POLICY ENVIRONMENT FOR ADOLESCENT HEALTH IN INDONESIA

The world's largest archipelago, Indonesia has over 46 million adolescent population in the country accounting for 17% of total population. The country has a rich variety of cultures with over 1,300 ethnic groups living across approximately 17,000 islands.

Risks to adolescents health

The common risk factors found among adolescents are -

Substance abuse and Smoking

- Smoking is highly prevalent – 9.1% of adolescent males are smokers and 17.32% of adolescents tried smoking for the first time at an age of less than 13 years. More than 10% of adolescents in high school drink alcohol despite the very restrictive laws on alcohol consumption and 2.7% of adolescents use drugs.

Nutritional Status and Physical Activity

- Indonesia has a double burden of malnutrition including for the adolescent population: 6.8% of adolescents of the age of 13–15 years are malnourished, 11.2% are overweight and 4.8% are obese. For the older age group (16–18 years) the numbers are quite similar.
- The prevalence of anaemia is 26.4%.
- About 64.4% and 49.6% of adolescents aged 10–14 and 15–19 years respectively are lacking adequate physical activity.

Sexual and Reproductive Health

- 16.4% of female adolescents aged 15–19 years have had an unwanted pregnancy.

Violence

- 32.74% of high-school students reported physical assault in the last 12 months - 42.25% males and 23.67% of females.

Mental Health

- 5.14% of adolescents in high school ever had suicide ideation in the past 12 months; 5.54% ever planned to commit suicide, and 3.86% ever tried to commit suicide.

National Policies and Programs

AFHS has been implemented in Indonesia since 2003 and national AFHS standards were developed in 2010 with support from WHO Headquarters. Guidelines to implement the national AFHS standards were developed in 2013, using limited monitoring tools and ensuring that the AFHS practice quality improvement cycle was consistent every six months.

- Five standards of AFHS included: human resources, health facility, adolescent participation, networking and health management.

In 2003, the Ministry of Health (MOH) launched an adolescent-friendly health programme called Pelayanan Kesehatan Peduli Remaja (PKPR) loosely translated as Youth Care Health Service that drew on a model devised by the World Health Organization (WHO). The intention was for the PKPR programme to be integrated into the government-run community health centres Pusat Kesehatan Masyarakat (PUSKESMAS), as there is at least one in every sub-district.

- It encourage providers, especially Puskesmas (to be able to provide comprehensive health services, according to and meet the needs of adolescents who want privacy, to be recognized, valued and involved in planning, implementation and evaluation of activities.
- A referral system was also implemented in AH care through a tiered referral process. Hospitals were provided for secondary and tertiary level of friendly health services for adolescents.

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Access to Health Benefits/Information

PKPR Interventions include:

- Adolescent reproductive health services (covering sexually transmitted infections, STIs, HIV AIDS) including sexuality and puberty Prevention and control of adolescent pregnancy.
- Nutrition services (anemia, deficiency and excess nutrition) including counseling and education Adolescent growth and development Screening for TT status in adolescents .
- Adolescent mental health services, including: psychosocial problems, mental disorders, and quality of life Drug prevention and control.
- Detection and treatment of violence against adolescents.

Role of Social Media

A paper exloring Role of Multi-Stakeholder in Adolescent Health Program in Indonesia talks about use of media.

- Smartphone application as education media for adolescent reproductive health effectively increased the connection of adolescents with parents and health workers, improved screening of sexual transmition infection diseases, was more attractive and innovative, took into privacy, was accurate information, wider reach, easy access, affordable costs, interactive, practical, and appropriate to the needs of today's adolescent.
- Other research also stated that there was a relationship between the role of information media and the role of peers with the prevention of risk behavior in students.

School Based Approaches

Health services for school children and adolescents are carried out through **School Health Program (Usaha Kesehatan Sekolah or UKS)** - cross-sector activity, which includes various efforts such as health screening and periodic examinations, supplementation of iron tablets to female adolescents, fostering healthful school canteens, immunization, and fostering school health cadres.

Health Educator for Youth program is a form of peer education program implemented to prevent risky behavior of adolescent with edutainment methods that were preferred by adolescents and involved roles among stakeholders. For example, the campus use access and peer support can reduce a negative experience in young adults.

It is an **ongoing form of the Rumah Remaja (Home of Adolescents) community that was modified to bridge the roles of stakeholders related to adolescent health efforts**. Rumah Remaja was a form of stakeholder collaboration in providing adolescent training in reproductive health with peer education methods, stakeholders involved include Primary Health Care, Higher Education Institutions, and NGOs

Implementational capacity

Challenges faced in implementation phase

- More than 60 of households in Indonesia think that it is challenging to access primary health care such as the puskesmas service. In 2012 more than half of all adolescents (50.7%) aged 15– 19 years faced at least one barrier in accessing health care such as the need to obtain permission to go for health care (9.5%), not wanting to go alone (46.8%), problem with distances (14.5%) or not having the money to go for health care (19.5%).

- There are no guidelines for planning and financing the development of adolescent friendly health services (AFHS) at the district level, incomplete implementation of school health programmes (SHP), and no data and indicators related to school health programmes for preconception care and adolescent mental health.

- Equitable access of adolescents and unmarried girls to reproductive health and family planning information services is hampered by the misinterpretation of some regulations and decrees restricting access to contraceptive services in public facilities, although some are available from the private sector. A ministerial decree authorizes a minimal form of female genital mutilation to be performed only by doctors, nurses or midwives but this practice is sometimes extended.

- Peer Programs - stakeholder support for peer education programs was still limited to informative and instrumental support. There was a lack of emotional support, social networking support, and reward support by stakeholders.

- Adolescent health problems, especially sexual health, through peer education need stakeholder engagement from school, parents, and community, but adolescents prefer less involvement from parents and teachers because of their confidentiality concerns.

- Most of the funding comes from central government and thus, programs doesn't have to depends on external financing. Even still there exists budgeting issues because of decentralized functioning of government.

Issues in implementation of 2003 Program

- Even more than 15 years since the programme was launched, only around 50% of Puskesmas have integrated PKPR services.

- The number of adolescents who have used the services also remains low.

- A key challenge for some young patients in using the Puskesmas is the geographical distance to clinics, which requires that they pay transportation fares.

- In addition, despite guidelines on ensuring accessibility of services, young people face barriers such as inconsistent and inconvenient operating hours in different clinics.

- Other challenges include the irregular rotation of trained PKPR staff and the recruitment of untrained staff which results in most PKPR personnel having insufficient skills to provide adolescent-friendly health services.

- Among those adolescents who are able to access PKPR services, many report experiencing verbal abuse, judgement and stigma due to gender bias, a lack of respect for adolescents and beliefs that youth are unable to make their own decisions about their health issues.

- Most personnel were found to be influenced by religious norms and personal values that can result in discrimination against youth. This is particularly true for girls who are trying to access services relating to issues such as unwanted pregnancies.

Other partnerships and programs

Routine coordination among UN agencies is carried out through the UN Country Team (UNCT) consisting of the heads of all the UN agencies under the leadership of the Resident Coordinator.

- For technical issues, WHO's closest partners are UNICEF, UNFPA and UNAIDS. UNICEF has been working with a number of issues especially those related to the MDGs. They have worked jointly with WHO on maternal health, child health including the integrated management of childhood illnesses (IMCI), nutrition and expanded programme of immunizations (EPI).

- WHO and UNFPA have worked together on maternal and reproductive health, HIV/AIDS and adolescent health. They rely on WHO to provide special support for quality of reproductive health services and financial protection to ensure access to obstetrical services"

GEAS

Global Early Adolescent Study is a collaboration lead by Johns Hopkins (JHU) Bloomberg School of Public Health in collaboration with the World Health Organization (WHO) and various research institutions in 10 countries.
One of its area is to measure the impact of the SETARA curriculum.

- SETARA is a CSE curriculum for junior high school students (12-14 year-olds) in Indonesia. It aims to equip students with a comprehensive understanding of sexuality, reproductive health, as well as preparing young people to become peer educators.

- It consists of two sets of guidelines, one for the teachers and another for students.

- It is taught in two stages, in the 7th and 8th grade covering 15 topics in each stage i.e. self identity, emotional and physical changes during puberty, healthy and responsible relationships, gender, individual human rights, sexuality and love, pregnancy, sexually transmitted infections, HIV/AIDS, substance abuse, healthy and non-violent romantic/dating relationship, planning for the future, and peer education.

Multi-sectoral approach

The government has been doing the best in overcoming problems with mental health and drug abuse among adolescents.

- One of the methods is having at minimum 30% of senior high schools and equivalent in each province conduct prevention and control efforts on mental health and drug abuse problems.

- To perform this, the school is required to have school counselors who are trained in mental health, to have available media for communication, information, and education related to mental health and drug abuse problems, and to have the capability to conduct counseling and early detection of students who experience mental health and drug abuse problems.

- As of 2019, all provinces in Indonesia had successfully met the 30% target with a total of 10,317 schools.

Nutrition International's adolescent nutrition program in Indonesia

- It is the result of a collaboration between Indonesia's Ministry of Health and Nutrition International, through its Indonesia country office, who worked with the Ministries of Education and Religious Affairs to design and implement a school-based project to offer weekly iron and folic acid supplementation to adolescent girls and nutrition education and counselling for both adolescent boys and girls.

- The program was developed to address high levels of anaemia and low access to preventative nutrition and health services among adolescent girls in Indonesia. pregnancies.

Sources/Links

http://apps.who.int/iris/bitstream/handle/10665/250550/ccs_idn_2014_2019_en.pdf?sequence=1&isAllowed=y

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