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# **Adolescent-friendly health services in Jakarta and Makassar**

**A gender and cultural analysis**

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# Key messages

- In 2003 Indonesia's Ministry of Health (MOH) established the youth-friendly health services programme Pelayanan Kesehatan Peduli Remaja (PKPR) to operate at government-run community health clinics (Pusat Kesehatan Masyarakat, PUSKESMAS) at the sub-district level. However, 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.
- This qualitative research used a 'mystery patient' approach, in-depth interviews and focus group discussions to assess the behaviours and beliefs of providers of youth-friendly health services. Only some providers were rated as acceptable by youth.
- 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. These attitudes are held not only by many health providers but also by support staff.
- 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.
- The Ministry of Health should develop a standard training module and more detailed guidelines that cover gender-sensitive services. Gender experts from non-governmental organisations (NGOs) and other organisations should also provide trainings to ensure that staff treat adolescents in a respectful, fair and friendly manner, and that staff do not pass judgement based on their own cultural or religious beliefs.
- PUSKESMAS should strive to implement the minimum requirements set out in PKPR guidelines to at least ensure that consultation rooms are available, that the capacity and skills of personnel fit with national standards, and that clinic hours fit with the common schedules of adolescents around schooling.
- Crucially, adolescents should be involved in the planning, monitoring and evaluation of the PKPR programme to ensure better service provision by PUSKESMAS as well as better service uptake by youth.

# Introduction

Of 267 million people, 16% of Indonesia's population are adolescents aged 10–19 years old (Badan Pusat Statistik, 2013). The country has a rich variety of cultures with over 1,300 ethnic groups living across approximately 17,000 islands. The national motto is *Bhinneka Tunggal Ika* ('Unity in diversity'), and yet most of the cultures share patriarchal beliefs which often value women beneath men, and adolescents and children beneath adults (Badan Pusat Statistik, 2015).

Young people's sexual and reproductive health and rights (SRHR) warrant attention in Indonesia. The latest data show a maternal mortality rate of 305 per 100,000 live births, while the age-specific fertility rate of adolescents is 40.1 per 1,000 women. Both are the highest figures among member countries of the Association of Southeast Asian Nations (ASEAN) (Kementerian Kesehatan RI, 2015). There is no recent data on unsafe abortions as abortion is illegal in Indonesia and women who undergo abortions are criminalised. The latest year for which data is available is 2008, during which an estimated 2.5 million abortions were carried out – most were unsafe since the law forbids the practice (Utomo, 2013).

Added to this, Indonesia's 1992 Law on Population Development and Family Improvement<sup>1</sup> prohibits access to contraceptives for unmarried people regardless of their age. Although unmarried sexually active people can still access condoms in convenience stores, there is a stigma attached to this as condoms are considered a tool for infidelity. Young people in particular are stigmatised by adults when purchasing contraceptives.

And yet Indonesia recognises that adolescents are distinct from people of other age groups, and that they are at a transition phase from childhood to adulthood with unique characteristics. Moreover, it is recognised that adolescent health and development may affect an individual's health in later life during their adult years.

In 2003, the Ministry of Health (MOH) launched an adolescent-friendly health programme called *Pelayanan Kesehatan Peduli Remaja* (PKPR) that drew on a model devised by the World Health Organization (WHO) (World Health Organization, 2002) (see Box 1 also). 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.

## Box 1: WHO indicators of adolescent-friendly health services (AFHS)

**Accessible:** Adolescents can obtain the health services that are available.

**Acceptable:** Adolescents are willing to obtain the health services that are available.

**Equitable:** All adolescents, not just selected groups, can obtain the health services that are available.

**Appropriate:** The right health services (i.e. the ones they need) are provided to adolescents.

**Effective:** The right health services are provided in the right way and make a positive contribution to adolescents' health.

*Source: World Health Organization, 2002*

<sup>1</sup> See <https://cyber.harvard.edu/population/policies/INDONES.html>



# Research objective and methodology

The aim of this research was to gain a better understanding of the quality of PKPR in PUSKESMAS, particularly in terms of providing SRHR services to unmarried adolescents. The specific objectives were:

- a. to gain insights on the quality of daily services available to adolescents in PUSKESMAS
- b. to better understand gender and cultural values that affect service provision for adolescents
- c. to capture the opinions and perceptions of health department and PUSKESMAS staff regarding the PKPR programme.

The qualitative research was conducted in Jakarta and Makassar from August to December 2018. Jakarta has the highest gender equality index score among Indonesian cities while Makassar ranks among the bottom five. Six out of 326 PUSKESMAS were selected for the research in Jakarta (three PKPR PUSKESMAS and three non-PKPR PUSKESMAS) and four of 43 PUSKESMAS were selected in Makassar (two PKPR PUSKESMAS and two non-PKPR PUSKESMAS).

The following data-collection approaches were used:

1. *Desk review.* A desk review was conducted to explore the policies and regulation related to PKPR in Indonesia.
2. *Mystery patient approach.* This approach was performed by four well-trained youth in Jakarta and in Makassar who look like adolescents and acted as patients facing common SRHR issues. The roles included: a) a virgin girl who had recently experienced oral sex for the first time, b) a sexually active girl wanting to use an intrauterine device (IUD), c) a boy who was worried because he had had sex for the first time and d) a boy who felt confused because he was sexually attracted to both sexes. The approach followed a code of ethics applicable in research, including risk and mitigation (Boyce and Neale, 2006).
3. *Focus group discussions (FGDs).* FGDs were held with young people who had used PKPR services in the past two years. Two FGDs were held in each city. In Jakarta, one FGD was attended by seven young women while the second group was attended by eight young men. In Makassar, one FGD was attended by nine young women while twelve young men attended the second group.
4. *In-depth interview (IDI).* Interviews were held with two groups of respondents. The first group included young people who had used PKPR services in the past two years. To achieve gender balance, these young people (six in Jakarta and four in Makassar) were randomly selected from the FGD participants. The second group included relevant staff from the MOH, the Provincial/District Health Office (PHO/DOH) and PUSKESMAS. These government staff were interviewed to understand their perceptions of PKPR services.

## Challenges

There were some obstacles when conducting the research. First, Jakarta and Makassar have different bureaucratic processes, which meant that the research permit was obtained earlier in Makassar and that the data-collection process was delayed in Jakarta. A further challenge was the scheduling of the IDIs with government staff in Jakarta, which took considerable time. The situation became further complicated as two sizeable earthquakes hit Nusa Tenggara Barat (NTB) and Palu provinces during the time of the research. Consequently, all decision-makers and programme leaders in the MOH were occupied with the emergency health response.

## The PKPR policy context and implementation guidelines

The MOH launched the PKPR programme in 2003 but the implementation guidelines for PUSKESMAS were not released until 2005 (called *Pedoman Pelayanan Kesehatan Peduli Remaja di Puskesmas* or ‘Guideline on adolescent friendly health services in Puskesmas’) (Kementerian Kesehatan RI, 2005). The umbrella law for the PKPR is the Law on Health (No. 23 of

1992),<sup>2</sup> which later became the Law on Health (No. 36 of 2009)<sup>3</sup> and specifically mentions the importance of having a health programme targeted at adolescents.

The PKPR guidelines remained unchanged from 2005 until 2017 when the MOH developed guidelines on the integrated management of PKPR (called *Manajemen Terpadu Pelayanan Kesehatan Peduli Remaja (MTPKPR)* or 'Integrated management of adolescent friendly health services') (Kementerian Kesehatan RI, 2017). However, these guidelines have been piloted in several provinces only and have not been distributed nationally. In Jakarta, the PHO stated that all PUSKESMAS received the document, while in South Sulawesi province the PHO only allocated one copy to each district/city. In Makassar, the guidelines were stored in the DHO but none of the PUSKESMAS were aware of it.

Despite the Law on Health of 2009, it was only in 2013 when Jakarta launched the Governor's Regulation Number 31/2013 on Adolescents' Reproductive Health<sup>4</sup> that efforts were made to ensure all PUSKESMAS in the area were implementing the PKPR programme and the programme was socialised to the community. And later, in 2018, Jakarta's Governor's Regulation Number 8/2018 on Adolescent Health Care<sup>5</sup> stipulated that adolescents should have easy access to all types of health services in Jakarta such as PUSKESMAS and government hospitals. This means a gap of eight years between the launch of the PKPR guidelines in 2005 and issuance of the Jakarta Governor Regulation in 2013. In Makassar, the capital city of South Sulawesi, there is still no regulation to ensure that the national PKPR guidelines are adjusted to the local context. Taken together, the situations in Jakarta and Makassar suggest that adolescent health services have not been a priority in these two cities to date.

In 2018, the target in Jakarta was to integrate the PKPR programme in all PUSKESMAS (sub-district and satellite PUSKESMAS). However, a key informant from Jakarta's PHO stated that, in reality, only 174 of 326 (50%) PUSKESMAS have achieved this. The key informant from Makassar DHO said that only 8 of the 48 PUSKESMAS in the city have achieved it.

To encourage all PUSKESMAS in Jakarta to implement the PKPR programme, the PHO organised technical assistance (TA) activities assisted by the DHO. However, the effectiveness of the training is unclear as the TA was not implemented consistently.

In Makassar, the DHO recently held a meeting to re-motivate the PUSKESMAS to integrate the PKPR programme. Not all PUSKESMAS were invited to this meeting, however, although many that were not invited were sent the 2014 National PKPR Standards (SN-PKPR) book (Kementerian Kesehatan RI, 2014). PUSKESMAS that did not receive the book had to make copies of it themselves.

*'The information on PKPR is not evenly distributed. The modules have not yet been implemented properly and thoroughly.'*  
Staff member of Makassar DHO

From the PUSKESMAS' perspective, many health centres perceived various obstacles to implementing the PKPR programme and were therefore unwilling to do it. Some facilities have been named PKPR PUSKESMAS, but in reality implementation has not met the requirements. This is partly the result of unpredictable staff rotation between PUSKESMAS and PHO/DHO, which can mean that trained PKPR staff move to different divisions and therefore services are delivered inconsistently. PUSKESMAS have also been reluctant to adopt the programme due to a lack of internal capacity for knowledge transfer and implementation.

*'There is not enough staff to implement PKPR, thus staff need to cover each other, and this will lower the quality of the service delivered.'*  
Staff member from a certified PKPR PUSKESMAS

According to one respondent, implementation of the PKPR programme is further hindered because there is no specific regulation below the Law on Health. While the MOH has drafted the PERMENKES (Minister Regulation) that includes specific clauses on implementation of the PKPR programme, one staff member from the PHO in Jakarta said that the PERMENKES has remained in draft form since 2015 and it remains unknown when it will be ratified.

<sup>2</sup> See <http://www.flevin.com/id/lgs0/translations/JICA%20Mirror/english/6.23.1992.eng.qc.html>

<sup>3</sup> <http://extwprlegs1.fao.org/docs/pdf/ins160173.pdf>

<sup>4</sup> See: [https://jdih.jakarta.go.id/uploads/default/produk hukum/PERGUB\\_NO\\_31\\_TAHUN\\_2013.pdf](https://jdih.jakarta.go.id/uploads/default/produk hukum/PERGUB_NO_31_TAHUN_2013.pdf)

<sup>5</sup> See: [https://jdih.jakarta.go.id/uploads/default/produk hukum/No\\_8\\_Tahun\\_2018.pdf](https://jdih.jakarta.go.id/uploads/default/produk hukum/No_8_Tahun_2018.pdf)

*‘How can we carry out this program when there is no legal umbrella to legalize it? Until now the Ministry of Health Regulation on PKPR programme implementation is still in draft form.’*

Staff member at Jakarta District Health Office

## Accessibility of services

Based on the FGDs and IDIs with youth, access to PKPR services remains inconsistent. Many adolescents are not aware of the availability of services, while others know about them but have to travel a long distance to reach a PUSKESMAS that offers the PKPR programme.<sup>6</sup> For those adolescents who are able to access PKPR services, many still face challenges in using them or are reluctant to seek support. PUSKESMAS’ reputation for being unfriendly to adolescents and youth – especially to girls – remains a barrier despite efforts by particular PUSKESMAS to claim the contrary.

This research also found that the PKPR guidelines are not applied uniformly in terms of eligibility for the PKPR services. When adolescents arrive at the PUSKESMAS, the administration process is done differently in different centres. Several PUSKESMAS have banned adolescents aged over 18 years from accessing services, even though the 2014 SN-PKPR raised the age limit to 19 years old. This has become a serious problem since many high school students are below 20 years old and still want to access the PKPR, but instead are referred to services for adults.

*‘...they [registration staff] argued if I am allowed to access PKPR because I’m 19’*

Mystery patient, Jakarta

Another challenge relates to the operating hours of PKPR PUSKESMAS. In Jakarta, the PUSKESMAS have to operate between 08.00 until around 16.00, Monday to Friday. However, the research found a PKPR PUSKESMAS in Jakarta that closed by 14.00. In Makassar, PUSKESMAS generally operate from 08.00 to 14.00, Monday to Saturday. Interestingly, PUSKESMAS in Makassar are willing to serve adolescents who visit the facilities after the standard operating hours, although the adolescents have to use the general polyclinic. The operating hours in neither city are practical for adolescents, however, as most have to be in school until 15.00 or 15.30.

## Acceptable standards within PUSKESMAS

As stated in the PKPR guidelines, services should be provided that maintain patient confidentiality and by personnel who are non-judgemental. PUSKESMAS should ensure that there are short waiting times (with or without an appointment); a clean environment; adequate availability of information, education and communication (IEC) materials for adolescents; and involvement of adolescents in designing and delivering PKPR services.

In Jakarta, the physical difference between PKPR and non-PKPR PUSKESMAS is clear. The former have a designated room for PKPR services, while the non-PKPR PUSKESMAS do not allocate a room for this purpose.

Image 1. Puskesmas Waiting Area



<sup>6</sup> Current data from the Ministry of Health 2017 shows of 9,825 PUSKESMAS in Indonesia only 4,154 offer the PKPR programme (Kementerian Kesehatan RI, 2017).

Both PKPR and non-PKPR PUSKESMAS require youth patients to register at the same registration table/counter as other patients, and to either bring their identity card or provide their personal information, including their contact details. It is common for youth to be asked in public spaces within the PUSKESMAS about their specific issues in relation to SRHR. This lack of privacy can cause adolescents, especially girls, to refrain from accessing health services.

Not all PKPR-PUSKESMAS in Jakarta have a dedicated consultation room for seeing PKPR patients. Some service providers provide counselling in the same room with other specialists. In Makassar, all PKPR PUSKESMAS have a specific consultation room but some are not ideal as the room is only separated by a curtain or thin wall and the consultation can be overheard easily. The inadequate facilities for PKPR service provision is a result of limited funds and insufficient space available within PUSKESMAS.

Unfortunately, in all of the PUSKESMAS within the research sample there was no designated waiting room for adolescent patients, as required in the PKPR guidelines. As a result, the mystery patients reported feeling uncomfortable waiting in a crowded area and being questioned by adult patients. The PKPR guidelines state clearly that PKPR PUSKESMAS should have separate waiting lines and rooms for adolescents.

The mystery patients also reported feeling uncomfortable in the consultation rooms due to a lack of privacy, regardless of whether there were dedicated spaces for PKPR patients or not. They expressed that a private consultation room was essential due to the confidential nature of the SRHR issues being discussed.

*‘Inside the consultation room, I saw three tables for doctors located close to each other. After that, I met the doctor and asked if it was okay if I consult here. The doctor said it was okay because there were only doctors in the room. Then the doctor started to close the curtains. I began to share my problem. I told the doctor that I haven’t got my period this month.’*

Mystery Patient C accessing a non-PKPR PUSKESMAS in Makassar

Based on reports from the IDIs with PHO and DHO staff, the availability of a consultation room relates to levels of PKPR PUSKESMAS compliance. In the plenary-level PUSKESMAS<sup>7</sup> (fulfilment >80%), a consultation room is a must. However, if PUSKESMAS compliance is between the minimum (<60%) and maximum (60%–79.9%), a consultation room will not necessarily be available.

*‘The consultation room is rather wide, so there are three tables in one room, and fortunately I was there when the rest time, there was only one doctor and one nurse in the room, but the nurse peered during my consultation. It’s annoying.’*

Mystery Patient accessing a non-PKPR PUSKESMAS in Makassar

Both in Jakarta and Makassar only a few educational materials were displayed in the waiting rooms, such as posters on mother and child health, infectious diseases, the danger of smoking, and on adolescent mental health. Only a few PUSKESMAS display posters about family planning (and these are targeted at adults and families), and fewer still display posters about sexually transmitted diseases (STDs). In two PKPR PUSKESMAS only very limited PKPR-related materials were seen in the waiting rooms. Only one PKPR PUSKESMAS in Jakarta stated that they distributed reproductive health-related posters to schools, however this was only during socialisation activities. Based on the interviews with PHO staff in Jakarta, the lack of educational materials is due to the limited budget of each PUSKESMAS. Moreover, the availability of the educational materials is highly dependent on the policy and the decision made by the head of a PUSKESMAS.

*‘We get the EIC materials from the Ministry of Health. If we want more of it, each PUSKESMAS should make their own EIC using their budget.’*

Staff member from PUSKESMAS B, Jakarta

<sup>7</sup> PUSKESMAS accreditation by the Health Office classifies facilities across four levels.

# The expertise and attitudes of service providers

Every time a mystery patient entered a PUSKESMAS in Jakarta, a security guard would approach them and ask what brought them to the clinic – which can be intrusive. The security guard then assisted the mystery patient to obtain a registration number. In Makassar, most of the PUSKESMAS registration staff lacked knowledge or were unaware of the PKPR programme. This resulted in different referrals for mystery patients who visited the same PUSKESMAS. In non-PKPR PUSKESMAS, mystery patients were referred to specialists based on their medical condition. However, the assignment of a specialist depended on the registration staff's understanding of the patient's medical condition. Most mystery patients were referred to the General Polyclinic and received the same treatments as adult patients. There was only one mystery patient who received different treatment: this individual (who was playing the role of a virgin who had performed oral sex) was referred to an HIV specialist for voluntary counselling and testing (VCT), but her consent was not actively sought, based on a full explanation of the risks and of the process.

*'I don't understand why the doctor told me that I need VCT test to ensure if I was HIV free. The doctor did not even bother to explain to me first about the process of HIV infection. When I asked about it, then the doctor explained it to me while leading me to the blood sample test room.'*

Mystery Patient C accessing a PKPR PUSKESMAS in Jakarta

In Jakarta, not all of the PKPR health providers who participated in the research had the relevant certification card to show they had passed the PKPR training. The situation is worse in Makassar as none of the participating staff had received any PKPR-related training. According to Makassar's PUSKESMAS staff, there is no special certification for implementing the PKPR programme. The staff reported only having attended one brief meeting to introduce the PKPR programme and receiving the SN-PKPR (2014) guidebook.

The lack of trained staff creates an unfavourable environment for PKPR patients. Some staff and doctors give biased and subjective information, which is often mixed with their cultural and religious values. Young women who had experienced SRHR issues spoke about very judgemental comments and attitudes from the doctor, who seemed unaware of the girls' specific needs and how to communicate with them. One mystery patient reported that she wanted to cancel her visit to the PUSKESMAS because of the judgemental attitudes of service providers. Another mystery patient reported that a doctor had provided subjective information that was full of religious beliefs. A doctor commented, for example, that being anything other than heterosexual is a sin that makes God mad and creates earthquake or tsunami to remind the people living in the areas. The mystery patient thought that a doctor should have given only objective insights related to the services available. Likewise, a mystery patient in Makassar also received subjective recommendations and was told to get closer to God. The doctor did not give any information related to reproductive health. Similar experiences were reported in Jakarta.

*'Are you sure that you are only afraid for your health? Aren't you afraid of Allah because of your sin? Don't think only about yourself, many earthquakes and disasters because of many sinners now.'*

Doctor in PUSKESMAS C, Jakarta

A mystery patient in Jakarta reported that she felt offended by the comments of a female doctor, and that the doctor negatively judged her because she was sexually active. The doctor even gave inaccurate information by telling the patient that she could become pregnant through oral sex, and gave unwelcome advice 'to get closer to God' instead of providing further information on safe sex.

Among the FGDs, three out of eight female participants reported that they felt uncomfortable when examined by male doctors. One female patient in Jakarta stated that she felt uncomfortable speaking to a male doctor about vaginal discharge, especially when she was asked about the symptoms she experienced. When asked further in the FGDs, it transpired that such feelings of unease among patients resulted from health providers lacking the communication skills to handle gender-sensitive issues rather than from a gender difference between the doctor and the patient.



Image 2. FGD with female participants



According to some mystery patients, a common response from service providers to adolescents seeking information on their SRHR issues is to be encouraged to speak to a psychologist instead of a doctor. As stated by a key informant from Jakarta's PHO, the doctors seem to lack confidence to conduct the counselling themselves, probably because they rarely meet young patients with SRHR issues. Added to this, doctors only receive a single session of counselling training.

*'From your story, I think there's nothing wrong with you clinically. I think it would be better if you talk more to Mrs Di\*\*\*, there is a psychologist next to our room. Do you want to meet her? If you do, let us go to the next room. If you don't want to, it's fine.'*

Doctor at PUSKESMAS in Jakarta

## Planning, monitoring, evaluation and learning

According to the SN-PKPR standards from 2014, a planning, monitoring, evaluation and learning (PMEL) meeting should be held annually at a PKPR PUSKESMAS. The SN-PKPR even provides a tool to evaluate PKPR programmes not only for the PHO and DHO, but also for the PUSKESMAS. In reality, however, few PUSKESMAS have organised the required meetings due to other priorities, and the research suggests that no adolescents have been involved in the PMEL process to date in the sample areas.

Jakarta's PHO and DHOs perform regular evaluations using the SN-PKPR tools. The components that are evaluated include the attitudes of staff, the facilities available to PKPR patients, and the relevant information provided to young people through IEC materials, networks and the referral system.

In Makassar, the PKPR programme was launched through relevant networks and adolescent reproductive health counselling services. The DHO has submitted regular monitoring reports of PKPR services at PUSKESMAS to the MOH, and in 2019 will conduct resocialisation activities on PKPR's essential components amongst all PUSKESMAS. Unlike in Jakarta, each PUSKESMAS in the sub-district is required to assist some schools with SRHR education, with a target of reaching at least

10% of adolescents at the assisted schools. As part of these efforts, PUSKESMAS in Makassar have been asked to organise socialisation activities on reproductive health with at least six schools per year.

The SN-PKPR 2014 states the importance of coordination and collaboration among the MOH, PHO, DHO and PUSKESMAS, together with NGOs and youth organisations to promote, support and monitor the PKPR programme. Unfortunately, in reality, this coordination and collaboration falls short of the expected standards. Currently many PUSKESMAS in both cities fail to collaborate with NGOs and other independent institutions in their coverage areas.

Those PUSKESMAS that have collaborated with NGOs have used the organisations to help them reach more youth and to promote the reproductive health services available. This cooperation has focused more on building the capacity of reproductive health services among staff, however, without direct involvement from adolescents. Adolescents were only enlisted to complete questionnaires as required by the SN-PKPR. NGOs have also provided training and technical assistance on SRHR issues.

*‘As for monitoring process from the youth, we use instruments from SN-PKPR (2014). And then, we usually involve students (to fill in the questionnaires) from PKPR assisted schools.’*

Staff member at Jakarta District Health Office

## The way forward to improve PKPR service provision

The mystery patients who participated in the research perceived that PKPR services are still not sufficiently adolescent-friendly: contraceptives are not provided for girls, there are insufficient IEC materials to raise awareness of available services and to educate adolescents and adults about the importance of SRHR services, and the operating hours of PKPR PUSKESMAS facilities are inconvenient for adolescents who attend school. Some of the health providers were not prepared to assist adolescents with SRHR issues, instead judging or preaching to patients due to their own cultural or religious beliefs. The unplanned rotation of trained PKPR health providers to other divisions within the PHO/DHO or to other PUSKESMAS poses another serious challenge and means that the few trained PKPR staff may be unavailable to consult with adolescents seeking SRHR care. Often, replacement staff lack the soft skills needed to work effectively in the PKPR programme.

Due to underlying social norms and customs, some adolescents reported that they felt uncomfortable when assisted by a health provider of the opposite sex. Therefore, ideally, the PUSKESMAS should have female and male health providers available for consultations at the same time. Irrespective of gender, however, PKPR service providers must possess the right skills and capacity to show gender-sensitivity towards patients seeking SRHR care.

Support staff – including clinic security guards – play a significant role as PKPR gatekeepers. Therefore mandatory training should also be provided to these individuals so they treat adolescents with friendliness and respect.

According to the PKPR guidelines, sessions on gender are obligatory within health provider trainings, however there is no further explanation on what this means in practice and whether it also includes gender-sensitive service provision. Nevertheless, during interviews, all PKPR staff said that trainings delivered by the DHO or NGOs always contain a gender aspect. Such trainings should incorporate greater sensitisation of gender concepts, in addition to supporting service providers to be respectful of a patient’s gender and aware of their own cultural gender values that might affect their approach to patients.

The research suggests that the lack of distinction between the service needs of young men and women contributes to gender-based discrimination. For example, young women who are faced with an unwanted pregnancy require information about their options as unmarried young women in a patriarchal environment. Presently, such needs are not accommodated by service providers who generally react with discrimination and judgement towards young girls. On the other hand, health providers seem less judgemental towards male patients – one mystery patient was even reassured by a doctor that he need not worry too much and that unprotected sex is not that uncommon among unmarried young men.

To tackle this, the MOH should develop a standard training module that covers gender-sensitive services, among other elements. Furthermore, gender experts from NGOs and other organisations should be brought in to provide trainings to all PUSKESMAS staff to: a) ensure all staff are able to treat every young person in a respectful, fair and friendly manner regardless of their backgrounds; b) raise awareness of negative norms and attitudes that can influence their work, especially concerning gender or age discrimination and its impact on young patients; and c) focus on how to help young patients to solve their health issues and to refrain from passing judgement. Unfortunately, a standard training module on these matters does not exist. Currently, every PHO/DHO has their own interpretation of the trainings needed for PKPR staff, therefore standardised, more detailed guidelines are needed. PUSKESMAS should then be socialised on the updated, standardised guidelines to ensure consistent service provision.

With regards to the rotation of trained PKPR staff, the rotation and recruitment process should allow for departing staff to transfer knowledge to new service providers.

The MOH could use online technology to improve trainings provided to staff and subsequently raise the quality of services provided to adolescents. Online courses could prove to be more interesting to participants and would avoid the existing mass training sessions during which it is impossible to address the specific concerns of individual staff. Youth-led organisations which understand both the SRHR issues and the online teaching technology could also be involved here, to develop youth-friendly materials.

From time to time, young people from related NGOs could be invited to attend monthly PHO/DHO coordination meetings, in order to provide feedback on PKPR services. PUSKESMAS could ask young people who have used the PKPR services to share their perspectives and feedback on their experiences too. However, gender responsiveness can only be improved if the MOH provides clear guidelines on the indicators of 'gender responsiveness' (even better if it provides a comprehensive training module about it, alongside any guidelines). The MOH/PHO/DHO could also collaborate with NGOs to strengthen the capacity of PUSKESMAS across provinces.

Regular technical assistance from the MOH, PHO or DHO should cover the capacity of health providers as well as other staff within the clinics to ensure every young patient feels comfortable and welcome in the PUSKESMAS. Moreover, the technical assistance should support the PUSKESMAS to maintain an adolescent-friendly physical environment that protects the privacy of patients. Efforts will need to be made to implement practical changes within minimal budgets.

Finally – and importantly – it is crucial to involve adolescents in all aspects of the PKPR programme, from planning to monitoring and evaluation. Listening to their inputs has the potential to not only improve the quality of services provided, but also to motivate adolescents to trust the PUSKESMAS and to make greater use of the services they need.

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**About ALIGN**

ALIGN is a four-year project aimed at establishing a digital platform for the Community of Practice (CoP) centred on gendered norms affecting adolescents and young adults. Project ALIGN seeks to advance understanding and challenge and change harmful gender norms by connecting a global community of researchers and thought leaders committed to gender justice and equality for adolescents and young adults. Through the sharing of information and the facilitation of mutual learning, ALIGN aims to ensure knowledge on norm change contributes to sustainable gender justice.

**ALIGN's Research Fund**

ALIGN's Research Fund supports small-scale action research or research translation projects which advance knowledge and evidence on gender norms across a wide range of contexts.

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**Research conducted by**

This study in Indonesia is led by Aliansi Remaja Independen (Independent Youth Alliance Foundation, ARI). ARI is the only youth-led organisation in Indonesia that works by and for young people aged 10-24 years old on issues related to health, education and employment.

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