortion appears to have significantly affected their understanding of abortion; this influence their attitudes to it.

6.3.4 Young women's experiences of abortion

Gaining information about young people's experience with abortion is never easy, especially when abortion is done secretly. Most Indonesian women, especially those who are unmarried, are reluctant to share information on this stressful experience. Considering the sensitivity of the matter in this study, questions related to respondents' experiences of abortion were only asked in personal interviews. Press reports in local magazines about young people's experiences with abortion are also cited to give more understanding of the reasons why unmarried young women turn to abortion.

The decision to obtain an abortion is not simple. It involves morals, health, religion, law, psychology and economics. A girl who terminates her pregnancy is often in a desperate situation; when marriage is not an option, abortion is often seen as the best way to avoid more problems. Raising an ex-nuptial child, in a country like Indonesia where premarital sex is socially unacceptable but privately common, may cause trouble not only for the girl and the child, but for the whole family. For some girls abortion may also be seen as a 'punishment' for their sin of having premarital sex.

Information concerning young people and abortion was obtained from Cc, 26 years old, who works in a private company in Medan. I met Cc accidentally when I was having lunch and observing young high school students hanging around in a shopping centre. Seeing me sitting alone, Cc approached me and told me that she fell uncomfortable eating alone in a public area. She looked nice and very mature for her age. While waiting for her food, Cc saw that I bought a lot of magazines and newspapers with reports on abortions as the headlines. She asked my opinion about abortion. After talking for a while, perhaps because she was impressed with my opinions (I did not tell her that I was doing research on the topic), Cc mentioned that she had had an abortion about four years ago. I had a feeling she wanted to share her experience with someone who did not know her, so I just let her talk and asked some questions. I did not take notes when we were talking, afraid that she might feel uncomfortable. When she

finished telling me of her experience, I asked her for an interview for my research. She looked hesitant and said that she had already told me everything. She said she wanted to forget her past. I could understand her reluctance and I did not wish to push her. However, she gave me permission to quote her story using a pseudonym. I wrote the following field note on my return home. This is Cc's story:

> I had an abortion about four years ago, when I was a student in Jakarta. I was 22 years old at that time. Actually I wanted to keep the baby, but because it was impossible to marry my boyfriend I had no choice but to give it up. I cannot imagine being an unwed mother. You know our society. I pitied my family. For myself I might say 'this is my fault and this is my risk; but I could not say that to my family. They are not to blame. I come from a respectable family.
>
> I could not marry my boyfriend because he is married, and also he is my cousin's husband. I did not want to ruin his family and also my family. So, I had no choice but to terminate my pregnancy. By doing this I would be the only one who got hurt and be burdened by sins (*menanggung dosa*). I told myself this was my punishment. It hurt. I was very scared and depressed. There is no one I could talk to because I did not want anyone to know my affairs.
>
> When I found out that I did not have my period on time, I was scared. After three days, I tried to regulate my menstruation by taking traditional herbs (*jamu peluntur*). I doubled the doses. I took them for about a week. When I still had not had my period, I told my boyfriend about it. I told him I wanted to abort it. I did not ask his permission, I just told him what I had decided. I think he was happy with my decision. He gave me money. It was quite a lot at that time.
>
> At first I didn't know where to go. I had heard about Raden Saleh Clinic, but I didn't want to go there. For me it was too public. I was afraid I might meet someone that I knew there. So I went to a gynaecologist. I told the doctor that I just married and my husband is still studying overseas so we are not ready to have a baby. The doctor refused to do any abortion if not for a health problem. I tried to persuade him, telling him that I would be unable to stay with my husband if I continued with this pregnancy. Maybe he pitied me, so he sent me to one of his colleagues in a maternity clinic.
>
> I went to the clinic, and made an appointment with a nurse for two days away. I was asked to arrive at seven in the morning, and was not allowed to eat anything after 10 pm a day before. The abortion

> was fast. The doctor did not say much. The nurse introduced me to the doctor when I was already on the bed. There were only two nurses and a doctor. I was given a general anaesthetic. When I woke, I was already in a different room. And it was done. The doctor was already gone. The nurse gave me a cup of sweet tea, a 'painkiller' and vitamins. I was asked to have a rest until I felt strong enough to go home. I only needed about fifteen minuets rest before I went home by taxi. On the way home, I bought the doctor's prescriptions. I only felt a bit dizzy that day and the next day I could do my regular activities.
>
> After I had the abortion, I felt a bit depressed. My feelings were a mixture of sadness, guilt and relief. I did not talk to anyone. I even felt ashamed to pray. I felt very guilty and sinful. I decided to stop my affair. Until now I still avoid being alone with him. It is not easy since he is also my relative. Fortunately he lives in a different city. No one knows about our relationship and I want to keep it that way. He is still nice and kind to me, but we both know that we had to stop it. When I graduated, I left Jakarta and looked for work here [in Medan]. I want to forget about Jakarta.

When I asked if they ever used contraception, Cc said:

> In a way yes, because most of the times we only had it [sex] during my safe period, or else he pulled and 'threw it outside' [withdrawal]. I did not use pills because I heard that pills need a doctor's prescription. Since I am not married, I did not want to go to the doctor for that. I was shy to ask my boyfriend to use a condom. It is a kind of dilemma for me. I am afraid that he will think that I am the one who suggested to have sex. I heard that a man would not enjoy it [sex] if he wears a condom. Also, we did not do it [have sex] often, just once a month or once every two or three months. So we thought the calendar system was sufficient. But then I mis-calculated it, I got pregnant.

Previous studies and reports in the mass media suggest that many women in Indonesia in similar situations turn to abortion (Khisbiyah *et al.*, 1997; *Tiras*, 15 December 1997; *D&R*, 6 December 1997). Those who have money to seek medical treatment go to a doctor, but those who lack money often go to traditional birth attendants in unsafe conditions. Compared to other girls, Cc was lucky because her boyfriend provided her with enough money, but many pregnant girls lack such support and financial assistance.

6.4 Sexually transmitted diseases, HIV/AIDS

Recently there has been growing awareness of the risks of sexually transmitted diseases (STDs) including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) among young people. Young people, the especially unmarried, are particularly vulnerable to these infections because most of them have little knowledge about them (Adekunle & Ladipo, 1992; Utomo *et al.*, 1997:8), do not or inconsistently use condoms (Gifford *et al.*, 1999; Varga, 1999), have multiple sex partners, including prostitutes (Carael, 1995:80; Domingo, 1995; Lee, 1995:173; Balk *et al.*, 1999), and are reluctant to seek medical treatment (WHO, 1989 cited in Senderowitz, 1995:20).

Young people, both in developed and developing countries, are reported as the group suffering most from STDs including HIV. Data from the Population Reference Bureau in 1994 indicated that one in 20 teenagers through the world contracts STDs and about half of all HIV infections so far have occurred in people younger than 25 years of age (Keeting, 1995:29). In developed countries, more than two-thirds of all reported gonorrhoea occurs among young people under 25 (Senderowitz, 1995:19). Data from developing countries are limited, but considering that treatment is less accessible, the prevalence in developing countries may be higher. In Kenya and Uganda the highest incidence of STDs was among those 15-25 years old (WHO, 1986, 1989 cited in Senderowitz, 1995:20). In Thailand, according to government statistics in 1992, 47 per cent of STD patients were those in the age group 15-24 years and half the HIV cases were in the age group 15-25 years (Boonmongkon, 1997:2).

In Indonesia, there are no official data regarding STDs among young people in general. Most research and programs on STDs are specifically focused on prostitutes and those who visit family planning or maternal clinics (Daili *et al.*, 1994:3, Hull *et al.*, 1996:230-231). However, national data about HIV/AIDS cases suggest that in Indonesia young people aged 20-29 years old are the largest group reported to be HIV positive (Utomo *et al.*, 1997:3).

6.4.1 Young people's knowledge of STDs, HIV/AIDS

This study limited its focus to the most common STDs in Indonesia, gonorrhoea, syphilis and HIV/AIDS. These diseases are commonly known by the local people as *penyakit kotor* (dirty diseases), or *penyakit kelamin* (genital disease). Among young people, STDs and AIDS are not strange, because they are discussed in high schools as part of the subject Sport and Health (*mata pelajaran olah raga dan kesehatan*). Nevertheless misinformation abounds. In focus groups many participants said that the information they received from school was too general and not comprehensive enough.

To gain information about young people's knowledge, respondents were asked several questions such as: 'Have you ever heard of gonorrhea, syphilis, HIV/AIDS or vaginal discharge? Do you know the symptom of those diseases?'.

Table 6.3 Percentage of respondents who reported have heard of and recognized the symptoms of STDs and HIV/AIDS

	Males	Females	Males+Females
Have heard of			
Gonorrhoea	64	52	58
Syphilis	81	52	73
HIV/AIDS	92	96	95
Recognize the symptoms of			
Gonorrhoea	35	19	28
Syphilis	47	22	36
HIV/AIDS	59	68	63

Source : Medan Adolescent Reproductive Health Survey, 1997- 98

Table 6.3, shows that more than half of all respondents had heard of gonorrhoea, 73 per cent had heard of syphilis and almost all had heard about HIV/AIDS. The results suggest that although gonorrhoea and syphilis have been around for a long time in Indonesia (Van der Sterren *et al.*, 1997), the more recent yet more virulent disease of AIDS is much better-known among young people. This is partly because programs regarding HIV/AIDS in Indonesia, especially in Medan, are more intensive than general STD programs: in Medan, apart from government institutions, at least two NGOs have specialial programs on

HIV/AIDS for young people (see Chapter 7). There is no similar program for other STDs.

The findings also suggest that although young people reported knowing or having heard about STDs, few of them were confident of recognizing the symptoms. Only 28 per cent of all respondents reported recognizing gonorrhoea's symptoms, 36 per cent recognizing syphilis symptoms and 63 per cent recognizing HIV/AIDS symptoms, compared to the 58 per cent, 73 per cent and 95 per cent of all respondents respectively who claimed to have heard of these diseases.

The figures indicate that men reported better knowledge than women of STDs, excluding HIV/AIDS. This is understandable, because many young people believe only those who have sex with prostitutes may have these 'dirty' diseases. Therefore, as men are likely to visit prostitutes, they may be more concerned than women about STDs.

Focus group discussions also supported this result. In female focus groups, when asked about STDs many participants said they did not know much. They are not to keen to know about STDs because they believe only promiscuous persons suffer from them. As stated by two participants among female college students:

> I do not know much about STDs. I knew about them from school when I was in high school. It was part of the subject Sport and Health. At that time we learned about the symptoms of syphilis, gonorrhoea, AIDS and others. I was not interested at that time. That is why I have forgotten now. What I know is just that STDs are diseases that a man can get from prostitutes (Silvi, 22-year-old college student).

> They are diseases suffered by those who like to go to prostitutes (Tetty, 21- year-old college student).

When the same question was asked in focus groups among males, most participants claimed to know about STDs and explained the symptoms correctly. Although none of young men in focus groups reported having had STDs, many reported having friends who had contracted the diseases. In-depth interviews

among young men on the street revealed that many of them had experienced STDs (see 6.4.3).

Most young people in this study have heard about AIDS and know some of the symptoms. However, data from in-depth interviews and focus groups revealed that their understanding about it is still poor. Some young people believe that AIDS is a 'moral disease', it is a *'penyakit kutukan'* (a disease resulting from being cursed). They believe only those who are immoral and sinful suffer the disease. This opinion is found not only among those who are uneducated, but also among college students. As stated in two in-depth interviews:

> In my opinion, AIDS is a disease that is given by God because people are sinful. It is a warning [from God]. But it can also be said to be a disease transmitted through sexual contact (Iyan, 19-year-old high school dropout, *preman*).

> In my opinion, AIDS is like a disease brought on by a curse. Mostly those who conduct a 'bad life' suffer this disease. That is why until now there is no medicine to cure it, although much research has been done, but with no success (Deny, 20-year-old college student).

Many focus group participants also said that AIDS is a disease brought by Westerners. Therefore, many believed that one way to prevent AIDS is by avoiding sex with Westerners. According to these young people those who are involved with Westerners have a higher risk of contracting AIDS than those not involved.

6.4.2 Misinformation regarding STD and AIDS prevention

Most young people in Medan know that using condoms can prevent them from contracting STDs and AIDS, but few of them use condoms consistently. Condoms are considered to be barriers to their sexual pleasure. In-depth interviews show that many respondents, especially those who work on the streets, believe that STDs and AIDS can be prevented by maintaining physical stamina, only having sex with 'a clean and healthy' person and taking some 'medicine' before sex.

Data from the survey and in-depth interviews reveal that most young men who work on the streets are sexually active and visit prostitutes regularly. Unlike students, who claimed to be always prepared with condoms when visiting prostitutes, those who work in informal sectors do not feel a need to use condoms even though they are aware of the possibility of getting STDs; according to these young people condoms hamper sexual activities. Also many of them believe that STDs and AIDS can be prevented by maintaining their physical stamina (eating nutritious food) or taking antibiotics before have sex with a prostitute. In-depth interviews produced the following statements.

> I usually have sex with a prostitute. I do not use any contraception, like a condom. When I use it I can not feel 'it', I do not feel good. I have never been asked to use condom by a prostitute, if someone asked me to, I would leave her, because it means she already has diseases. About 'genital diseases', that depends on the blood immunity *(ketahanan darah)*. That depends on the stamina. Usually when I am going to do 'it' with a prostitute, I'll ask her first whether she is healthy or not. Whether she is honest or not is a different matter, the important thing is her 'confession'. But just in case, I often have Kanamycin [an antibiotic]. Generally, in a month I will go to prostitutes maybe two times. Frequently, I go to Bandar Baru, because the weather is cold there and also I can choose the prostitutes that I like (Oman, 23 year-old university dropout, *Preman*, Karo Batak).

> Sometimes, I have sex with a *bondon* that I meet in the mall, plaza or discotheque, but sometime I also have to go to a prostitute, because not all *bondons* are willing to have sex. Usually the prostitutes that I date are in Bandar Baru or Nibung. I do not use a condom, but I often use 'magic power' [a kind of cream rubbed on the penis]. I buy it at the chemist or in Sambu [a traditional market in Medan]. When I think about the diseases, I am afraid that I might get them, but I do not feel comfortable using condoms (David, 20-year-old junior high school graduate, working in an illegal gambling place/*Toto gelap*, Mandailing Batak).

> I prefer to go to a *bondon*, although we don't have money, we can date them until morning. We just give them *'gelek'* (marijuana) or *'kancing'* (drugs in the form of pills) and they will be happy. I never use a condom, I don't feel good. The good thing when having sex is 'the rubbing', using condom we cannot feel that, so it doesn't feel good. Also when you're aroused, you don't have time to think about those things, there is a saying 'you just need a place for two people to stand' (Adi, 18-years-old junior high school drop out, informal parking person).

> I go to prostitutes more often [than to *bondon*]. Usually to Bandar Baru or to Nibung or sometimes with a *bodon* in a discotheque. When I 'play' I do not like using a condom, because I could not 'feel', it does not feel good. Whenever I go to a prostitute, I maintain my stamina. I have to be fit, because we can get 'dirty diseases' if our bodies are 'weak'. Usually I choose a clean prostitute, I do not just pick her up. I know how to tell a prostitute that is already 'dirty'. Usually her eyes are yellowish and her face is pale and her vagina feels hot. It means she has 'dirty diseases'. For a person like me, who are regular visitors in Nibung or Bandar Baru, I already know about most prostitutes there, their 'cleanness', *goyangannya* (how they 'perform') and 'services' (Edi, 24- year-old broker/*calo*)

Misconceptions about STDs and HIV/AIDS also occur among college students. In focus groups among male college students, most participants believe that using a condom is essential when having sex with a prostitute but not when having sex with a *bondon*. They argue that a *bondon* is clean because usually she chooses her partners carefully and because most *bondon* come from relatively well-off families. Two focus group participants said when asked whether they used condoms when having sex with a *bondon* or a prostitute:

> With a prostitute I have to use a condom, because it is dangerous, but not with a *bondon,* because usually a *bondon* is much 'cleaner' than a prostitute. A *bondon* would not have sex with just anybody (*sembarang orang*), she is choosy (*pilih-pilih bulu*), so with a *bondon* without using a condom is OK (*enggak usah diapakan kali*) (Joni, 21-year-old college student, Malay).

> With *bondons* it is different as I mentioned before, they have higher status than prostitutes, so when dating a *bondon* (*ngebondon*) it is rare for a man to use a condom, but when we go to prostitutes we prepare them (condoms) (Ramos, 24 year-old college student, Toba Batak).

Although a *bondon* is regarded as having higher status, some young people prefer to go to a prostitute. In an in-depth interview, 20- year old Deny, a college student who spends most of his time hanging around with *preman,* told of his sexual experiences with prostitutes and *bondon*:

> I more often go to prostitutes than to *bondons*. I do not like *bondons,* because I have to look for them, and I have to take them back to

> where I need them. I prefer to go directly to a prostitute, I only go to a *bondon* when my friends take me to the 'base camp' in Darussalam street. When I have sex with a *bondon*, I do not use a condom because I do not feel satisfied and neither does the *bondon*. The important thing is both of us are clean. But with a prostitute I use a condom, I am afraid I might get AIDS. Usually I go to Nibung and when I have money, I go to Bandar. The rate for prostitutes that I have been dating is Rp. 10,000 to Rp. 15,000 per trip.

Lack of knowledge on the nature of STDs and HIV/AIDS has caused many young men in this study, especially those on the street to be unaware that they are engaging in risky sexual activities. Even when they are unlucky and contract STDs, many believe they can cure the diseases themselves.

6.4.3 **Young people's experiences with STD symptoms and self-medications**

Young people are typically difficult to reach with STD treatment and control. Since STDs and AIDS are often associated with sin and immorality, most young people are too shy or afraid to seek medical treatment. When they have contracted an STD, they tend to treat themselves. In addition, many young people do not know they have an STD, although they may be aware of some pains or symptoms. The problems are worse for women, among whom infections are more likely to be asymptomatic than among men (IWHC, 1991:3).

In in-depth interviews with males who reported having sex with prostitutes or *bondons*, many of the respondents said that they had contracted a sexually transmitted diseases at least once. When they noticed some symptoms, they went to friends to seek advice. According to respondents who work on the streets, such diseases are relatively common among their friends. They found out about medicine to cure STDs from friends who had previously had the disease. Below are some answers given by respondents in in-depth interviews.

> I once had *'patel'* (an STD), at first I felt like I had a fever and when I urinated there was pus. I cured it myself with Proxitor and Surbex. I was told that Proxitor would kill the virus, and Surbex, a vitamin, would cure the wound. Both are pills, they can be bought without a doctor's prescription. I knew about the medicine from a friend of mine who had had syphilis. He used those medicines and it was cured. When I had it, I told my friend, he asked me to take those medicines. And in four to five days I was cured (Deny, 20-year-old college student)
>
> I have had 'the dirty diseases' twice. The symptoms that I felt where that when I urinated there was pus, I did not feel comfortable, it [the penis) had to be held. I cured it by taking an antibiotic injection, also with Ampicillin or other antibiotics (Oman, 23-year-old university dropout, *Preman*).

When asked why they did not seek medical treatment, some respondents replied: 'what for, because the doctor would give us similar prescriptions'. They do not feel the need to go to a medical doctor, because they believe they can cure the disease themselves. Others said they were too shy to go to a doctor and a doctor cost a lot of money. Most respondents said they only seek medical treatment when they fail to cure the disease themselves.

According to many young people on the street interviewed personally, STDs are relatively common. They believe that sexually transmitted diseases can be cured relatively easily. That is why they seem unworried about the adverse effects of STDs including HIV.

6.4.4 Vaginal discharge

Among Indonesian women, vaginal discharge (often called *keputihan*) is very common; it is the most common affliction reported by them (Hull *et al.*, 1996). Nevertheless it is ignored by most women. Hull *et al.*'s (1996) study among married women in Jakarta suggests that many women, including medical doctors, do not consider vaginal discharge a serious problem. Most Indonesian women cure this disease themselves.

Table 6.4 shows that vaginal discharge is well known to most young women in this study. Almost all female respondents reported having heard of vaginal discharge, 66 per cent reported recognizing the symptom and more than half reported experiencing the disease. However, discussions with young women in this study revealed that few women know what the conditions are likely to cause *keputihan*. Many young women believe it just happens, while others say it is because they eat too much pineapple or green banana (*pisang ambon*).

Table 6.4 Percentage of female respondents who reported having heard, recognized the symptoms and had experience of vaginal discharge

	Number of respondents N=412	Percentage
Heard of vagina discharge	382	93
Recognized the symptoms of vaginal discharge	271	66
Experienced of vaginal discharge	233	57

Source : Medan Adolescent Reproductive Health Survey, 1997- 98

Most young women participating in focus group discussions reported experiencing vaginal discharge (*keputihan*), but few said they went to a doctor for medical treatment. Most women stated that they did not feel it was necessary to see a doctor just for vaginal discharge, because they believed they could cure it themselves. When they have vaginal discharge, most young women in this study say they cure it by using the water from boiled betel leaves (*air rebusan daun sirih*) to wash the vagina. Others drink special *jamu*. One participant said that her mother advised her to prevent vaginal discharge by avoiding consumption of pineapples or green banana (*pisang ambon*).

6.5 Conclusion

The discussions above show that most young people in Medan, even the most educated college students, are ignorant of the consequences of risky sexual behaviour. This ignorance is partly because they have little knowledge about the problems that they may encounter and partly because they are willing to take

the risks. In addition, social-political and cultural constraints regarding premarital pregnancy, abortion and STDs have discouraged young people from reducing risk in coping with premarital pregnancy or using contraceptives and barrier methods for sexual intercourse. Despite the growing social acceptance of marriage as a means of resolving problems of premarital pregnancy, the incidence of abortion among single young women appears to be increasing.

Marriage is nonetheless widely considered the best solution of premarital pregnancy. Thus, as the number of young women pregnant before marriage has increased, so has the social acceptance of marriage resulting from premarital pregnancy. However, premarital pregnancy does not always end in marriage. Many pregnant young girls cannot marry because of incest, rape, a casual relationship or an affair with a married man; in such cases they commonly turn to abortion. This is mostly because single mothers and ex-nuptial children are not acceptable in the society. As abortion is illegal in Indonesia, many young people seek traditional healers for abortions that may cause health problems or even death.

Most young people disapprove of abortion and believe that it is sinful. However, as they have little knowledge of the facts of human reproduction and have a wide range of beliefs about the time when a foetus is considered alive, many young people are unclear on what they condemn as abortion. Many of them approve of some activities that can be categorized as abortion such menstrual regulation, either traditional or modern, in the belief that these activities are pregnancy prevention. Young people's confusion is also influenced by public debate about abortion that has yet to reach a consensus.

Apart from premarital pregnancy, young people's sexual behaviour also places them at risk of STDs including AIDS. Although the majority of young people know something about STDs, misinformation still abounds. Misunderstandings about problems such as the mechanism of contagion, prevention of diseases, the consequences of the infections and the medication to cure them are common

among young people. The most common errors are the belief that STDs and AIDS can be avoided by maintaining physical stamina, and the belief that someone who is 'clean' and comes from a better-off family cannot possibly be infected with STDs and HIV.

Young people, regardless their social status, need to be informed about the consequences of unprotected sexual intercourse, and how to prevent pregnancy and sexually transmitted diseases including HIV. However, the results suggest that comprehensive family planning information and services should be designed and directed to specific populations of young people, rather than to all adolescents in general. Youth on the streets, especially those who engage in very unhealthy sexual behaviour, need intensive education and reproductive health services.

7 Sexual and reproductive health programs for the unmarried: the views of young people

7.1 Introduction

Sexually active young single people constitute one of the largest groups whose needs for sexual and reproductive health information and services are not being met (*Population Reports*, 1995; Hughes and Mc Cauley, 1998). This is partly due to the ignorance of young people regarding sexual and reproductive health, and partly because of the reluctance of many governments to provide such services and the unwillingness of society to accept that young single people may have sexual relationships (Xenos, 1990). Heated debates continue on whether it is necessary to provide reproductive health services for young single people, or when, how much and what kind of sex education young people should receive (Muraskin, 1986; Grunseit *et al.*, 1997). Yet, despite socio-cultural constraints more young single people are engaging in risky sexual behaviour (see Chapters 5 and 6); these young people are urgently in need of comprehensive sexual and reproductive health programs.

This chapter explores Medan young people's views regarding sexual and reproductive health programs for young single people. First it discusses the Indonesian adolescents' reproductive health programs, provided by the government and non-government organizations (NGOs). Then it discusses about young people's knowledge, attitudes and experiences related to contraception. In the last section the controversial issues regarding sex education in school are discussed.

7.2 Reproductive health programs for young single people

The provision of access to and information about sexual and reproductive health services for young single people remains controversial in Indonesia. the Programme of Action of the 1994 ICPD in Cairo and the Platform of the Fourth International Conference on Women in Beijing suggested that governments should 'protect and promote the rights of adolescents to sexual and reproductive health information and services they need' (UN, 1994, 1995). Nevertheless these suggestions meet many obstacles to implementation. Many governments still regard young people as non-sexual beings who do not need information and services regarding reproductive health. In addition, fearing that providing such information and services to adolescents will encourage them to become promiscuous, many people oppose the proposal. In Indonesia, giving young single people family planning services is considered illegal. According to the Indonesian 'Family Welfare' law (UUD No. 10/1992), family planning programs are only available to married couples or families. Sex education is rarely found in the school curricula. Only a few private schools, mostly Catholic schools in big cities, provide sex education for their students.

Disapproving reactions to the provision of information and services to adolescents are common among Medan's various social groups. In a seminar that I attended during my fieldwork (see Chapter 5) one presenter, a senior medical doctor of the local PKBI, said that contraception, especially condoms, could prevent unwanted pregnancy, STDs and HIV. The seminar then was criticized in a local newspaper because of this presenter. The reporter wrote: 'Those involved in North Sumatra PKBI adolescent programs should have an understanding that information about contraception should be given for married couples only' (*Mimbar Umum*, 2 November 1997:3). According to a respondent, a medical doctor, this opinion is common, even among doctors in Medan. He said that some of his colleagues criticized him for giving information about contraception to young single people.

Only recently has concern about young single people's sexual and reproductive health begun to grow in the Indonesian population and family planning field. The Indonesian Government, through BKKBN, the Ministry of Health (MoH) and other research institutes, has started programs and research related to adolescents' reproductive health (YKB, 1993; Irdjiati, 1997; Achmad & Westley, 1999). These activities are conducted in collaboration with international donor agencies such as UNFPA, the Ford Foundation, WHO, Population Council and IPPF. Furthermore in 1999, BKKBN established a special division to deal with young people's reproductive health issues: the 'Adolescent and Reproductive Rights Protection Directorate'[1]. Yet, despite the government's growing awareness, the provision of sexual and reproductive health information and services to the young people is limited to NGOs: it is obviously still inadequate in quantity or quality owing to financial constraints as well as human resources (Gunawan, 1995:7; Wilopo *et al.*, 1999:27).

7.2.1 Government policies and programs

Following the 1994 ICPD and the 1995 Beijing meeting, the Indonesian government in collaboration with international agencies organized workshops and seminars to discuss the implications of the reproductive health approach for the national population program. Ford and Siregar (1998:15) noted four significant national meetings. The first was a national workshop on women's and men's equality: a follow up to the fourth world conference on women, coordinated by the Ministry of Women's Affairs. This meeting focused on indicators of gender equality from a religious (Islamic) and family centered and on economic development. There was a strong emphasis on the role of the family and family welfare as the broad context of reproductive health and gender issue in Indonesia. The second was a national workshop on reproductive health, coordinated by the Ministry of Health. The meeting provided a forum for a range of institutions including BKKBN, the Ministry of Education, Youth and

[1] Compared to the previous governments of Soeharto and Habibie, the current government has more positive attitudes toward young single people's sexual and reproductive health needs. However, most of the information for this study was collected during the previous governments.

Sport, Women's Affairs and various NGOs to raise their views on the new concept of reproductive health.

The third was a follow up meeting on the ICPD, coordinated by BKKN. The fourth and the final meeting was the national workshop on human resource development in reproductive health, coordinated by Faculty of Public Health University of Indonesia. The objective of this meeting was to seek a more analitycal and systematic review of the sexual and reproductive health situation in Indonesia in order to provide a basis for consideration a strategy options and training needs.

Several government institutions have the task of developing or promoting adolescent sexual and reproductive health programs. They are BKKBN, MoH, Ministry of National Education (MoNE), Ministry of Religious Affairs (MoRA), Ministry of Social Affairs (MoSA) and local governments. However, most of the programs regarding sexual and reproductive health are implemented by BKKBN and MoH. BKKBN is responsible for co-ordinating reproductive health programs for the nation. MoH through its hospitals, clinics and subclinics is responsible for reproductive health services; MoNE with its large network of schools is important for reaching young people to provide reproductive health information and educational materials. MoRA and MoSA both have networks reaching the community in general, especially out-of-school young people (Wilopo *et al.*, 1999; Ford and Siregar, 1998:16).

To provide information regarding adolescents' sexual and reproductive health for both young people and parents, various training modules have been introduced. These innovations include family, parents and relatives who are responsible for children during their adolescent years. BKKBN in collaboration with UNFPA and PKBI in collaboration with IPPF are among institutions that support these activities. Nevertheless, since the modules are not incorporated in the school curricula and distributed to a limited number of people and organizations, they have not reached most young people and parents; and

because of budget limitations, BKKBN has delayed the new impetus to adolescent reproductive health programs (Wilopo *et al.*, 1999).

The collapse of the *rupiah*, followed by economic and political crises in Indonesia since late 1997, has limited the government budget on the health and family planning program (Hull and Iskandar, 1999). This budget reduction may affect programs related to adolescent reproductive health. BKKBN's priority is to provide contraception for married clients. In a personal interview in October 1999, a senior official of BKKBN of North Sumatra said:

> The program related to adolescents is relatively new and there is no special budget for that. Our priority is to provide contraception for the acceptors especially nowadays, during the economic crisis. That is the most important thing. Reproductive health program for unmarried young people are not yet a priority.

Nevertheless, in early 1999 the BKKN of North Sumatra, collaborating with a private institution, *Biro Konsultasi Psikology* (Physiology Consultation Bureau) established a centre for family welfare consultation (*Pusat Konsultasi Keluarga Sejahtera*). The project aims to train the BKKBN field workers, counselling teachers (*guru Bimbingan Pelajar/BP*) and parents to give information related to adolescents' reproductive health. In a personal interview the project co-ordinator, a psychologist in her mid-forties, revealed conservative views and limited knowledge of adolescent reproductive health problems. She believed the module published by BKKBN and UNFPA for adolescents to be too vulgar and not appropriate for young single people. She believed the information needed to be screened when given to young people.

The Indonesian adolescent reproductive health programs are mostly limited to providing general information on reproductive health. They include integrated services with information, educational and counseling (IEC) materials that address young people's sexual and reproductive health problems such as unwanted pregnancy, unsafe abortion, STDs and HIV. However, the content of the IEC programs is limited to the promotion of family, moral and religious

values (Tumkaya, 2000). This approach undoubtedly involves no significant information or services related to family planning and sexual health for unmarried youth. The needs of sexually active but unmarried young people for family planning services remain unfulfilled.

7.2.2 Non Governmental Organization programs

Since providing sexual and reproductive health information and services for unmarried young people is restricted under the government programs, NGOs are expected to be active in filling the gaps. In many big cities established NGOs have collaborated with international funding agencies such as the Ford Foundation, IPPF, UNFPA, UNDP, Population Council and World Bank; these agencies have also helped establish special-purpose NGOs to provide services to young people.

One of the most important NGOs providing such information and services in Indonesia is the Indonesian Planned Parenthood Association (PKBI), which has 26 branch offices in many cities across the archipelago, including Medan. Since 1991, in collaboration with the IPPF, PKBI has promoted youth centres to provide information and counselling for young people on issues related to sexual and reproductive health. As the aim of these centres is to provide peer education, those working in the centre are young people.

Currently in Medan there are three NGOs interested in young people's sexual and reproductive health: Citra Mitra Remaja (CMR), Galatea and SaHIVA. CMR and Galatea were established by PKBI, while SaHIVA is mostly funded by UNDP through the Local Commission for HIV/AIDS Prevention (*Komisi Penaggulangan HIV/AIDS Daerah*).

Citra Mitra Remaja means 'image of adolescent partner'. CMR focuses on providing information and counselling for young people on sex and reproductive health. It was established in 1994 and at the moment it is the only

youth centre specializing in adolescent sexual and reproductive health in Medan. Most centre volunteers are university students or just graduated from university.

CMR's current activities are counselling by telephone (hot line), mailing and face-to-face meetings (*tatap muka*). According to a CMR co-ordinator, the young people who use the services are mostly girls aged 13-19. The most frequent questions asked are problems related to menstruation, dating and virginity. Most clients prefer to use the telephone or mail for consultations and avoid face-to-face meetings; this is understandable since sexual and reproductive health matters are still considered embarrassing.

To provide information about sexual and reproductive health for adolescents, CMR conducts seminars and workshops, and collaborates with some high schools to train their peer educators about sexual and reproductive health. Unfortunately, as stated by one of CMR's co-ordinators, some high schools refuse to collaborate. The school authorities argue that their students are too busy already or they object to informing their students more about sexual and reproductive health; they believed that these issues are adequately covered in Biology and Physical Health (*Kesehatan Jasmani*).

At the moment the target groups of CMR are limited to high school and college students, while the high-risk group, those who are not studying and spend most of their time in the streets or hanging around in shopping malls, remain uncontacted. This is partly because many CMR volunteers feel uncomfortable about approaching these groups. Most of the volunteers at CMR are young Moslem women who wear veils. They were afraid that society would regard them with disapproval, as explained by Atin, a CMR coordinator:

> Our limitation here is until now we only reached 'good young people'. We have not worked with those young people who are no longer in school or university, particularly those who spend most of their time hanging around in the shopping malls or on the streets. Many of the volunteers are reluctant if they have to spend time in the shopping malls or on the streets. As you know in our culture, women are not supposed to do such things.

Another NGO funded by PKBI is *Galatea,* which was established in January 1997. The focus of this centre is on provision of information and counselling related to HIV and AIDS. The target groups of the center are people of all ages, especially high-risk groups such as prostitutes. However, in view of the centre's limitations, the programs mostly are school visits, seminars and collaborating with other NGOs to disseminate information about HIV/AIDS. As with CMR, the volunteers in this centre are mostly young people.

As both CMR and Galatea are supported by PKBI, young people who may need medical attention are referred to the PKBI clinics. Despite the government policy to restrict abortions, almost all PKBI clinics perform abortions for a broad range of reasons. The procedure is commonly called menstrual regulation (MR), and takes place before 12 weeks of gestation. According to the senior staff of PKBI both in Jakarta and Medan, the rate of requests for MR from both married and unmarried people in Indonesia is quite high. However, for unmarried young people to proceed to MR services, the parent's approval is needed, while for a wife, the husband's written approval needs to be provided.

SaHIVA stands for *Sahabat HIV/AIDS* (Friends of HIV/AIDS); the group is interested in issues related to HIV/AIDS and drugs, and was established in 1998. The target group of the SaHIVA centre is young people who work or spend most of their time on the street. The centre is located in the campus area of North Sumatra University (USU) and most its volunteers are USU students and staff members.

Despite their effort to reach all young people from various social classes, these NGOs obviously do not reach the majority of Medan's young people. As stated by the co-ordinators of the centres, at the moment their programs serve only a few young people. This is not only because their centers are relatively new, but mostly because lack of funds and staff at the centres make it almost impossible for them to reach the majority of young people. When I asked young people in

my study about CMR, most of them said they had never heard about it; some said they had heard of it but did not know about its programs.

7.3 Young single people and contraception

As indicated in chapter 6, many sexually active young people are using contraception inconsistently or not using it at all, partly through lack of knowledge about contraception and about the consequences of unprotected sexual intercourse. Another reason may be that young people are willing to take the risks, but generally it is a matter of ignorance.

Many explanations for unmarried young people's low levels of contraceptive use have been offered (Collins and Robinson, 1986; Khan *et al.*, 1990). These mostly relate to the fact that unmarried young people are more likely to have limited knowledge about contraception (Kang and Zador, 1991), are more likely to engage in unplanned sexual intercourse (Needle, 1977), have limited knowledge of the consequences of unsafe sex including pregnancy and STDs (Carballo and Kenya, 1994) and lack services as a consequence of the negative attitudes of many governments (Xenos, 1990; Cruz and Grace, 1999), and negative societal attitudes to premarital sex (Collins and Robinson, 1986:146; Billy *et al.*, 1994).

For young people in Medan knowledge of contraception and attitudes to it are undoubtedly influenced government and societal attitudes. Even though young people's access to condoms and selected contraceptives is not strictly restricted, providing contraceptives to the unmarried is considered illegal. Some people agree with this policy while a few oppose it.

To explore Medan adolescents' knowledge and attitudes toward contraceptive methods and policy, young people in the survey were asked several questions. These are: have you ever heard about the family planning methods mentioned below? Do you know how to use the family planning methods mentioned below? What is your main source of contraceptive information? Do you think

contraception is readily available for unmarried adolescents? Do you think unmarried young people have received sufficient information about contraception? If not what information do you think needs to be provided?

7.3.1 Respondents' knowledge of contraception

Despite the hesitancy of the government to provide information for young single people, most Medan young people have heard of at least one contraceptive method. Table 7.1 indicates that the majority of respondents have heard of the pill, IUD, injection and condom. However, compared to other methods, the condom is the best-known method. Almost all the men and over three-quarters of the women in this study have heard of condoms. This may be because recently, condoms have been advertised widely in the media, especially on television, as a method to avoid pregnancy.

The pill, IUD and injection are also well known among respondents, but unlike the condom, these methods are better known among women than among men. More than 70 per cent of women have heard about the pill, IUD and injection compared to 68 per cent, 58 per cent and 67 per cent respectively of men respondents. Although information from personal interviews and focus groups among sexually active young people indicated that many of them practise withdrawal, few respondents (men 38 per cent, women 31 per cent) reported having heard about it. However, this may be because the term for withdrawal which I used in the questionnaire was a formal Indonesian word, *senggama terputus* (*coitus interruptus*), instead of informal words used by young people such as *tembak diluar* ('fire out side'), or *buang diluar* (throw out side). Some respondents might not familiar with the formal terms. In focus groups and personal interviews few respondents used formal words to refer to activities related to sexual intercourse. Some of them said they did not comfortable using them, while others said they were not familiar with the formal words.

Media, especially the press, is considered the main source of contraceptive information for many young people. More than a third of respondents said they received contraceptive information mostly from printed media. Compared to the men respondents, the women in this study are more likely to receive contraceptive information from the family (parents and siblings). In contrast young men are more likely to receive contraceptive information from their peer group.

Table 7.1 Respondents' knowledge of contraceptive information by sex

	Males % N=463	Females % N=412	Males+Females % N=875
Contraceptive method			
Pill	68	74	71
IUD	58	71	64
Injection	67	77	72
Condom	93	78	87
Norplant	27	34	30
Vaginal foam	13	12	13
Tissue (n=875)	17	13	15
Traditional herbs	43	51	46
Withdrawal	38	31	35
Rhythm	31	35	33
Source of information			
Family	4	18	11
Peers	29	11	20
School+health personnel	16	20	18
Printed media	33	36	35
Electronic media	16	12	14
Other	2	3	2
Know how to use selected method[a]			
Condom[b]	90	66	80
Vaginal foam[c]	50	63	56
Tissue[d]	51	78	62
Aware that contraception can be obtained by unmarried young people			
Yes	55	40	48
No	17	25	21
Unsure	28	35	31

Notes: [a]These question are only applicable for those who reported have ever heard the methods.

[b]N for males=429; N for females= 328; N for males and females= 757

[c]N for males=58; N for females= 51; N for males and females= 109

[d]N for males=80; N for females= 55; N for males and females= 135

Source: Medan Adolescent Reproductive Health Survey, 1997-98

Since most respondents obtained information from the media (usually through advertisements) or friends, and information from such sources is often misleading or incomplete, it is not surprising to find that their knowledge is very superficial. Ability to name one or more contraceptive methods does not necessarily mean knowledge of use or sources. Of those who said they had heard about vaginal foam and tissue, almost half did not know how to use vaginal foam and almost a third reported no knowledge of how tissues are used. The proportion of those who knew how to use condoms is much higher, 90 per cent for males and 66 per cent for females.

In addition, although condoms and other selected contraceptives are available in some supermarkets and drugstores in Medan, many people are not aware that they can obtain them. Of women in this study, only 40 per cent were aware that young single people can obtain contraceptives. The figure among men was slightly higher, 55 per cent.

Young single people's lack of knowledge of contraceptive issues was also revealed in personal interviews and focus group discussions. Even though all of them could mention one or more contraceptive methods, very few were able to explain correctly how the methods work. Many young people in this study, mostly women, said although they often heard about condoms, they never saw them.

When asked how they learned about contraceptive methods, many of them said from friends or advertisements in the television, radio or newspaper. Only a few, mostly women, said they read a comprehensive article in a women's magazine, or watched or heard a special program about family planning on television or radio. None of participants in the men's focus groups said they ever talked about sex or contraception with the family.

When young men who spend most of their time on the street were asked what they knew about contraception a participant said his knowledge of it was limited:

> My knowledge about *alat KB* (family planning) is very basic (*tahu-tahu alam*). I knew condom from friends *(dari pergaulan)*. When we gathered together (*lagi ngumpul-ngumpul*), one of us brought a condom and showed how to use it. At that time most of us were a bit drunk. On such occasions usually we talked about a lot of things, mostly about sex and drugs freely, without feeling shame (*enggak malu-malu*) (Koko, aged 20 years, primary drop out, youth street FGD).

The girls who reported obtaining contraceptive information from family did not necessarily have more comprehensive information than those who reported obtaining it from friends, perhaps because they receive the information indirectly. A personal interview with a female university student revealed that she learned about contraception mostly from her family, by overhearing her mother talking about family planning with her married sister or her mother's friends. Although talking about contraception among married women in Indonesia is quite common, it is uncommon to talk about it directly with single people.

Those who received contraceptive information from school also said they did not know a lot about contraception. A focus group participant among high school students said:

> I learned about types of contraception from school in the biology subject. We were taught about family planning methods. For example: pill, IUD and injection are methods for a woman and condom for a man. That was all, not much (Indri, aged 18 years).

7.3.2 Respondents' attitudes to contraception

In contrast to the government policy, many young people believe that they need to be given more comprehensive family planning information and services. Table 7.2 showes that the majority of respondents said that contraceptive information they received was insufficient. Only 17 per cent of males and 13 per

cent of females said that young people have received sufficient contraceptive information.

Table 7.2 Respondents' attitudes to contraceptive information for single people by sex

	Males % n=463	Females % n=412	Male+females % n=875
Information for single people			
Sufficient	17	13	15
Insufficient	57	60	58
Unsure	27	27	27
Type of information are needed by young people[a]			
Type of contraception[b]	56	63	59
How to use contraception[b]	64	64	64
How to obtain contraception[b]	45	42	44

Notes: [a] These questions are only applicable for those who said that contraceptive information for young people is insufficient or they were unsure about it.
[b] N for males =385; N for females = 357; N for males and females = 743
Source: Medan Adolescent Reproductive Health Survey, 1997-98

Of those who said that young people need to be given more information about contraception and of those who said they were not sure about it, around 60 per cent agreed that young people should be given more information. The proportion of those who believed that young people needed more information on use of the methods was higher, while 44 per cent agreed that young people need more information about how to obtain contraception.

In focus groups among unmarried young people, there were slightly different opinions between men's and women's groups on whether unmarried young people need to be given comprehensive information regarding family planning. In all female focus groups (high school and university students) there were two opinions, those for, and those against, but all male focus groups (high school and university students, workers in informal sectors) only had one opinion. All agreed. The female who disagreed argued that if unmarried young people knew too much about how to avoid pregnancy, and STDs including HIV, they would not be afraid to engage in premarital sex, while those who agreed believed that in contemporary society premarital sex among young people is common. It is

almost impossible to stop them from having relationships, so if sufficient information about contraception is given, unexpected risks can be reduced.

The positive opinions were also shared by those who worked with young people, such as medical doctors, researchers and NGOs. Two medical doctors who have a weekly program about young people and sexuality on local radio stations said they were often asked about problems related to unsafe sex. In answering those questions they chose to give information about contraception and safe sex in their programs, although they were aware some people might disagree.

7.3.3 Respondents' contraceptive behaviour

Given the fact that most respondents have limited knowledge about contraception, it is not surprising to find that few sexually active young people use contraception consistently. Information about young people's contraceptive behaviour in this study was obtained through personal interviews and focus groups among married and unmarried young people.

Discussion among married young women about the contraceptive methods they used was relatively open. All participants in the married women's focus groups talked freely about their opinion and experiences of family planning. Of five participants who said they did not want to have more children or did not want children for three or four years, only two were using effective methods (injection). Others said they were practising withdrawal, rhythm, and massage or taking *jamu* whenever they missed their periods. Injection is considered the most suitable among young women in this study, because it is practical and they never have bad experiences using it. A respondent said her husband complained when she used the IUD and many of her friends have similar experiences. Condoms were not popular among married women, because their husbands refuse to use them.

Lack of knowledge about the common side-effects of contraception may influence young people's contraceptive behaviour. In a discussion with married women, a mother of two children said:

> I do not want to have any more children, at least for the next four or five years. At that time my youngest child will be in school. To avoid pregnancy I am using natural family planning (*KB alami*) such as withdrawal and rhythm. My father forbids me to use family planning and my husband agreed with my father's views. They said family planning is not good. Many people have bad experiences from using family planning (Zariah, a housewife).

Misconceptions about contraception were also revealed among married men. In a discussion, a married man with two children said he did not allow his wife to use IUD, pill or injection: he believed putting them into a healthy person might cause bad effects. He said he preferred to practise withdrawal or rhythm to avoid pregnancy. When asked why he was not using condoms, he said:

> Condom also has a bad effect. A friend of mine suggested to me not to use condoms, because they can cause 'weakness' (*lemas*) they also can cause illness, because of the white powder (*zat kapur yang putih-putih*) in a condom. My colleague has five children and during his marriage he never used one, and when he wants to have intercourse he uses the 'fire it outside' method (*cara tembak luar*), he told me that the white powder has negative effect, so do not use condoms, they are not good (Dd, high school graduate, married for 1.5 years, a driver in a private company).

There was no argument from other participants. When I asked whether or not they agreed with this opinion, some of them said it made sense, others were unsure.

Information about young single people's contraceptive behaviour is mostly gained from personal discussions and focus groups among male university students and street youth. None of them who reported having had sex used condoms consistently. Some, mostly university students, said they only use condoms when having sex with prostitutes, but not with their girl friends or *bondons* (see Chapter 6). When having sex with their girl friends they often use

withdrawal or rhythm, because they only have sex occasionally; when having sex with *bondons,* they do not use any method, because *bondons* are usually on the pill. They believe that they do not need to worry about STDs or AIDS in sex with their girl friends or *bondons*. One respondent, a high school student, said he was not prepared with contraception when having sex with his girlfriend, because it happened 'accidentally'. Nevertheless, he acknowledged that they had had sex more than once. In the personal interviews and discussions with the street youth, most of them said they seldom used condoms, even for sex with prostitutes. Some of them said condoms hampered their sexual activities, others said that most of the time when they visited prostitutes they were a bit drunk or on drugs. At those times it was almost impossible to think about using condoms.

7.4 Sex education: whose responsibility?

Until recently, in Indonesia, the issue of whether sex education needs to be incorporated in school curricula has still been controversial (*Jakarta Post Online*, 23 May 1996; 5 July 1999). During the Soeharto and Habibie regimes, the government believed sex education to be the parents' responsibility (*Jakarta Post Online*, 23 May 1996; Jones, 2000). Despite many research findings to the contrary (Kirby *et al.*, 1991; Grunseit *et al.*, 1997; Utomo, 1997), many policy makers believe that giving family planning information and services to the unmarried may be interpreted as the government supporting premarital sex, and thus acting in contradiction to social values. Facing the increased incidence of premarital sex, premarital pregnancy, abortion, STDs and HIV among young people, the government promoted a 'family-centred approach' (Jones, 2000:274). Within this approach, the family is responsible for educating its members on reproductive health issues. This opinion was stressed by a senior staff member of the Minister of Population when talking to the press:

> This particular education is the responsibility of parents, not teachers... it is more in the parents' interest -rather than the teacher- to provide children with information on sex. It's the parents who should provide children at an early age with that

> information, laced with religious and cultural values (*Jakarta Post Online*, 23 May 1996).

Among scholars, the family-centred approach raises some concerns about its effectiveness. This is in part because both parents and children often found it very difficult to initiate and conduct open discussions about sexual matters (Barker and Rich, 1992:199-210; Forrest, 1990). In part it is because most family life education programs emphasize conservative values and conventional family norms which are likely to promote an abstinence only approach (Ford *et al.*, 1992 cited in Hawkins and Meshesha, 1994:215).

In Indonesia, considering the sensitivity of the issue, many studies have suggested that it is not sufficient to give responsibility to the parents to educate their children about reproductive health (Djaelani, 1996: 315; Ramonasari, 1996:301; Iskandar, 1997:5; Utomo, 1997; Jones, 2000). In most cultures in Indonesia societies, sex is a very private issue: it is unlikely that unmarried young people will turn to their parents for information related to sexual health and family planning. Parents do not talk about sex openly, especially with their unmarried children. Studies in Jakarta found that most parents were not comfortable and felt inadequate to talk to their children about issues related to reproductive health (Iskandar, 1995:33; Utomo, 1997). In addition, given the fact that many young people are not living with their parents, because they are studying or working elsewhere (Jones, 2000), communication between parents and children may not be effective.

My study also found that parents often felt uncomfortable and inadequate about talking to their children about sex. Information from in-depth interviews revealed that many parents feel there is no need for them to educate their children about reproductive health and sexual health: they believe their children will receive the information eventually from schools and their friends. When asked whether she ever talked about contraception and sexual health to her unmarried children, a Javanese housewife aged 65 year, mother of eight children

and grandmother of five, looked surprised because I asked that kind of question. She replied:

> Of course no. That is impossible! How can I talk about such things with my children. That is not our culture and also what for? When they marry they will know about it eventually. And also young people in today's era are very smart. They might know about those things more than me.

Similar responses were also received from another respondent, a Batak housewife aged 47 years, mother of four children (aged 18-26 years), diploma graduate:

> Do I need to? I do not think parents need to talk about those things with their children. They know that already from school and friends. I do not think they need that information from me. Also, I can not imagine what and how I am going to tell them, it will be very embarrassing for us.

This hesitancy is also shared by young people (see also Chapter 4). In focus group discussions among young people almost all participants stated they never talked about contraception and sex with their parents. When asked whether they might want to have such discussions, most of them said no. Most young people in Medan would feel embarrassed to raise those issues with their parents; also they fear that their parents may think that they are already sexually active if they ask questions about such things, especially about contraception.

Parents are often unaware of the extent of young people's problems regarding their sexual activities. Because of limited knowledge, they are not aware that today young people have a high risk of STDs including HIV. Some believe that only those who come from broken homes and those who are not devoted to their religion engage in premarital sex. A 59- years-old respondent, a father of four daughters and two sons said:

> I know many young people nowadays have engaged in premarital sex, but I am not too worried about my children, because I believe I have taught them to be afraid of God (*takut pada Allah*). I think, if the parents provide proper religious teaching to their children

> (*pelajaran agama yang cukup*), God willing their children will avoid premarital sex.

Many researchers argue that the moral approach is considered ineffective for today's young people (Mohamad, 1996:79; Whatley and Trudell, 1993 cited in Grunseit *et al.*, 1997; *Jakarta Pos Online*, 1 December 1997). It is argued than an abstinence-only approach ignores the developmental diversity in young people's sexuality and marginalizes, and possibly alienates, those who, for whatever reason, do not adopt the 'no sex' option (Whatley and Trudell, 1993 cited in Grunseit *et al.*, 1997:444-445). An Indonesian scholar, Sarwono, argued that the religious approach is not effective for many Indonesian young people, especially those who are sexually active:

> Religion is no longer their life's guidance. Talking about religion to them is nonsense. They definitely have to know how to use condoms rather than become infected with HIV/AIDS (*Jakarta Pos Online*, 1 December 1997).

Lack of awareness among many parents is partly due to the lack of information on the seriousness of the problems faced by young people. Very few studies related to unmarried young people's sexual activities and their consequences are published widely. Most research findings on this topic are disseminated only to specialized groups such as researchers and NGOs. When studies of research on premarital sex among young people are published in the media, government officials tend to claim the results are not true and cast doubt on the quality of the research by questioning the research procedure of the studies[2] (Utomo, 1997).

Another argument to against sex education being added to the school curriculum is the belief that information about sex has been covered in the existing curricula for junior and senior high schools such as sport and health (*olah raga dan kesehatan*), biology and religion. In addition, many people consider

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[2] Nowadays the government is more open in discussing reproductive health issues such as premarital sex, premarital pregnancy and abortion in the seminars, the cabinet, the parliament as well as to the press. The state minister of women's empowerment and the head of BKKBN often

that there are too many subjects in the existing curriculum, thus adding a new subject will be very difficult. In a personal interview, a director of high-prestige private high school said:

> Basically I agree with the provision of sex education in school. But it is not an easy task. Not only because of the sensitivity of the issues, also because the existing curriculum for high school is already a lot. It is difficult to add another subject. Many teachers already complained because they do not have enough time to teach all the materials suggested in the national curricula.

At the same time many young people in this study said that the reproductive health information they received from school was superficial and too general. In focus groups among female high school students, a participant said:

> In school we were taught about human reproduction such as conception and puberty but it was very technical and superficial. It was not interesting, I've already forgotten all I studied (Ana, aged 17 years).

Similar information was also revealed in focus groups among male high school students. Most participants, especially those who were studying in the public schools, supported it.

When asked their opinion about sex education in school, most focus group participants said that it is important that sex education should be included in the school curriculum. They argued that by nature young people are curious about such issues: to satisfy their curiosity, it is better to give comprehensive sex education in school. Furthermore it is almost impossible to stop the young watching or reading pornographic materials, especially through the Internet. Some participants suggested that sex education should to be given in senior high school; others believed it should begin in the third grade of junior high school. They argue that some junior high school students have already been involved in premarital sex.

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quotes NGOs' studies regarding the high proportion of young people involved in premarital sex and abortion.

7.5 Conclusion

Given the fact that an increasing number of Indonesian young people are involved in risky sexual behaviour, there is an urgent need for comprehensive sexual and reproductive health programs for young people in general. The Indonesian government is increasingly aware of these problems. Nevertheless the provision of information and services regarding sexual and reproductive health for unmarried young people remains controversial. Recently the governments and NGOs in collaboration with various international agencies have initiated many programs related to these issues, yet the need of young people for information and services remains unsatisfied.

Government programs are mostly limited to providing basic information on sexuality and reproductive health, but not providing services. The information provided in the IEC programs is limited to the promotion of family, moral and religious values; thus the family planning needs of sexually active unmarried young people are neglected. In addition the family-centred approach initiated by the government places a huge burden on ill-prepared parents and is not effective. Parents do not know how to deal with their children's sexuality any better than young people know how to deal with it themselves. Both parents and young people are uncomfortable talking about sexual issues. It may take a generation to obtain significant changes in this climate of ignorance.

NGO programs seem to be more realistic in approaching young people's sexual and reproductive health programs. However, since they have inadequate funds and staff, the programs cannot reach the majority of Medan young people.

Considering the socio-cultural constraints on both young people and their parents, incorporating reproductive health education in the school curriculum is likely to be the most effective way to disseminate information to young people. The government and the society need to be aware that the denial of family planning information and services to young single people will not prevent them

engaging in premarital sex, just as the provision of information and services will not cause promiscuity. In fact, lack of information and services for sexual and reproductive health will just leave many young people ignorant of the risks they are facing.

8 Conclusion: serving the reproductive health needs of young people

8.1 Introduction

Chapter 4 to 7 present an analysis on the attitudes and behaviour of Medan's single young people regarding puberty and sexuality. This study suggests that Medan young people today confront demands, expectations and temptations that are more numerous and complex than those of young people in the previous generation. Traditional expectations that young people remain virgins until marriage are incompatible with the realities of city life. Since they spend their days away from families, sometimes even far from home, these young people face temptations that are difficult to resist. Many of them engage in risky sexual behaviour: they practise unprotected sex with multiple sexual partners or seek out partners who are likely to carry high risks, such as prostitutes or *bondons*. These place them at high risk of unwanted pregnancy, abortion, and STDs including HIV. At the same time, because of socio-cultural and political concerns, these young people receive limited parental guidance and community, and government support.

This chapter summarizes the significant themes and broader issues that emerged from the Medan study. First it highlights the study's major findings; then some policy implications and recommendations are provided.

8. 2 Major findings

8.2.1 Today's Medan single young people and sexuality: changing attitudes and behaviour

As indicated in Chapter 2, young people aged 15-24 years constitute a large proportion of Medan's population. As in other Asian countries that experiencing 'youth transition' (Xenos and Kabamalan, 1998), Medan young people are also experiencing dramatic socio-demographic changes. The proportion of young people in school as well as in the labour force increased over a decade. Today's young people are also tend to marry later than the previous generation. Many young people have to live away from their parents for study or work. Furthermore, as a consequence of economic and technological development, the pace of changes that threaten young people seems to have accelerated. The explosion of information across cultural frontiers gives Medan young people access to modern cultures that are often conflict with the conservative and religious norms of their homes. Unfortunately, in the context of these changes, which have led to increasing pressure on young people, Medan young people do not have sufficient information about the biological and social changes experienced during adolescence.

Information regarding puberty, mostly gained from friends and religious teachers, is likely to be incomplete, uninformative or obscured by religious and moral messages. Therefore, although most young people reported having received information about the onset of puberty before it happened, many girls reported fear and surprise the first time they menstruated, while some boys said they felt guilty and sinful the first time they had a wet 'dream'. Misunderstanding is evident on issues related to menstruation, ejaculation, masturbation and a woman's fertile period. Many young people have picked up unfortunate myths. They may believe menstrual blood is 'dirty' and must be hidden. Some think that masturbation will cause impotence.

Girls receive more information about puberty from their mothers than boys do from their fathers. Both young males and their fathers reported feeling discomfort

talking about problems related to reproductive maturity such as nocturnal emissions and masturbation. Nevertheless when asked whether it is necessary for fathers to provide such information for their sons, most agree that it is.

As they reach puberty, Moslem boys in this study are circumcised, while Moslem girls were usually circumcised at an early age, mostly during infancy. Despite the uncertainty of the rationale for this practice (see Chapter 4), all Moslems in this study, males and females alike, reported they had been circumcised, while no non-Moslems reported this practice. Recently there has been heated debate over the health aspects of circumcision, especially female circumcision, in international forums, but the issue is rarely raised in the national debate in Indonesia. For those who believe that circumcision is a religious requirement, the debate over health consequences may be insignificant. In addition many Indonesians believe that male circumcision is relatively safe while female circumcision is only practised symbolically, though this is clearly not true in the Medan case. Although more parents prefer medical personnel to perform the operation, some, especially the uneducated, still have it done by traditional practitioners. Very few young people in this study were aware of the potential health consequences of the activity.

Lack of knowledge regarding puberty and human reproduction have caused some young people to engage in risky behaviour. Many young people believe that a woman cannot become pregnant from a single act of sexual intercourse; therefore, to avoid causing a pregnancy, some young men prefer to have sex in a casual relationship or have sex only once in a month with the same girl. This attitude means that if a girl becomes pregnant the man is unlikely to believe that the baby is his and marriage may be out of the question as a responsible reaction to the girls' predicament. In such cases the couple also expose themselves to risks related to abortion, not to mention sexually transmitted diseases including HIV resulting from relations with multiple sexual partners.

Young people in Medan are increasingly tolerant of premarital sex. Although for most of them a woman's virginity is a great concern, it is no longer seen as the

most important factor in choosing a future spouse. The demise of parental arrangement of marriage and the growing opportunity to know a future spouse long before marriage means that the potential wife's personality is now of more significance than her virginity. Furthermore, despite the conservative and moral values held by many parents, religious leaders and policy makers, few young people consider virginity as the symbol of morality. Losing virginity does not necessarily mean losing respectability.

With this attitude, many single young people are engaging in sexual activity. Of 875 single young people studied, 18 per cent (9 per cent of women and 27 per cent of men) reported having had sex. Given that premarital sex is not socially accepted, the real proportion is likely to be much higher. As would be expected, as their age increased, the tendency of young people to report having had sex increased. Forty-two per cent of men and 14 per cent of women aged 21-24 years reported having had sex, compared to only 12 per cent of men and three per cent of girls aged 15-17 years. Compared to those who were studying, out-of-school young people were more likely to report having had sex. Two thirds of employed and 48 per cent of unemployed young men reported having had sex, compared to only 13 per cent who were still being educated. The pattern was slightly different among young women: those who were unemployed were more likely to report having had sex than those who were working or studying (29 per cent, 12 per cent and six per cent, respectively).

The proportions of young people who approved of premarital sex were even higher (18 per cent females and 44 per cent of males) than the proportion reporting experience; this suggests that the number of young people involved in premarital sex will continue to increase. Moreover, many young men believe that a man is expected to be good in bed when married, therefore they need sexual experience before marriage.

The reactions of unmarried men and women to first sexual intercourse varied considerably: young men in this study had more positive reactions than women to

their first sexual intercourse. More than half of men who reported having had sex did not feel guilty or sinful the first time they did so, compared to only 20 per cent of girls. For these young men, the moral and religious approaches which promote messages that premarital sex is forbidden by God may not be effective. In addition, in most focus group discussions among young men, religion was rarely raised as an issue. When a participant brought up religious reasons for not agreeing with premarital sex, others would say: 'I do not want to be hypocrite here, I prefer to talk about reality'. This suggested that for some of Medan's young people, especially males, religious teachings are simply not relevant to the realities of their everyday life.

Although religious affiliation appeared to be significantly related to respondents' attitudes for both sexes, it was insignificant as a determinant of differences in respondents' reported sexual experiences: religious affiliation influences adolescents' attitudes but not their behaviour. On the other hand age appeared to be important factors in predicting the likelihood of reporting sexual experience among male respondents, but they were not significant in predicting attitudes.

Despite the strong link of most Medan young people to their ethnic-religious groups, there is no significant difference regarding sexual attitudes and behaviour among the different communities. Bivariate and multivariate analysis of respondents' reported experience of premarital sex suggest that ethnicity and religious affiliation are insignificant as determinants (Chapter 5). The study findings challenge ethnic-religious stereotyping, such as the idea that Chinese and non-Moslems are more permissive toward premarital sex than Moslems.

Their main activity, whether they are studying, working or unemployed was the most important predictor of the likelihood of young people in this study approving of premarital sex as well as the likelihood of reporting experience of premarital sex. Out-of-school young people are more likely to approve of premarital sex and more likely to report having had sex.

In line with the increasing incidence of premarital sex, the number of ex-nuptial pregnancies also rose. Although marriage is regarded as the best solution for premarital pregnancy, those for whom marriage is not an option often turn to abortion, and as abortion is highly restricted, girls pregnant out of wedlock are likely go to traditional healers for abortions, which are unlikely to be safe. Moreover, since their knowledge of human reproduction is limited, many girls agreed with 'menstrual regulation' (either traditionally or medically) before four to 12 weeks gestation, in the belief that it is pregnancy prevention (see Chapter 6). When they miss their period, many young women, including those who are married, 'regulate' their menstruation by drinking traditional herbs, or a mixture of young pineapple, carbonated beverages and fermented sticky rice (*tape ketan*) or through vigorous massages. Few of them are aware that these practices may harm women's reproductive organs.

Most young people, even the most educated, college students, are ignorant of the consequences of risky sexual behaviour. Many of those who reported having had sex practise unprotected sex, even with casual partners such as *bondons* or prostitutes. Moreover, those who have sex with steady partners claim that the relations often are not the result of premeditated or conscious decisions but just 'happen', so they are unlikely to be prepared with contraception. These young people obviously face problems such as unwanted pregnancy that often leads to forced marriage, abortion, or STDs including HIV.

In addition, although the majority of Medan young people have known or heard about STDs and AIDS, misinformation still abounds. There is frequent misunderstanding of problems such as the mechanism of infection, preventive measures to avoid diseases, the consequences of infections and the medication to cure them. The most common misunderstandings are the belief that STDs including HIV can be avoided by maintaining physical stamina and the belief that someone who is 'clean' and comes from a better-off family cannot possibly be suffering from HIV. As a consequence, many young people, especially men, did not feel a need to use condoms in casual relationships including with *bondon*.

Medan young people in this study also have only limited knowledge of contraception. Even though most young people could name more than one contraceptive method, few of them were able to correctly describe how the methods work and how to obtain them. Misconception about the side-effects of using condoms are also found. Fears that condoms may cause 'weakness' (*lemas*) and discomfort are evident. The government policy of not providing family planning information and services for unmarried people may be associated with this ignorance.

8.2.2 Sexual and reproductive health programs for the unmarried: 'moral approach' versus 'health approach'

In accordance with the consensus reached in the 1994 ICPD meeting and the 1995 Beijing meeting, the Indonesian government is increasingly aware of the need for comprehensive sexual and reproductive health programs for young people. In collaboration with international agencies such as UNFPA, Ford Foundation, WHO and World Bank, several government institutions and established NGOs have introduced programs regarding the issues.

BKKBN in collaboration with UNFPA has introduced training modules that cover IEC, counselling and referral programs on adolescent reproductive health. These programs involve family, parents, and relatives who are responsible for their children during adolescence. In 1999, the State Ministry of Women's Empowerment and head of BKKBN established a special division to deal with adolescents' reproductive health rights and protection. The Ministry of Health has initiated a counselling program for adolescents in junior and high schools by providing information about adolescents' reproductive health to teachers and those responsible for teenagers (Irdjiati, 1997:20). The Department of National Education, in collaboration with the World Bank, has introduced a pilot project on 'adolescent reproductive health education' in 10 cities in the Central and East Java; this project focuses on training and information for junior and high school teachers about the importance of adolescent reproductive health (*Tempo Online*,

14-20 February 2000). Nevertheless, as these programs are not included in the school curricula and involve only a limited number of people and organizations, they have not reached the majority of young people and parents. Until recently sex and reproductive health education was rarely taught in public schools, while family planning programs still restrict their services to married couples or families.

As most government programs are limited to providing basic information on sexuality and reproductive health but not services, the needs of young people, particularly those who are sexually active, remain unfulfilled. In addition the government approach to these highly controversial issues tends to be based on morality, rather than the 'health approach'. Thus the information provided in the IEC programs is limited to the promotion of family, moral and religious values rather than information on sexual health such as how to avoid unsafe sex.

In contrast young people want an open approach to enable them to explore themselves and to decide whether or not to use the services. Most young people in this study stated that single people should be given more information about contraception, not only about the methods, but also about how to use and to obtain them. For some adolescents, sex may be regarded as part of the normal process of becoming an adult physically and socially. Therefore, provision of comprehensive family planning information and services can reduce unexpected health risks.

Compared to the government programs, those of NGOs seem to be more realistic in approaching unmarried young people's needs. Several established NGOs have provided information and services directly to young people both in school and out of school. However, given the limited budget and human resources of most NGOs in Medan, it is impossible to expect the programs to reach the majority of Medan young people. Moreover, since NGOs have no authority, some school authorities refuse to co-operate, stating that their students are too busy or the issues are adequately covered in the school curriculum.

8.3 Need for more comprehensive approaches: preparing young people entering adulthood

Sexual maturity is often associated with the transition from childhood to adulthood; it is commonly seen as one of the biggest problems among young people. To complicate the problems, sexuality relates not only to health issues; it also involves religion and culture. Thus in order to invent suitable programs for adolescent these aspects must also be taken into account. Programs which are effective in developed countries may face many obstacles in implementation in developing countries.

The Indonesian government seems trapped in these problematic situations. While bureaucrats have become more aware of the importance of sex education for young people, the religious and moral approach is also stressed. With these attitudes, the information and services provided for single people tend to be incomplete. The needs of unmarried people for reproductive health services will not be faced realistically. Nevertheless, the willingness of the government to raise the issues of premarital sex and premarital pregnancy has certainly begun a new era for reproductive health policy for single young people.

After the fall of Soeharto, the press gained freedom to publish whatever they thought could be sold without fear of censorship. Many books, reports and articles appeared on previously censored topics such as reports on young people's sexual activities. Many newspapers published reports and research on the sexual life of single young people in Indonesia. Books about sex flooded bookshops in Medan and Jakarta. Some media were even accused of publishing pornography, which is illegal in Indonesia, but the definition of pornography was hotly contested.

Despite the increasing concerns among many policy makers on the importance of reproductive health information for adolescents, those in authority often deliver inconsistent messages. Facing the increased number of unmarried young people involved in abortion and premarital sex, Khofifah Indar Parawarsa, the State

Minister of Women's Empowerment and the head of BKKBN, reiterated government policy that contraception is only for married couples and not for single persons (*Media Indonesia Online*, 13 February 2000). She then challenged the press to campaign for the importance of virginity for a single woman. These statements may raise questions about the content of information and services that the government is expected to provide for adolescents.

The concerns over young people's premarital sex also motivated many Moslem organizations to demonstrate on the street (*Waspada Online*, 18 December 1998). They demanded that police close the places they believed were a bad influence on young people, such as night-clubs, discotheques and pubs; and that people publishing or selling pornographic materials should be taken to court. In December 1998, Medan police 'caught' (*menjaring*) many young people in hotels, pubs, nightclubs and other places that had been reported as places of undercover prostitution (*prostitusi terselubung*) (*Waspada Online*, 6, 16, 18, 19 December 1998). In November 1998 three discotheques were closed and in-mid December 1998, 10 discotheques were warned (*Republika*, 21 March 1999). This was rather surprising for many people in Medan, since it was common knowledge that most of those places were backed by a 'big man' in the army.

Many people supported the police efforts to control 'adult life' in Medan. They believed it would decrease prostitution and premarital sex among Medan's people. However, most people, especially the young, believed that this movement was ephemeral. They believe that people will simply find other ways to enjoy such activities in future.

The findings of this study suggest that both young people and parents today face different and more complicated problems regarding sex than young people and parents in the past. Apart from the increasing age at first marriage, economic and technological developments have enabled today's young people to receive information that often encourages them to engage in risky sexual behaviour. As some of them are just out of childhood, these young people certainly need help in

dealing with the challenges they face. Most parents were raised according to cultural traditions in which sex was regarded as a secret domain, not to be discussed publicly; many of them find it awkward to talk to their unmarried children about sex and reproductive health. Increasingly, unmarried young adults are in higher education or in industrial employment; they do not live with their parents but rather are in boarding houses while they study or work. This increases their opportunities for sexual contact and experimentation, while they receive less parental supervisions.

In the past children were expected to be married soon after puberty, but today's young people are encouraged to finish university or at least high school, and remain single until age 21 for women and 25 for men. This delay extends adolescence and lengthens the time in which young people may engage in sexual activities before marriage.

Today's young people need different approaches and programs of services for their needs. They urgently need comprehensive sex education as well as access to safe and effective reproductive health services. The conservative approach of shielding young people from information about sex and blocking their access to reproductive health services is not effective. The majority of young people in Medan who are yet not involved in premarital sex, crave information on how to maintain reproductive and sexual health. They understand that the moral and religious approach is stressed by institutions but they also want to be provided with information about safe sex when the need arises. Sexually active young people in particular need both information and services. The argument that providing reproductive services for single young people will encourage promiscuity is obviously counterproductive. For these young people, the issue is not how to prevent premarital sex, but how to reduce the risks attached to something they enjoy. Many young people, especially those who have left school and spend most of their time on the street, are involved in risky sexual activities out of ignorance.

Before the situation gets worse we need to face this problem. The government needs to develop and implement comprehensive reproductive health programs that directly reach the majority of Indonesian young people, including those who have left school. Given the socio-cultural constraints on both young people and their parents, at the moment incorporating sexual and reproductive health education in school curricula is likely to be the most effective approach. However, it needs to be taught at all levels of school, starting from primary school. If sex education is provided at the primary level, when most Indonesian children are in school, those who may drop out at the higher level will at least have some knowledge and vocabulary about the issues, and feel free to discuss sexual matters with health personnel.

Nevertheless, to create an appropriate environment for such an education system, Indonesia needs to reach a consensus on the rights of young people to reproductive health information and services, and on the cultural and religious norms of reproductive health including premarital sex and abortion. This is not easy, as it involves not only young people but also policy makers, religious leaders, parents, educators and media. The religious leaders have to face the fact that the moral and religious approach they advocate is not acceptable or relevant for many young people. Policy makers must open their eyes to the statistics on premarital pregnancy, STDs, forced marriage, and rising age at marriage, and recognize the need to open services to single young women and men. The young people, activists and health experts need to face the importance of serving the real sexual health needs of single young people. And parents and young people must face each other without fear or shame, so they can co-operate to make adolescence safe and the process of maturation smooth. Only in this way will the young people, and the nation, face a bright future.

References

Achmad, Sulistinah Irawati, and Sidney B. Westley. 1999. Indonesian survey looks at adolescent reproductive health. *Asia-Pacific Population and Policy* 51:1-4.

Adegoke, Alfred A. 1992. The experience of spermarche (The age of onset of sperm emission) among selected adolescent boys in Nigeria. *Journal of Youth and Adolescence* 22 (2):201-209.

Adekunle, A.O and O.A. Ladipo. 1992. Reproductive tract infections in Nigeria: chalenges for a fragile health infrastructure. In *Reproductive Tract Infection: Global Impact and Priorities for Women's Reproductive Health*, edited by A Germain *et al.* New York: Plenum Press, pp. 297-316).

Adrina, Kristi Purwandari, NKE Triwijati, and Sjarifah Sabaroedin. 1998. *Hak-hak Reproduksi Perempuan yang Terpasung (Women's Reproductive Rights that are Repressed)*. Jakarta: Pustaka Sinar Harapan.

Aitken, Iain, and Laura Reichenbach. 1994. Reproductive and sexual health services: expanding access and enhancing quality. In *Population Policies Reconsidered, Health, Empowerment, and Rights*, edited by G. Sen, A. Germain and L. C. Chen. Boston: Harvard University Press, pp. 177-192.

Ajayi, Ayo A., Leah T Marangu, Janice Miller, and John M. Paxman. 1991. Adolescent sexuality and fertility in Kenya: a survey of knowledge, perceptions, and practices. *Studies in Family Planning* 22 (4):205-216.

Alwi, Bin Sheikh Alhady. 1962. *Malay Customs and Traditions*. Singapore: Eastern Universities Press, Ltd.

Amazigo, Uche, Nancy Silva, Joan Kaufman, and Daniel S. Obikeze. 1997. Sexual activity and contraceptive knowledge and use among in-school adolescents in Nigeria. *International Family Planning Perspectives* 23 (1):28-33.

Ausubel, David P., Raymond Montemayor, and Pergrouhi (Najarian) Svajian. 1977. *Theory and Problems of Adolescent Development*. Second edition. New York: Grune & Stratton.

Balk, Deborah, Lita J. Domingo, Grace T.Cruz and Tim Brown. 1999. HIV/AIDS. In *Adolescent Sexuality in the Philippines*, edited by Corazon M. Raymundo, Peter Xenos and Lita J. Domingo. Quezon City: UP Office of the Vice Chancellor for Research and Development, pp. 81- 98.

Barker, Gary Knaul, and Susan Rich. 1992. Influences on adolescent sexuality in Nigeria and Kenya: findings from recent focus-group discussions. *Studies in Family Planning* 23 (3):199-210.

Barry, Herbert, and Alice Schlegel. 1986. Cultural customs that influence sexual freedom in adolescence. *Ethnology* 25:151-162.

Bernard, R. 1988. Unstructured and semi-structured interviewing. In *Research Methods in Cultural Antrophology*. Beverly Hills: Sage Publications, pp. 203-223.

Beyene, Yewoubdar. 1989. *From Menarche to Menopause: Reproductive Lives of Peasant Women in Two Cultures*. New York: State University of New York Press.

Billy, John O. G., Karin L. Brewster, and William R. Grady. 1994. Contextual effects on the sexual behavior of adolescent women. *Journal of Marriage and the Family* 56 (2):387-404.

Biro Pusat Statistik (BPS). 1981. *Penduduk Indonesia Hasil Sensus Penduduk 1980 (Population of Indonesia Results of the 1980 Population Census)*. Jakarta

Biro Pusat Statistik (BPS). 1990. *Sumatera Utara dalam Angka Tahun 1989 (North Sumatera in Figures in1989)*. Medan.

Biro Pusat Statistik (BPS). 1991. *Penduduk Indonesia Hasil Sensus Penduduk 1990 (Population of Indonesia Results of the 1990 Population Census)*. Jakarta.

Biro Pusat Statistik (BPS). 1993a. *Profile Kependudukan Indonesia (Indonesian Population Profile)*. Jakarta.

Biro Pusat Statistik (BPS). 1993b. *Profil Kependudukan Propinsi Sumatera Utara (North Sumatera Population Profile)*. Jakarta.

Biro Pusat Statistik (BPS). 1999. *Kotamadya Medan dalam Angka tahun 1998 (Medan in Figures in 1998)*. Medan

Blanc, Ann K., and Ann A. Way. 1998. Sexual behavior and contraceptive knowledge and use among adolescents in developing countries. *Studies in Family Planning* 29 (2):106-116.

Berg, B.L. 1989. *Qualitative Research Methods for the Social Sciences*. Boston:Allyn and Bacon.

Blos, Peter. 1962. *On Adolescence: a Psychoanalytic Interpretation*. New York: The Free Press of Glencoe.

Bogue, D.J. 1993. Role of the qualitative method in demographic research. In *Reading in Population Research Methodology*, 1980-1982, edited by D.J. Bogue, E.E. Arriaga and D.L. Anderson. Cairo: Agency for International Development.

Bongaarts, John, and Barney Cohen. 1998. Introduction and overview. *Studies in Family Planning* 29 (2):99-105.

Boonmongkon, Pimpawun. 1997. Adolescent sexual health: lessons learned and new directions. Paper presented to conference on Future needs of Thailand in Population and Reproductive Health, Prachubkirikun, 17-18 April.

Bovill, Kathryn J. 1986. Toba Batak Marriage and Alliance: Family Decisions in Urban Context. PhD thesis, University of Illinois. University Microfilms International, Ann Arbor.

Boyd, Billy Ray. 1998. *Exposing Circumcision: Rethinking a Medical and Cultural Tradition*. California: The Crossing Press.

Brooks-Gunn, Jeanne, and Edward O. Reiter. 1990. The role of pubertal processes. In *At the Threshold: The Developing Adolescent.* edited by S. S. Feldman and G. R. Elliott. Cambridge: Harvard University Press, pp. 16-53.

Bruner, Edward M. 1973. Kin and non-kin. In *Urban anthropology: Cross-cultural Studies of Urbanization,* edited by A. Southall. New York: Oxford University Press, pp. 373-392.

Bruner, Edward M. 1974. The expression of ethnicity in Indonesia. In *Urban Ethnicity,* edited by A. Cohen. London: Tavistock Publications, pp. 251-280.

Bruner, Edward M. 1987. Megaliths, migration and the segmented self. In *Cultures and Societies of North Sumatra,* edited by R. Carle. Hambrug: Dietrich Reimer Verlag, pp. 133-149.

Caldwell, John C., Pat Caldwell, Bruce K. Caldwell, and Indrani Pieris. 1998. The construction of adolescence in a changing world: implications for sexuality, reproduction, and marriage. *Studies in Family Planning* 29 (2):137-153.

Carael, Michel. 1995. Sexual behaviour. In *Sexual Behaviour and AIDS in the Developing World,* edited by John Cleland and Benoit Ferry. London: Taylor and Francis Ltd, pp. 75-123.

Carpenter, Carol. 1987. Brides and bride-dressers in contemporary Java. University Microfilms International, Ann Arbor, Anthropology, Cornel University, Michigan.

Casper, Lynne M. 1990. Does family interaction prevent adolescent pregnancy?. *Family Planning Perspectives* 22 (3):109-114.

Chirawatkul, Siriporn. 1996. Blood beliefs in a traditional culture of Northeastern Thailand. In *Maternity and Reproductive Health in Asian Societies,* edited by P. L. Rice and L. Manderson. Amsterdam: Harwood Academic Publishers, pp. 247-259.

Cleland, John. 1995. Risk perception and behavioural change. In *Sexual behaviour and AIDS in the Developing World,* edited John Cleland and Benoit Ferry. London: Taylor and Francis, pp. 157-192.

Cohen, Yehudi A. 1964. *Childhood to Adolescence.* Chicago: Aldine Publishing Company.

Collins, John K., and Lesley Robinson. 1986. The contraceptive knowledge, attitudes and practice of unmarried adolescents. *Australian Journal of Sex, Marriage & Family* 7 (3):132-152.

Cooksey, Elizabeth. 1990. Factors in the resolution of adolescent premarital pregnancies. *Demography* 27 (2):205-218.

Cruz, Grace T. and Clarinda L. Berja. 1999. Reproductive health. In *Adolescent Sexuality in the Philippines,* edited by Corazon M. Raymundo, Peter Xenos and Lita J. Domingo. Quezon City: UP Office of the Vice Chancellor for Research and Development, pp. 58-80.

Daili, Sjaiful F., Nuning M.K. Masjkuri, and Asri C. Adisasmita. 1994. Literature review on reproductive tract infection in women associated with sexually transmitted diseases in Indonesia. Jakarta: University of Indonesia.

Dawson, Deborah Anne. 1986. The effect of sex education on adolescent behavior. *Family Planning Perspectives* 18 (4):162-170.

Day, Randal D. 1992. The transition to first intercourse among racially and culturally diverse youth. *Journal of Marriage and the Family* 54:749-762.

DeLamater, John. 1987. A sociological approach. In *Theories of Human Sexuality*, edited by J. H. Geer and W. T. O'Donohue. New york: Plenum press, pp. 237-255.

Delaney, Janice, Mary Jane Lupton, and Emily Toth. 1988. *The Curse: a Cultural History of Menstruation*. Chicago: University of Illinois Press.

De Silva, W. Indralal. 1998. Socio-economic change and adolescent issues in the Asia and Pacific region. In *Report and Recommendations of the Expert Group Meeting on Adolescents: Implications of Population Trends, Environment, and Development, 30 September- 2 October 1997, Bangkok*. New York: United Nations, pp. 46-81.

Dewi, Made Heny Urmila. 1997. *Aborsi Pro dan Kontra di Kalangan Petugas Kesehatan (Abortion, Pro and Contras among Health Personnel)*. Yogyakarta: Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Dixon-Mueller, Ruth. 1993. The sexuality connection in reproductive health. *Studies in Family Planning* 24(5):269-282.

Djaelani, Joyce S.H. 1996. Kebijakan pelayanan kesehatan reproduksi remaja (Adolescent reproductive health services policy). In *Seksualitas, Kesehatan Reproduksi, dan Ketimpangan Gender (Sexuality, Reproductive Health and Gender Gaps)*, edited by A. Dwiyanto and M. Darwin. Jakarta: Pustaka Sinar Harapan, pp. 307-316.

Doan, Helen McKinnon, and Janice M. Morse. 1985. *Every Girl: Learning about Menstruation*. Selangor: Pelanduk Publications.

Elliott, Glen R., and S. Shirley Feldman. 1990. Capturing the adolescent experience. In *At the Threshold: the Developing Adolescent*, edited by S. S. Feldman and G. R. Elliott. Cambridge MA: Harvard University Press, pp. 1-13.

Emiyanti, Sri, Baren R. Sembiring, Linda T. Maas, and Syarifah. 1997. *Aborsi: Sikap dan Tindakan Paramedis (Abortion: Attitudes and Actions of Paramedical)*. Yogyakarta: Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Faisal, Muhamad, and Sabir Ahmad. 1998. *Aborsi Tradisional:Pengalaman Dukun dan Klien (Traditional Abortion: The Experience of Traditional Healer and Client)*. Yogyakarta: Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Fathalla, M.F. 1992. Reproductive health in the world: two decades of progress and challenge ahead. In *Reproductive Health: a Key to a Brighter Future*, edited by J.Khanna, P.F.A. Van Look and P. D. Griffin. Geneva: World Health Organization, pp. 3-31.

Fine, Gary Alan, Jeylan T. Mortimer, and Donald F. Roberts. 1990. Leisure, work, and the Mass Media. In *At the Threshold: the Developing Adolescent*, edited by S. S. Feldman and G. R. Elliott. Cambridge: Harvard University Press, pp. 225-252.

Ford, N.J., and K.N. Siregar. 1998. Operationalizing the new concept of sexual and reproductive health in Indonesia. *International Journal of Population Geography* 4:11-30.

Forrest, Jacqueline Darroch. 1990. Cultural influences on adolescents' reproductive behavior. In *Adolescence and Puberty*, edited by John Bancroft and June Machover Reinisch. New York: Oxford University Press, pp. 235-253.

Friedman, Herbert L., Mark A. Besley, and Jane Ferguse. 1990. Adolecent health: promise and paradox. In *Health Care of Women and Children in Developing Countries*, edited by H. M. Wallace and K. Giri. California: Third Party Publishing Company, pp. 453-469.

Friedman, Herbert L. 1993. A global overview of adolescent reproductive health. In *Family Planning Meeting Challenges: Promoting Choices*, edited by P. Senanayake and R. L. Kleinman. New Delhi: Parthenon Publishing Group, pp. 277-284.

Furby, Lita, Linda M. Ochs, and Catherine W. Thomas. 1997. Sexually transmitted disease prevention: adolescents' perceptions of possible side effects. *Adolescence* 32 (128):782-809.

Furstenberg, Frank F. Jr., S. Philip Morgan, Kristin A. Moore, and James L. Peterson. 1987. Race differences in the timing of adolescent intercourse. *American Sociological Review* 52 (4):511-518.

Furstenberg, Frank F. Jr.. 1998. When will teenage childbearing become a problem? the implication of western experience for developing countries. *Studies in Family Planning* 29 (2):246-253.

Gaddis, Alan, and J. Brooks-Gunn. 1985. The male experience of pubertal change. *Journal of Youth and Adolescence* 14 (1):61-69.

Gagnon, John H., and William Simon. 1973. *Sexual Conduct: The Social Sources of Human Sexuality*. London: Hutchinson & Co.

Gagnon, John H. 1983. Age at menarche and sexual conduct in adolescence and young adulthood. In *Menarche: The Transition From Girl to Woman*, edited by S. Golub. Massachusetts: LexingtonBooks, pp. 175-184.

Geertz, Clifford. 1960. *The Religion of Java*. Chicago: University of Chicago Press.

Geertz, Hildred. 1961. *The Javanese Family: A Study of Kinship and Socialization*. New York: Free Press of Glencoe, Inc.

Gifford, S.M., N. Suanching, J. Tusing, Neng Ngaih Lian, B. Langkham, and V.L. Muana. 1999. The social context of risk and protection amongst young people and women in Churachandpur, India. In *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries*, edited by John C. Caldwell *et al.*. Canberra: Australian National University. pp. 171-182.

Golub, Sharon. 1983. Menarche: the begining of menstrual life. In *Lifting the Curse of Menstruation: A Feminist Appraisal of the Influence of Menstruation on Women's Lives*, edited by S. Golub. New York: The Haworth Press, pp. 17-36.

Gorgen, Regina, Birga Maier, and Hans Jochen Diesfeld. 1993. Problems related to school girl pregnancy in Burkina Faso. *Studies in Family Planning* 24 (5):283-294.

Graber, Julia A., Jeanne Brooks-Gunn, and Britt R. Galen. 1998. Betwixt and between: sexuality in the context of adolescent transitions. In *New Perspectives on Adolescent Risk Behavior*, edited by R. Jessor. Cambridge: Cambridge University Press, pp. 270-316.

Grunseit, Anne, Susan Kippax, Peter Aggleton, Mariella Baldo, and Gary Slutkin. 1997. Sexuality education and young people's sexual behaviour: a review study. *Journal of Adolescent Research* 12 (4):421-453.

Gunawan, Nardho. 1995. *Reproductive Health Services in Indonesia.* New Delhi: Technical Consultation on the Development of Reproductive Health Strategies in SEARO Countries.

Habsjah, Attashendartini. 1996. Men and Reproductive Health: Understanding Their Potential Role. Jakarta: Atma Jaya University.

Hassan, Riaz. 1980. *Ethnicity, Culture and Fertility: An Exploratory Study of Fertility Behaviour and Sexual Beliefs.* Singapore: Chopmen-Publisher.

Haurin, R. Jean, and Frank L. Mott. 1990. Adolescent sexual activity in the family context: the impact of older siblings. *Demography* 27 (4):537-557.

Hawkins, Kirstan , and Bayeligne Meshesha. 1994. Reaching young people: ingredients of effective programs. In *Population Policies Reconsideration: Health, Empowerment, and Rights*, edited by G. Sen, A. Germain and L. C. Chen. Boston: Harvard University Press, pp. 212-222.

Henshaw, Stanley K., Susheela Singh, and Taylor Haas. 1999. The incidence of abortion worldwide. *International Family Planning Perspectives* 25 (Supplement): S30-S38.

Hetherington, E.M. 1972. Effect of father's absence on personality development in adolescent daughters. *Developmental Psychology* 7:313-26.

Hidayana, Irwan Martua, Amir S. Nadapdap, Surati Suwiryo, Irene Marpaung, and Agung Utama Lubis. 1997. *Perilaku Seksual Remaja di Kota dan di Desa, Kasus Sumatera Utara (Adolescents' Sexual Behaviour in the Urban and Rural Area: A Case Study in North Sumatra).* Jakarta: Laboratorium Antropologi, Universitas Indonesia.

Hill, John P., and Mary Ellen Lynch. 1983. The intensification of gender-related role-expectations during early adolescence. In *Girls at puberty: biological and psychosocial perspectives*, edited by J. Brooks-Gunn and A. C. Petersen. New York: Plenum Press, Pp. 201-228.

Hillier, Lynne, Lyn Harrison, and Deborah Warr. 1998. "When you carry condoms all the boys think you want it": negotiating competing discourses about safe sex. *Journal of Adolescence* 21:15-19.

Hofferth, Sandra L. 1990. Trends in adolescent sexual activity, contraception, and pregnancy in the United States. In *Adolescence and Puberty*, edited by John Bancroft and June Machover Reinisch. New York: Oxford University Press, pp. 215-233.

Hopwood, Nancy J., Robert P. Kelch, Paula M. Hale, Tarina M., Mendes, Carol M. Foster, and Inese Z. Beitins. 1990. The onset of human puberty: biological and environmental factors. In *Adolescence and Puberty*, edited by John Bancroft and June Machover Reinisch. New York: Oxford University Press, pp. 29-49.

Hosken, Fran P. 1993. *The Hosken Report: Genital and Sexual Mutilation of Females.* Lexington MA: Women's International Network News.

Hotvedt, Mary E. 1990. Emerging and submerging adolescent sexuality: culture and sexual orientation. In *Adolescence and Puberty*, edited by John Bancroft and June Machover Reinisch. New York: Oxford University Press, pp. 157-172.

Howard, Marion, and Judith Blamey McCabe. 1990. Helping teenagers postpone sexual involvement. *Family Planning Perspectives* 22 (1):21-26.

Hughes, Jane, and Ann P. McCauley. 1998. Improving the fit: adolescents' needs and future programs for sexual and reproductive health in developing countries. *Studies in Family Planning* 29 (2):233-245.

Hull, Terence H., Sarlito W. Sarwono, and Ninuk Widyantoro. 1993. Induced abortion in Indonesia. *Studies in Family Planning* 24 (4):241-251.

Hull, Valerie, Ninuk Widyantoro, and Tamara Fetters. 1996. 'No problem': reproductive tract infections in Indonesia. In *Maternity and Reproductive Health in Asian Societies*, edited by P. L. Rice and L. Manderson. Amsterdam: Harwood Academic Publisher, pp. 227-246.

Hull, Terence H., and Meiwita B. Iskandar. 1999. Indonesia's reproductive health program: swept aside in the deluge? Paper presented to Annual Meeting Population Association of America, New York.

Humble, Morag. 1995. Women's perspectives on reproductive health and rights. *Planned Parenthood Challenges* 2 (Women's Health, Women's Rights):26-31.

Husny, Tengku Haji M. Lah. 1977. *Langgam dan Pantun pada Upacara Perkawinan Menurut Adat Melayu di Sumatra Timur (Song and Poem in Wedding Ceremony among Malay in East Sumatera).* Medan: Badan Penerbit Husny.

Husny, Tengku Haji M. Lah. 1986. *Butir-butir Adat Budaya Melayu Pesisir Sumatera Timur (Malay Culture in the East Coast of Sumatra).* Jakarta: Departemen Pendidikan dan Kebudayaan.

International Women's Health Coalition (IWHC). 1991. *Reproductive Tract Infections in Women in the Third World: National and International Policy Implications.* New York: IWHC and Rockefeller Foundation.

Irdjiati, Ieke. 1997. Kebijaksanaan pemerintah di bidang kesehatan reproduksi remaja di Indonesia (Government policy on adolescent reproductive health in Indonesia). *Majalah Ilmiah Fakultas Kedokteran Universitas Trisakti*:18-32.

Irvine, Janice M. 1994. Cultural differences and adolescent sexualities. In *Sexual Cultures and the Construction of Adolescent Identities*, edited by J. M. Irvine. Philadelphia: Temple University Press, pp. 3-28.

Iskandar, Meiwita B., Umi Pujiastuti, and Herna Lestari. 1994. *Kualitas Pelayanan Keluarga Berencana di Indonesia: Review Analitik untuk Menentukan Prioritas (The Quality of Family Planning Services in Indonesia: Analytical Review to Decide the Priority.* Jakarta: Universitas Indonesia, BKKBN and Population Council.

Iskandar, Meiwita B. 1995. Laporan Akhir Perngembangan Module KIE Materi Kesehatan Reproduksi Untuk Keluarga dengan Anak Usia Sekolah dan Remaja (The Final Report of Development of Reproductive Health EIC Module for the Family with School Age Children and Adolescent), Jakarta: Pusat Penelitian Kesehatan UI, BKKBN and UNFPA.

Iskandar, Meiwita B. 1997. Masalah kesehatan reproduksi remaja di Indonesia (Adolescent reproductive health problems in Indonesia). *Majalah Ilmiah Fakultas Kedokteran Universitas Trisakti*:1-10.

Iskandar, Meiwita B., Jane Patten, Siti Nurul Qomariyah, Catherine Vickers, and Subadra Indrawati Molyneaux. 1998. Health care providers' behavioral factors: a challenge in implementing reproductive health care in Indonesia. Paper presented to Fourth Asia Pacific Social Science and Medicine Conference, Yogyakarta, 7-11 December.

Jaccard, James, Patricia J. Dittus, and Vivian V. Gordon. 1996. Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives* 28 (4):159-165, 185.

Jain, Anrudh, and Judith Bruce. 1994. A reproductive health approach to the objectives and assessment of family planning programs. In *Population Policies Reconsideration,* edited by G. Sen, A. Germain and L. C. Chen. Boston: Harvard University Press, pp. 193-209.

Jones, Gavin. 1998. Population dynamics and their impact on adolescents in the ESCAP region. In *Report and Recommendations of the Expert Group Meeting on Adolescents: Implications of Population Trends, Environment, and Development, 30 September- 2 October 1997, Bangkok.* New York: United Nations, pp. 21-45.

Jones, Gavin. 2000. Approaches to understanding sexuality and reproductive health. In *Health Social Science Action and Partnership: Retrospective and Prospective Discourse,* Yogyakarta, Population Studies Center Gadjah Mada University, pp. 261-288.

Kabeer, Naila. 1992. From fertility reduction to reproductive choice: gender perspectives on family planning: Institute of Development Studies.

Kahn, Joan R., Ronald R. Rindfuss, and David K. Guilkey. 1990. Adolescent contraceptive method choices. *Demography* 27 (3):323-335.

Kang, Melissa S., and Deborah A. Zador. 1993. Sexual behaviour and contraceptive practices of year 10 schoolgirls in inner metropolitan Sydney. *Australian Journal of Marriage and Family* 14 (3):137-142.

Kaptein, Nico. 1995. Circumcision in Indonesia: Muslim or not. In *Pluralism and Identity: Studies in Ritual Behaviour,* edited by J. Platvoet and K. Van Der Toorn. Leiden: E. L. Brill, pp. 285-302.

Katchadourian, Herant. 1990. Sexuality. In *At the Threshold: The Developing Adolescent*, edited by S. S. Feldman and G. R.Elliott. Cambridge: Harvard University Press, pp. 330-351.

Keeting, Evert. 1993. A global picture. *Planned Parenthood Challenges* (2) (Sexual and Reproductive Health):28-30.

Keeting, Evert. 1995. Meeting young people's sexual and reproductive health needs worldwide. *Planned Parenthood Challenges* (1) (Empowering Youth):28-31.

Khisbiyah, Yayah, Desti Murdijana, and Wijayanto. 1997. *Kehamilan tak Dikehendaki di Kalangan Remaja (Unwanted Pregnancy among Adolescents)*. Yogyakarta: Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Kiem, Christian G. 1993. *Growing up in Indonesia: Youth and Social Change in a Moluccan Town*. Saarbrucken: Verlag Breitenbach Publisher.

King, Bruce M. 1999. *Human Sexuality Today*. Third edition. New Jersey: Prentice Hall.

Kiragu, Karungari, and Laurie S. Zabin. 1993. The correlates of premarital sexual activity among school-age adolescents in Kenya. *International Family Planning Perspectives* 19 (3):92-97,109.

Kirby, Douglas, Richard P. Barth, Nancy Leland, and Joyce V. Fetro. 1991. Reducing the risk: impact of a new curriculum on sexual risk-taking. *Family Planning Perspectives* 23 (6):253-263.

Koentjaraningrat. 1985. *Javanese Culture*. Singapore: Oxford University Press.

Koetsawang, Suporn. 1990. Adolescent reproductive health. In *Health Care of Women and Children in Developing Countries*, edited by H. Wallace and K. Giri. Oakland: Third Party Publishing Company, pp. 491-503.

Koff, Elissa, and Jill Rierdan. 1995. Preparing girls for menstruation: recommendations from adolescent girls. *Adolescence* 30 (120):795-811.

Koso-Thomas, Olayinka. 1987. *The Circumcision of Women: a Strategy for Eradication*. London: Zed Books Ltd.

Kristanti, M. 1996. Kehamilan yang tidak direncanakan dan aborsi di Indonesia (Unplanned pregnancy and abortion in Indonesia). *Majalah Kesehatan Masyarakat Indonesia* 24(3): 202-205.

Ku, Leighton C., Freya L. Sonenstein, and Joseph H. Pleck. 1992. The association of AIDS education and sex education with sexual behavior and condom use among teenage men. *Family Planning Perspectives* 24 (3):100-106.

Lacson, Romel Saulog, Theocaris R. Theocaris, Robert Strack, Francisco S. Sy, Murray L. Vincent, Trinidad S. Osteria, and Pilar Ramos Jimenez. 1997. Correlates of sexual abstinence among urban university students in the Philippines. *International Family Planning Perspectives* 23 (4):168-172.

Ladjali, Malika. 1993. Networking: an approach to adolescent health problems. In *Family Planning Meeting Challenges: Promoting Choices*, edited by P. Senanayake and R. L. Kleinman. New Delhi: Parthenon Publishing Group, pp. 285-290.

Lauritsen, Janet L., and C. Gray Swicegood. 1997. The consistency of self-reported initiation of sexual activity. *Family Planning Perspectives* 29 (5):215-221.

Lee, Romeo Bulalaque. 1995. Towards male involvement in population and AIDS programs in the Philippines: exploring heterosexual dating and sexual behaviour, and condom use among unmarried young males, Ph.D thesis, Australian National University, Canberra.

Lubis, Agung Utama. 1997. Pengetahuan remaja pria dalam mencegah kehamilan di desa Bogak, Kabupaten Asahan (The knowledge of adolescent males about pregnancy prevention in Bogak village, Asahan District). Sarjana thesis, Universitas Sumatra Utara, Medan.

Magnis-Suseno. 1997. *Javanese Ethics and World-view: The Javanese Idea of the Good Life.* Jakarta: Gramedia Pustaka Utama.

Makinwa-Adebusoye, P. 1992. Sexual behavior, reproductive knowledge and contraceptive use among young urban Nigerians. *International Family Planning Perspectives* 18 (2):66-70.

Marsiglio, William, and Frank L. Mott. 1986. The impact of sex education on sexual activity, contraceptive use and premarital pregnancy among American teenagers. *Family Planning Perspective* 18 (4):151-154+157-162.

Martin, Karin A. 1996. *Puberty, Sexuality, and the Self: Girls and Boys at Adolescence.* New York: Routledge.

McCarthy, James, and Jane Menken. 1981. Marriage, remarriage, marital disruption and age at first birth. In *Teenage Sexuality, Pregnancy, and Childbearing*, edited by F. F. Furstenberg, R. Lincoln and J. Menken. Philadelphia: University of Pennsylvania Press, pp. 223-233.

Mehryar, Amir. 1995. Condoms: awareness, attitudes and use. In *Sexual Behaviour and AIDS in the Developing World*, edited by J. C. a. B. Ferry. London: Taylor &Francis Ltd, pp. 124-156.

Mensch, Barbara S., Judith Bruce, and Margareth E. Greene. 1998. *The Uncharted Passage: Girls' Adolescence in the Developing World.* New York: Population Council.

Mohamad, Kartono. 1992. UU kesehatan membolehkan mematikan ibu? (Does the health law allow the killing of women?), *Kompas*, 12 December:4.

Mohamad, Kartono. 1996. Prioritas pelayanan kesehatan reproduksi di Indonesa (The priority of reproductive health services in Indonesia). In *Seksualitas, Kesehatan Reproduksi, dan Ketimpangan Gender (Sexuality, Reproductive Health and Gender Gaps)*, edited by A. Dwiyanto and M. Darwin. Jakarta: Pustaka Sinar Harapan, pp. 73-89.

Mohamad, Kartono. 1998. *Kontradiksi dalam Kesehatan Reproduksi (Contradiction in Reproductive Health).* Jakarta: Pustaka Sinar Harapan.

Moore, Kristin A, and Steven B. Caldwell. 1981. The effect of government policies on out-of-wedlock sex and pregnancy. In *Teenage Sexuality, Pregnancy, and Childbearing*, edited by F. F. Furstenberg, R. Lincoln and J. Menken. Philadelphia: University of Pennsylvania Press, pp. 126-135.

Moore, Susan, and Doreen Rosenthal. 1993. *Sexuality in Adolescence*. London: Routledge.

Morris, Leo. 1993. Pre-marital sexual experience and use of contraception among young adults in Latin America. In *Family Planning Meeting Challenges: Promoting Choices*, edited by P. Senanayake and R. L. Kleinman. New Delhi: The Parthenon Publishing Group, pp. 505-511.

Morse, Janice M., and Peggy Anne Field. 1995. *Qualitative Research Methods for Health Professionals*. Second edition. Thousand Oaks: Sage Publication.

Mott, Frank L., Michelle M. Fondell, Paul N. Hu, Lori Kowaleski-Jones, and Elizabeth G. Menaghan. 1996. The determinants of first sex by age 14 in a high-risk adolescent population. *Family Planning Perspectives* 28 (1):13-18.

Muhaimin, Abdul Ghoffur. 1995. The Islamic traditions of Cirebon: ibadat and adat among Javanese Muslims. Ph.D thesis, The Australian National University, Canberra.

Muninjaya, A.A. Gde. 1993. 'Needs assessment' reproduksi sehat remaja di Kota Madya Denpasar, 1993 ('Needs assessment': adolescents' reproductive health in Denpasar, 1993). Denpasar: Yayasan Kusuma Buana dan KLH/BKKBN.

Muraskin, Lana D. 1986. Sex education mandates: are they the answer? *Family Planning Perspectives* 18 (4):171-174.

Murphy, Barbara, Jill Cockburn, and Michael Murphy. 1992. Focus groups in health research. *Health Promotion Journal of Australia* 2 (2):37-40.

Nagata, Judith A. 1974. What is a Malay? Situational selection of ethnic identity in a plural society. *American Ethnologist* 1 (2):331-350.

Needle, R.H. 1977. Factors affecting contraceptive practices of high school and college students. *Journal of Social Issue* 29: 95-112.

Nemecek, Ottokar. 1958. *Virginity, Pre-nuptial Rites and Rituals*. New York: Philosophical Library.

Netting, Nancy S. 1992. Sexuality in youth culture: identity and change. *Adolescence* 27 (108):961-976.

Newcomer, Susan F., and J. Richard Udry. 1985. Parent-child communication and adolescent sexual behaviour. *Family Planning Perspectives* 17 (4):169-174.

Lan Nio, Joe. 1961. *Peradaban Tionghoa Selayang Pandang (An overview of Tionghoa Culture)*. Djakarta: Keng PO.

Noller, Patricia, and Victor Callan. 1991. *The Adolescent in the Family*. London: Routledge.

Oey-Gardiner. 1997. Educational development, achievement and challenges. In Indonesia Assessment: Population and Human Resources, edited by Gavin W. Jones and Terence H. Hull, Canberra: Australian National University, pp. 136-166.

Paige, Karen Ericksen, and Jeffery M. Paige. 1981. *The Politics of Reproductive Ritual*. Berkley: University of California Press, Ltd.

Paige, Karen Ericksen. 1983. Virginity rituals and chastity control during puberty: cross-cultural pattern. In *Menarche*, edited by S. Golub. Toronto: LexingtonBooks, pp. 155-174.

Pardede, J. 1987. The question of Christianity, Islam and Batak culture in North Sumatera. In *Cultures and Societies of North Sumatra*, edited by R. Carle. Hamburg: Dietrich Reimer Verlag, pp. 235-251.

Pelly, Usman. 1983. Urban migration and adaptation in Indonesia: a case study of Minangkabau and Mandailing Batak migrants in Medan, North Sumatra. Ph.D thesis, University of Illinois, Urbana.

Pick de Weiss, Susan , Lucille C. Atkin, and James N. Gribble. 1991. Sex, contraception, and pregnancy among adolescents in Mexico City. *Studies in Family Planning* 22 (2):74-82.

Ploss, Hermann Heinrich, Max Bartels, and Paul Bartels. 1935. *Women: An Historical Gynecological and Anthropological Compendium.* Edited by J. Dingwall. London: William Heinemann Ltd.

Population Reports. 1995. Meeting the needs of young adults. Series J (41) (Family Planning Programs):1-38.

Potts, D. Malcolm. 1990. Adolescence and puberty: an overview. In *Adolescence and Puberty*. New York: Oxford University Press, pp. 269-279.

Rahardjo, Yulfita. 1990. *Jamu peluntur:* traditional medicine for menstruation regulation and abortion in Indonesia. Paper presented to seminar *Third International Congress in Traditional Asian Medical Systems*, Bombay, 4-7 January.

Ramonasari. 1996. Perilaku remaja dan kesehatan reproduksi (Adolescents' behaviour and reproductive health). In *Seksualitas, Kesehatan Reproduksi, dan Ketimpangan Gender (Sexuality, Reproductive Health and Gender Gaps)*, edited by A. Dwiyanto and M. Darwin. Jakarta: Pustaka Sinar Harapan, pp. 299-307.

Reid, Anthony. 1979. *The Blood of the People: Revolution and End of Traditional Rule in Northern Sumatra.* Kuala Lumpur: Oxford University Press.

Reid, Anthony. 1988. *Southeast Asia in the Age of Commerce 1450-1680.* Vol. 1: The lands below the winds. New Haven: Yale University Press.

Remez, L. 1990. Adolescents' attitudes toward premarital sex affect religious activity. *Family Planning Perspectives* 22 (1):41-42.

Renne, Elisha P. 1993. Changes in adolescent sexuality and the perception of virginity in a southwestern Nigerian village. In *Sexual Networking and HIV/AIDS in Wesi Africa*, edited by John C. Caldwell *et al.* Supplement to *Health Transition Review* 3. Canberra : Australian National University, pp. 121-133.

Rind, P. 1991. Adolescents are more likely to use condom than pill at first coitus. *Family Planning Perspectives* 23 (2):92-93.

Rindfuss, Ronald R. 1991. The young adult years: diversity, structural change, and fertility. *Demography* 28(4):493-511.

Saifuddin, Achmad Fedyani, and Irwan Martua Hidayana. 1999. *Seksualitas Remaja (Adolescent Sexuality)*. Jakarta: Sinar Harapan.

Sarwono, Sarlito Wirawan. 1981. *Pergeseran Norma Perilaku Seksual Kaum Remaja: Sebuah Penelitian Terhadap Remaja Jakarta (Changing Sexual Behaviour Norms Among Adolescent: A Case Study Among Adolescents in Jakarta)*. Jakarta: C.V. Rajawali.

Schlegel, Alice. 1991. Status, property, and the value on virginity. *American Ethnologist* 18 (4):719-734.

Schneider, Jane. 1971. Of vigilance and virgins: honor, shame, and access to resources in Mediterranean societies. *Ethnology* 10:1-24.

Schofield, Michael. 1969. *The Sexual Behaviour of Young People*. Melbourne: Penguin Books.

Scrimshaw, S.C.M. 1991. Combining quantitative and qualitative methods in the study of intrahousehold resource allocation. In *Health Transition: Methods and Measures*, Canberra: Australian National University, pp. 237-250.

Sears, Laurie J. 1996. Fragile identities: deconstructing women and Indonesia. In Fantasizing the Feminine in Indonesia. London: Duke University Press, pp.1-44.

Seifert, Wolfram. 1987. The urban area of Medan: growth, development and planning implications. In *Cultures and Societies of North Sumatra*, edited by R. Carle. Hamburg: Dietrich Reimer Verlag, pp. 467-513.

Senanayake, Pramilla. 1990. Adolescent fertility. In *Health Care of Women and Children in Developing Countries*, edited by H. M. Wallace and K. Giri. Oakland: Third Party Publishing Company, pp. 470-475.

Senderowitz, Judith. 1995. *Adolescent Health: Reassessing the Passage to Adulthood*. Washington DC: World Bank.

Serbin, Lisa A., and Carol H. Sprafkin. 1987. A developmental approach. In *Theories of Human Sexuality*, edited by J. H. Geer and W. T. O'Donohue. Boston: Plenum Press, pp. 163-195.

Silva, Kalinga Tudor, Jay Schensul, and Priyani Ratnayake. 2000. Virginity, taboos against premarital sex and implications for sexual risk reduction among youth in Sri Lanka. In *Health Social Science Action and Partnership: Retrospective and Prospective Discourse*, Yogyakarta, Population Studies Center Gadjah Mada University, pp. 283-415.

Sinar, Tengku Luckman. 1980. The coming of the Chinese imigrant to East Sumatra in the 19th Century. In *Berita Antropologi*, 11 (37):29-41.

Sinar, Tengku Luckman. 1991. *Sejarah Medan Tempo Doeloe (Medan History in the Old Days)*. Medan: Lembaga Penelitian dan Pengembangan Seni Budaya Melayu.

Singarimbun, Masri. 1975. *Kinship, Descent and Alliance Among the Karo-Batak*. Berkeley: University of California Press.

Singarimbun, Masri. 1996. *Penduduk dan Perubahan (Population and Change)*. Yogyakarta: Pustaka Pelajar.

Singh, Susheela, and Renee Samara. 1996. Early marriage among women in developing countries. *International Family Planning Perspectives* 22 (4): 148-157, 175.

Singh, Susheela. 1998. Adolescent childbearing in developing countries: a global review. *Studies in Family Planning* 29 (2):117-136.

Singh, Susheela, Deirdre Wulf, Renee Samara, and Yvette P. Cuca. 2000. Gender differences in the timing of first intercourse: data from 14 countries. *International Family Planning Perspectives* 26 (1):21-28.

Siyaranamual, Julius, ed. 1997. *Etika, Hak Asasi, dan Pewabahan AIDS (Ethic, Human Right and the Epidemic of AIDS)*. Jakarta: Pustaka Sinar Harapan.

Smith, Edward A., J. Richard Udry, and Naomi M. Morris. 1985. Pubertal development and friends: a biosocial explanation of adolescent sexual behavior. *Journal of Health and Social Behavior* 26 (3):183-192.

Steinberg, Laurence. 1990. Autonomy, conflict, and harmony in the family. In *At the Threshold: the Developing Adolescent*, edited by S. Shirley Feldman and Glen R. Elliott. Cambridge: Harvard University Press, pp. 255-276.

Stoltzman, Susan Marie. 1986. Menstrual attitudes, beliefs, and symptom experiences of adolescent females, their peers, and their mothers. In *Culture, Society, and Menstruation*, edited by Virginia L. Olesen and Nancy Fugate Woods. Washington: Hemisphere Publishing Corporation, pp. 97-114.

Studer, Marlena, and Arland Thornton. 1987. Adolescent religiosity and contraceptive usage. *Journal of Marrage and the Family* 49 (1):117-128.

Sudana, Hilda, Adijanti Marheni, Made Sartama, and Emiliana Mariyah. 1991. Pengembangan Program Pembinaan Perilaku Reproduksi Sehat Remaja di Bali: Fase Identifikasi Masalah (The Development of Adolescent Reproductive Health Programs in Bali: Identification of the Problems). Denpasar: Universitas Udayana and BKKBN.

Sumapraja, Sudraji. 1992. Tindakan medis tertentu menurut Undang-Undang Kesehatan Nomor 23/1992 (Certain medical procedures according to Health Law Number 23 of 1992). Paper presented to *A Meeting of Directors and Administrators of the Indonesia Comprehensive Reproductive Health Care Clinic (WKBT) Network*, Semarang, 11-13 December.

Swee-Hock, Saw, and Aline K. Wong. 1981. *Youth in Singapore: Sexuality, Courtship and Family Values*. Singapore: Singapore University Press.

Szirom, Tricia. 1988. *Teaching Gender: Sex Education and Sexual Stereotypes*. Sydney: Allen & Unwin.

Tanner, J.M. 1990. *Foetus into Man: Physical Growth from Conception to Maturity*. Cambridge MA: Harvard University Press.

Thornton, Arland, and Donald Camburn. 1987. The influence of the family on premarital sexual attitudes and behavior. *Demography* 24 (3):323-340.

Tobing, Naek L. 1997. *Masalah Seks di Kalangan Remaja (Sex Problems Among Adolescents)*. Jakarta: Pustaka Kartini.

Trost, Jan E. 1990. Social support and pressure and their impact on adolescent sexual behavior. In *Adolescence and Puberty*, edited by John Bancroft & June Machover Reinisch. New York: Oxford University Press, pp. 173-181.

Tumkaya, Nesim. 2000. Reproductive health in Indonesia in light of ICPD: progress and challenges. In *Health Social Science Action and Partnership: Retrospective and Prospective Discourse*, Yogyakarta, Population Studies Center Gadjah Mada University, pp. 337-360.

Udry, J. Richard. 1979. Age at menarche, at first intercourse, and at first pregnancy. *Journal Biosocial Sciencies* 11:433-441.

Udry, J. Richard, Luther M. Talbert, and Naomi M. Morris. 1986. Biosocial foundations for adolescent female sexuality. *Demography* 23 (2): 217-230.

Udry, J. Richard, and John O.G. Billy. 1987. Initiation of coitus in early adolescence. *American Sociological Review* 52 (6):841-855.

Udry, J. Richard. 1988. Biological predispositions and social control in adolesent sexual behavior. *American Sociological Review* 53 (5):709-722.

Udry, J. Richard. 1990. Hormonal and social determinats of adolescent sexual initiation. In *Adolescence and Puberty*, edited by Shirley Feldman and Glen R. Elliot. New York: Oxford University Press, pp. 70-87.

Udry, J. Richard, and Peter S. Bearman. 1998. New methods for new research on adolescent sexual behavior. In *New Perspectives on Adolescent Risk Behavior*, edited by R. Jessor. Cambridge: Cambridge University Press, pp. 241-269.

United Nations (UN). 1989. *Adolescent Reproductive Behaviour: Evidence from Developing Countries*. Vol II. New York.

United Nations (UN). 1993. Adolescent fertility behaviour in Asia and The Pacific. Paper presented to The Fourth Asia and Pacific Population Conference, Denpasar.

United Nations (UN). 1994. International Conference on Population and Development, Program of Action of The Conference. Cairo, 5-13 September.

United Nations (UN). 1988. *Adolescent Reproductive Behavior: An Annotated Bibliography*: Population Division, Department of International Economic and Social affairs, United Nations.

United Nations (UN). 1995. Review and Appraisal of the World Population Plan of Action: 1994 report. New York.

United Nations (UN). 1995. Population and development: program of action. Paper presented to The International Conference on Population and Development, Cairo, 5-13 September 1994. New York.

Utomo, Budi, Sujana Jatiputra, and Arjatmo Tjokronegoro. 1982. Abortion in Indonesia: A Review of the Literature. Jakarta: Faculty of Public Health, University of Indonesia.

Utomo, Budi, Irwanto and Abdul Manaf. 1997. STD/HIV trends and behavior change in Indonesia. Paper presented to Workshop on Evidence of Behavioral Change in the Context of HIV Decline, Bangkok, 19-22 May.

Utomo, Iwu Dwisetyani. 1997. Sexual attitudes and behaviour of middle-class young people in Jakarta, PhD thesis, The Australian National University, Canberra.

Utomo, Iwu Dwisetyani. 2001. Sexuality among young people in Indonesia: conflicting condition between policy, programs and reality on reproductive health issues. Paper presented to The Asia Pacific Conference on Reproductive Health, Metro Manila, 15-19 February.

Van Der Sterren, Anke, Alison Murray, and Terry Hull. 1997. A history of sexually transmitted diseases in the Indonesian archipelago since 1811. In *Sex, Diseases, and Society: a Comparative History of Sexually Transmitted Diseases and HIV/AIDS in Asia and the Pacific*, edited by M. Lewis, S. Bamber and M. Waugh. London: Greenwood Press, pp. 203-230.

Van Gennep, Arnold. 1960. *The Rites of Passage*. Chicago: University of Chicago Press.

Vanlandingham, M.J, S. Suprasert, W. Sittitrai, and C. Vaddhanaphuti. 1995. Two views of risky sexual practices among Northern Thai males: the health belief model and theory of reasoned action. *Journal of Health and Social Behavior* 36 (2):195-212.

Varga, Christine A. 1999. South african young people's sexual dynamics: implications for behavioural responses to HIV/AIDS. In *Resistances to behavioral change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries*, edited by P. C. John C. Caldwell *et al.* Canberra: Australian National University Transition, pp. 13-34.

Vergouwen, J.C. 1964. *The Social Organization and Customary Law of the Toba- Batak of Northern Sumatra*. Translated by Jeune Scott-Kemball. Leiden: The Hague-Martinus Nijhoff.

Voydanoff, Patricia, and Brenda W. Donnelly. 1990. *Adolescent, Sexuality and Pregnancy*. Newbury Park: Sage Publications.

Wagner, Lola, and Danny Irawan Yatim. 1997. *Sesualitas di Pulau Batam: Suatu Studi Antropologi (Sexuality in Batam Island: An Anthropological study)*. Jakarta: Pustaka Sinar Harapan.

Weinstein, Maxine, and Arland Thornton. 1989. Mother-child relations and adolescent sexual attitudes and behavior. *Demography* 26 (4):563-577.

Wessing, Robert. 1978. Cosmology and Social Behavior in a West Javanese Settlement. Athens: Ohio University, Center for International Studies.

World Health Organization (WHO). 1995. Regional protocol for multicentric commissioned research on adolescent reproductive health. New Delhi: World Health Organization, South-East Asia Regional Office.

World Health Organization (WHO). 1995. Adolescent health and development: the key to the future. Geneva: WorldHealth Organization.

World Health Organization (WHO). 1998. *Female Genital Mutilation*. Available at www: http:// www.who.org/dsa/cat98/ fgmbook.htm. (30 August 1999).

Wibowo, Adik, and Anna B La Rocco. 1995. Reproductive health in Indonesia: a strategic planning study of program and research priorities. Jakarta: Population Council.

Widjanarko, Mochamad. 1999. *Seksualitas Remaja (Adolescent Sexuality)*. Yogyakarta: Pusat Penelitan Kependudukan Universitas Gadjah Mada.

Williams, Lenore R. 1983. Beliefs and attitudes of young girls regarding menstruation. In *Menarche: The Transition from Girl to Woman*, edited by S. Golub. Massachusetts: LexingtonBooks, pp. 139-148.

Wilopo, Siswanto Agus, Hananto Sigit, Tati Hatmaji, and Kartono Mohamad. 1999. Country Population Assessment: Republic of Indonesia. Jakarta: UNFPA.

Wilson, Pamela M. 1993. Challenging the status quo in sexuality education. *Family Planning Perspectives* 25 (1):41-42.

Winter, Laraine, and Lynn Cooper Breckenmaker. 1991. Tailoring family planning services to the special needs of adolescents. *Family Planning Perspectives* 23 (1):24-30.

Wood, Nancy Fugate, Gretchen Kramer Dery, and Ada Most. 1983. Recollection of menarche, current menstrual attitudes, and premenstrual symptoms. In *Menarche*, edited by S. Golub. Toronto: Lexington Books, pp. 87-97.

Xenos, Peter. 1990. *Youth, Sexuality and Public Policy in Asia: a Research Perspective.* Honolulu: East-West Population Institute.

Xenos, Peter. 1997. Survey sheds new light on marriage and sexuality in the Philippines. *Asia Pacific Population and Policy* 42:1-4.

Xenos, Peter, and Midea Kabamalan. 1998. The Changing Demographic and Social Profile of Youth in Asia. Hawaii: East-West Center.

Xenos, Peter, Corazon M. Raymundo and Clarinda L. Berja, 1999. Union formation and premarital sex. *In Adolescent Sexuality in the Philippines*, edited by Corazon M. Raymundo, Peter Xenos and Lita J. Domingo. Quezon City: UP Office of the Vice Chancellor for Research and Development, pp. 28-42.

Yayasan Kusuma Buana (YKB) and Kantor Mentri Negara Kependudukan, BKKBN/KLH.YKB. 1993. Hasil Need Assessment Reproduksi Sehat Remaja di 12 kota di Indonesia (Result of Assessment of Adolescents Reproductive Health Needs in 12 cities in Indonesia). Jakarta.

Yusuf, Abang bin Abang Puteh. 1966. *Some Aspects of the Marriage Customs Among the Sarawak Malays with Special Reference to Kuching*. Kuala Lumpur: Dewan Bahasa dan Pustaka.

Zabin, Laurie, John F. Kantner, and Melvin Zelnik. 1981. The risk of adolescent pregnancy in the first months of intercourse. In *Teenage sexuality, pregnancy, and Childbearing*, edited by F. F. Furstenberg, R. Lincoln and J. Menken. Philadelphia: University of Pennsylvania Press, pp. 137-148.

Zabin, L.S, M.B. Hirsch, E.A. Smith, and J.B. Hardy. 1984. Adolescent sexual attitudes and behavior: are they consistent? *Family Planning Perspective* 16 (4):181-185.

Zabin, Laurie Schwab, and Karungari Kiragu. 1998. The health consequences of adolescent sexual and fertility behavior in Sub-Sahara Africa. *Studies in Family Planning* 29 (2):210-232.

Zellman, G.V, and J. D. Goodchild. 1983. Becoming sexual in adolescence. In *Changing Boundaries: Gender Roles and Sexual Behaviour*, edited by E. R. Allgeier and N. B. McCormick. Palo Alto: Mayfield.

Zelnik, Melvin, John F. Kantner, and Kathleen Ford. 1981. *Sex and Pregnancy in Adolescence*. London: Sage Publication.

Appendix

Questionnaire

The Reproductive Health of Indonesian unmarried young people: a case study of Medan, North Sumatra.

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This research is conducted for a PhD degree in the Demography Program, Research School of Social Science, at the Australian National University, Canberra, Australia

All responses are confidential. You do not need to put your name, address, school or place of work in the questionnaire. When all the questions are completed, please put the questionnaire back in the envelope, seal it and hand it to the research assistant or myself. Thank you very much for your participation.
Date:_____

A. Characteristics of respondent

1. Age (month & year of birth):.....

2. How long have you been living in Medan?
   1. Less than six months (please stop)
   2. Six months or more (please continue)

3. Sex 1. Male 2. Female

4. Religion
   1. Moslem
   2. Protestant
   3. Catholic
   4. Hindu
   5. Buddhist
   6. Other.....

5. Ethnicity
   1. Javanese
   2. Sundanese
   3. Toba Batak
   4. Karo Batak
   5. Mandailing Batak
   6. Simalungun Batak
   7. Malay
   8. Nias
   9. Minangkabau
   10. Acehnese
   11. Chinese
   12. Pak-pak/Dairi Batak
   13 Angkola Batak
   14. Other...

6. Highest education completed.
   1. Primary
   2. Junior High School
   3. Senior High School
   4. Academy/University

7. What is your current main activity?
   1. Studying
   2. Vocational course (go to question no.10)
   3. Working (go to question no.9)
   4. Looking for job (go to question no.10)
   5. Unemployed (go to question no. 10)

8. In what level are you studying?
   1. High School level .....
   2. Academy semester.....
   3. University semester.....

   (go to question no. 10)

9. What is your occupation?
   1. Labourer (shop assistant, construction worker, factory worker)
   2. Trader
   3. Public service/Army
   4. Private service
   5. Other.....

10. Living arrangement
   1. With parents
   2. With father
   3. With mother
   4. With sibling
   5. Other relative
   6. Dormitory
   7. Boarding house
   8. Other....

11. Are you involved in an organization other than those in school/university?
    1. Yes 2. No - go to question no. 13

12. If yes please mention the name and type of organization in which you are involved.....

B. Family background

13. What is your father's occupation?
    1. Labourer (Shop assistant, construction worker, factory worker)
    2. Trader
    3. Public servant
    4. Private clerical
    5. Retiree
    6. Not employed
    7. Others.....

14. What is your mother occupation?
    1. Labourer (Shop assistant, construction worker, factory worker)
    2. Trader
    3. Public servant
    4. Private clerical
    5. Retiree
    6. Not employed
    7. Other.....

15. What is your father's highest education?
    1. Some primary
    2. Completed primary school
    3. Completed junior high school
    4. Completed senior high school
    5. Academy graduate
    6. University graduate
    7. Other.....

16. What is your mother's highest education?
    1. Some primary
    2. Completed primary school
    3. Completed junior high school
    4. Completed senior high school
    5. Academy graduate
    6. University graduate
    7. Other.....

17. What is your father's religion
    1. Moslem
    2. Protestant
    3. Catholic
    4. Hindu
    5. Buddhist
    6. Other.....

18. What is your mother's religion
    1. Moslem
    2. Protestant
    3. Catholic
    4. Hindu
    5. Buddhist
    6. Other.....

19. What is your parents' marital status?
    1. Parents living together
    2. Father died
    3. Mother died
    4. Parents died
    5. Parents divorced
    6. Other.....

20. How many siblings do you have?
    a. Age less than 15 years .....persons
    b. Age 15-24 years .....persons
    c. Age over 24 years .....persons

C. Knowledge related to human reproduction

21. Have you heard about **fertile age**?
    1. yes 2. No --- go to question no. 26

22. Can you explain **a woman's fertile age**?
    1. No
    2.Yes, please explain _____
    _____
    _____

23 Have you ever heard of a woman's **fertile period**?
    1. Yes 2. No ------go to question no. 26

24. Could you explain a woman's **fertile period**?
    1. No
    2. Yes, please explain _____
    _____
    _____
    _____

25. Could you identify the fertile period of a woman's menstrual cycle?
    1. No
    2. Yes, please explain _____
    _____
    _____
    _____

26. Do you know about a man's fertile age?
    1. No
    2.Yes, please explain _____
    _____
    _____
    _____

27. How old were you the first time you had
    * menstruation/menarche(only for female)_____years
    * wet dream (only for male) _____years

D. Attitude toward marriage and relationships before marriage

28. In your opinion what is the ideal age of marriage for:
    1. Woman .....year
    2. Man .....year

29. In your opinion what is the ideal age for a woman to have the first baby? ____

30. In your opinion how many children ideally in a family? _____

31. Do you think a woman should preserve her virginity until marriage?
    1. Yes 2. No

32. Do you think a man should preserve his virginity until marriage?
    1. Yes 2. No

33. What is your opinion about premarital sexual intercourse?
    1. Agree if it is based on mutual willingness
    2. Agree if it is in a steady relationship
    3. Agree to obtain an experience
    4. Do not agree
    5. Other_____

34. What factor do you think the most important in choosing a spouse (choose one)?
    1. Virginity
    2. Personality regardless her or his virginity status
    3. Family background including ethnicity and religion.
    4. Other _____

35. What would your reaction be if you found out your future spouse is no longer a virgin?
    1. Break the engagement
    2. No problem, as long as we love each other
    3. Reconsider the engagement
    4. Other

36. What would your reaction be if your best friend is involved in premarital sex relationship with her or his partner?
    1. Advise him or her to stop
    2. No problem, because it is not my business
    3 Keep some distance from her or him
    4. Other _____

37. How do you think the people in your neighbourhood would react to a girl who is pregnant before marrage?
    1. No problem if then married
    2. Do not care
    3. Condemn
    4. Other_____

38. In your opinion how would your family solve teenage premarital pregnancy?
    1. Marry her to the person who impregnated her.
    2. Remain single, the baby will be raised by the family.
    3. Abortion
    4. Other _____

39. In your opinion what is the best solution for teenage premarital pregnancy?
    1. Marriage
    2. Abortion
    3. Unwed mother
    4. Other_____

40. What is your attitude toward abortion?
    1. Do not approve for any reason
    2. Approve if it is needed to save the mother's life
    3. Approve to save family reputation
    4. Other

41. Do you know the place for abortion?
    1. Yes 2. No

42. Have you ever been involved in a steady relationship?
    1. Yes 2. No (go to question no.51)

43. Have you ever been involved in these activities with your steady partner?
    * Kissing on the cheek 1. Yes 2.No
    * Kissing on the lips 1. Yes 2.No
    * Touching for sexual arousal 1. Yes 2.No
    * Sexual intercourse 1. Yes 2.No
    * Other _____

44. Have you watch an X- rated movie (blue film)?
    1. Yes 2. No

45. Have you read X- rated printed material?
    1. Yes 2. No

46. Have you ever have sexual intercourse?
    1. Yes 2. No go to question no 50

47. If yes with whom did you have sex?
    * Steady partner 1. Yes 2. No
    * Casual friend 1. Yes 2. No
    * Prostitute 1. Yes 2. No
    * Sibling 1. Yes 2. No
    * Relative 1. Yes 2. No
    * Housekeeper 1. Yes 2. No
    * Other _____

48. Why were you involved in sexual intercourse?

* Mutual attraction	1. Yes	2. No
* Being raped/forced	1. Yes	2. No
* As a boy/girl friend	1. Yes	2. No
* Curiosity	1. Yes	2. No
* Stimulus from pornography	1. Yes	2. No
* Other _____		

49. How did you feel after the first sexual intercourse?

1. Nothing special
2. Sinful and then stopped
3. Sinful but still continued
4. Other_____

E. Knowledge related to sexually transmitted disease and HIV/AIDS

50. Have you heard about disease mentioned below?

*HIV/AIDS	1. Yes	2. No
*Syphilis	1. Yes	2. No
*Gonorrhoea	1. Yes	2. No
*Vaginal discharge	1. Yes	2. No

51. Do you know the symptoms of the disease mentioned below?

*HIV/AIDS	1. Yes	2. No
*Syphilis	1. Yes	2. No
*Gonorrhoea	1. Yes	2. No
*Vaginal discharge	1. Yes	2. No

52. Have you ever experienced these problems?

* Genital itching	1. Yes	2. No
* Vaginal discharge (just for female)	1. Yes	2. No
* Burning in micturition	1. Yes	2. No
* Smelly discharge	1. Yes	2. No
* Other _____		

F. Knowledge and attitudes about contraception

53. Have you heard about family planning methods mentioned below?

* Pill	1. Yes	2. No
* IUD	1. Yes	2. No
* Injection	1. Yes	2. No
* Condom	1. Yes	2. No
* Norplant	1. Yes	2. No
* Vaginal foam	1. Yes	2. No
* Tissue	1. Yes	2. No

54. What is your main source of information about contraception ? (chose one)

1. Parents
2. Sibling
3. Friends
4. School teacher
5. Religious teacher
6. Printed media
7. Electronic media
8. Health personnel
9. Other _____

55. Do you know how to use these methods?

* Pill	1. Yes	2. No
* Condom	1. Yes	2. No
* Vaginal foam	1. Yes	2. No
* Tissue	1. Yes	2. No

56. Do you know other methods to prevent pregnancy?

* *Jamu* (traditional herbs)	1. Yes	2. No
* Coitus interrupts	1. Yes	2. No
* Calendar system	1. Yes	2. No
* Other _____		

57. Do you think unmarried adolescents can obtain contraception?

1. Yes 2. No 3. Not sure

If yes, which methods? _____
How to obtain them? _____

58. What is your opinion about contraceptive information given to young people?

1. Sufficient (go to question no. 35)
2. Insufficient
3. Unsure

59. What kind of information do you think need to be given more?

* Type of contraception	1. Yes	2. No
* How to use contraception	1. Yes	2. No
* How to obtain contraception	1. Yes	2. No
* Others_____		

G. Source of information regarding reproductive health issues

60. Have you ever received information about reproductive health from health personnel?

1. Yes 2. No

61. Do you think adolescents have been given sufficient information regarding issues mentioned below?

* Puberty	1. Yes	2. No
* Human reproduction	1. Yes	2. No
* Contraception	1. Yes	2. No
* Abortion	1. Yes	2. No
* STDs	1. Yes	2. No
* HIV/AIDS	1. Yes	2. No

62. Whom would you suggest as the most effective individual or institution to give reproductive health education to adolescents (choose one).

1. Parents
2. School teachers
3. Religious leaders
4. Media
5. Peers
6. Health personnel
7. Other _____