

Early Adolescents' Health in Indonesia



Evidence Base from GEAS-Indonesia Baseline 2019

FULL INDICATORS REPORT OF GEAS INDONESIA WAVE 1



Rutgers



BILL & MELINDA GATES foundation

**Early Adolescent's Health in Indonesia: Evidence Base from GEAS-Indonesia
Baseline 2019**

Center for Reproductive Health, UGM Faculty of Medicine, Public Health and Nursing
Yogyakarta – Indonesia, 2019

Prepared by:

Siswanto Agus Wilopo
Ifta Choiriyah
Anggriyani Wahyu Pinandari
Althaf Setiawan
Agung Nugroho
Grhasta Dian P
Yufan Putri Astrini

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Layouting:
Anggriyani Wahyu Pinandari
Akto Adhi Kuntoro

Photo by:
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 www.geastudy.org

 [@geastudy](https://twitter.com/geastudy)

 globalearlyad@gmail.com

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We want to convey our warmest appreciation to local researchers and data collectors, whose profiles and stories are featured in Appendix 3.

This research would not be a success without the support from local stakeholders, school headmasters and teachers who allowed us to collect the data and eagerly participated in all steps of data collection and disseminations.

Finally, our highest appreciation to all adolescents and their parents who shared their information and experiences so generously with us.

Preface from Director of UGM Center for Reproductive Health

The Global Early Adolescent Study (GEAS) is a research initiative that aims to understand the gender socialization process and the factors that influence this process in the early period of adolescence (10-14 years). As part of evaluating the effectiveness of the Spirit of Youth (SETARA) intervention program, this study also explores how these two things can be transformed through the provision of comprehensive reproductive health and sexual education.

SETARA curriculum is a three-years (7th to 9th grade) program, and thus GEAS Indonesia will be conducted longitudinally from 2018 to 2021 to evaluate SETARA. Eighteen schools in three cities in Indonesia (Bandar Lampung, Denpasar and Semarang) were selected to participate in the GEAS. This study is the first study in Indonesia that focuses on sexual and reproductive health during early adolescence. This study utilizes the latest survey developments using smartphone technology to collect, analyze and disseminate information related to the health and well-being of adolescents. The GEAS is currently being conducted in 10 countries across five continents working in collaboration with universities and local research organizations with the aim of increasing local capacity. This survey has been carried out by local data collectors who will conduct interviews at least every year.

In Indonesia, the GEAS is undertaken in collaboration with Rutgers WPF, the Center for Reproductive Health, Faculty of Medicine, Public Health and Nursing, Gadjah Mada University (UGM), and the Indonesian Family Planning Association (PKBI) with the support from John Hopkins University (JHU), the Karolinska Institute and The World Health Organization (WHO). Financial support is provided by the Bill & Melinda Gates Foundation through a grant to Rutgers Netherlands.

On this occasion the writing team would like to express their deepest gratitude and appreciation to all research participants; schools; stakeholders and government at the central and regional levels who have allowed and supported us to collect the data in the field and provide valuable input during the process of disseminating research results.

Furthermore, we are also very grateful to the team of assistant researchers (coordinators, young researchers and data collectors) in the field for their participation and cooperation during this research assuring that it runs smoothly. We also thank Robert Blum, Miranda van Reeuwijk, Carroline Mureau, Anna Page, and Anna Kagesten for their continuous assistance and support during this study implementation.

It is our hope that this report will provide the greatest benefit to all stakeholders involved to support and help youth in Indonesia and the world to realize a better future through improving health and well-being in the early period of their development.

Prof. dr. Siswanto Agus Wilopo, SU., M.Sc., Sc.D

Center for Reproductive Health
Faculty of Medicine, Public Health and Nursing
Gadjah Mada University

Preface from Principal Investigator of GEAS International

We are pleased to present the Global Early Adolescent Study Baseline Report from Indonesia, the fifth site to complete baseline data collection of the longitudinal study. This data, collected in Denpasar, Semarang, and Bandar Lampung, provides a first picture of perceptions of gender norms, health and wellbeing among young adolescents living in resource-constrained contexts across three diverse settings in Indonesia.

In addition to implementation of the core survey, Indonesia is the first country participating in the Global Early Adolescent Study to collect data on attitudes and practices related to female genital cutting, future planning, and contraceptive self-efficacy, among other topics. The evaluation of the SETARA program, implemented by Rutgers will bring vital data to the evidence base about the role of such a comprehensive sexuality education program in shaping young people's health and wellbeing during adolescence and beyond.

The longitudinal Global Early Adolescent Study in Indonesia is made possible through generous support from the Bill and Melinda Gates Foundation. The global portfolio of work on the Global Early Adolescent Study is supported by the Bill & Melinda Gates Foundation, the David & Lucille Packard Foundation, the Oak Foundation, the United States Agency for International Development (USAID) and the World Health Organization (WHO).

The report that follows is a collaborative effort between Johns Hopkins, the University of Gadjah Mada and Rutgers Netherlands which is the lead organization for the exciting initiative. We also acknowledge the generous support of the Bill and Melinda Gates Foundation for their investment and trust they have placed in us. We look forward to the ongoing collaboration as we follow these wonderful young people across time and see the impacts that the SETARA program has on their health and wellbeing.

Robert Wm. Blum MD, MPH, PhD

Professor, Department of Population, Family and Reproductive Health
Principal Investigator, Global Early Adolescent Study
Johns Hopkins Bloomberg School of Public Health

Preface from Director of Explore 4action

We are very excited and proud to present the GEAS Indonesia Baseline Report. The data shed light on the experience, health, wellbeing, norms and attitudes of contemporary 12 years old adolescents from Denpasar, Semarang and Lampung. This data is hugely important for our understanding of how gender norms influence health and wellbeing. For Rutgers, joining the GEAS offers us the possibility to look at how our sexuality education program SETARA impacts on gender attitudes, knowledge, skills and health and wellbeing outcomes. Sexuality education is often evaluated in terms of its impact on sexual behavior: delayed first sex and use of condoms. But our sexuality education aims to do much more. It aims to support adolescents positive and healthy development with the skills and information that are appropriate for their developmental stage and that they need to feel better about themselves; to understand and manage their emotions; to have less fears and anxieties about their changing bodies; to have more understanding and empathy for others and their boundaries; and to make sense of the many (and sometimes conflicting) messages, norms and expectations they receive about 'how to behave as a boy or girl'. Thanks to the GEAS we now know how comfortable 12 years old are with their bodies and emerging puberty and how much they dare to speak up to unwanted attention or in case they see something bad happening to someone.

Sexuality and reproductive health is normal, positive and is closely related to health and welfare. The sexuality and reproductive health of teenagers is not limited to changes in body, sexual behaviour or health services, but also includes emotional maturity, social skills, interpersonal relationships and positive self-image.

Some data indicates hope for the future – with a large number of adolescents having high expectations, ambitions and plans for the future. But the data also give rise to concerns, especially around the high amount of adverse childhood experiences and anxiety and depressive symptoms that were reported by adolescents.

What Are the Desired Results?

The desired results in teenagers that have fully participated in this program acquire the following skills:

- Communication, which is the skill to convey ideas, opinions and feelings through speaking, writing, listening, facial expressions, body language and other means. This skill is useful for conflict resolution, understanding and managing emotions, negotiating deals and maintaining interpersonal relationships.
- Understanding their own identity and maintaining self-confidence. Teenagers realize their own potentials, including their strengths and flaws. This will instil confidence in their ability to make good decisions.
- Possessing motivation, leadership and independence. It is very important for teenagers to realize that they can influence and determine what happens in their life. This could encourage them to make positive choices and create change. This skill will in turn develop other aspects, such as decision making, critical thinking, self-management and collaboration.

- Recognizing, expressing and managing emotions and stress. This will help teenagers adapt to their environment. Proper management of stress and emotions will help teenagers choose healthy behaviours and avoid risky behaviours.
- Understanding differences, mutual respect and collaboration with other people. This skill will help teenagers hone their interpersonal skills.
- Creativity and innovation. Young people are encouraged to produce ideas and find new ways in conveying ideas and solving problems.
- Planning for and oriented to the future. Teenagers consider how their choices affect their well-being and others.

Miranda van Reeuwijk

Director of Explore for Action Program
Rutgers Netherland

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List of Abbreviations

ABRI	Angkatan Bersenjata Republik Indonesia/Republic Indonesia Army Force
ACASI	Audio Computer-Assisted Self-Interview
ACEs	Adverse Childhood Experiences
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of Southeast Asian Nations
BANSM	Badan Akreditasi Nasional Sekolah/Madrasah/ Accreditation Board of National Schools / Madrasas
BP/BK	Bimbingan Penyuluhan /Bimbingan Konseling/Conseling Guide
BKKBN	Badan Kependudukan dan Keluarga Berencana Nasional /National Family Planning Bureau
BPS	Badan Pusat Statistik/Central Statistics Bureau
BSNP	Badan Standar Nasional Pendidikan/ National Education Standards Agency
CASI	Computer-assisted personal interview
CASI	Computer-assisted self-interview
CHC	Community Health Centre
CIE	Counseling, Information and Education
CRH	Center for Reproductive Health
DSTV	Digital Satellite Television
FGC	Female Genital Mutilation
GBV	Gender Based Violence
GDI	Gender Development Index
GEAS	Global Early Adolescent Study
GEI	Gender Empowerment Index
GER	Gross Enrolment Ratio
GII	Gender Inequality Index
GPR	Gross Participation Rate
GRDP	Gross Regional Domestic Income
HDI	Human Development Index
HIV	Human Immunodeficiency Viruses
IPA	Ilmu Pengetahuan Alam/Natural Science
IPS	Ilmu Pengetahuan Sosial/Social Science
IT	Information and Technology
JHU	John Hopkins University
KIR	Kelompok Ilmiah Remaja/Adolescent Science Club
Kodam	Komando Militer/ Military Command Center
LE	Life Expectancy
MDGs	Millennium Development Goals
NER	Net Enrolment Rate
NPR	Net Participation Rate
OSIS	Organisasi intra sekolah/ intra-school organization
Paskibra	Pasukan Pengibar Bendera / Flag raisers
PBM	Proses Belajar Mengajar/ Teaching and learning process

Permendiknas	Peraturan Menteri Pendidikan Nasional/ Regulation of the Minister of National Education
PIK-Remaja	Program Informasi dan Konseling-Remaja/Adolescent Counseling and Information Program
PKBI	Perkumpulan Keluarga Berencana Indonesia/IPPF
PKBM	Pusat Kegiatan Belajar Masyarakat/Center for Community Learning Activity
PKPR	Pelayanan Kesehatan Peduli Remaja/ Youth Care Health Service
PMR	Palang Merah Remaja/Adolescent Red Cross
PNS	Pegawai Negeri Sipil/Public Servant
Polri	Polisi Republik Indonesia/Police of Republic Indonesia
Pramuka	Praja muda karana/Scout
RPJMN	Rencana Pembangunan Jangka Menengah Nasional/ national long-term development vision
SD	Sekolah Dasar/ Elementary School
SD	Standard Deviation
SDGs	Sustainable Development Goals
SETARA	Semangat Dunia Remaja
SMA	Sekolah Menengah Atas/ Senior High School
SMP	Sekolah Menengah Pertama/ Junior High School
SPR	School Participation Rate
STI	Sexual Transmitted Infection
SRH	Self-rated health
TU	Tata Usaha/Administration Office
TNI	Tentara Nasional Indonesia/ Indonesian National Army
UGM	Universitas Gadjah Mada
UKS	Usaha Kesehatan Sekolah/Healthy School Effort/Program
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
UPT	Unit Pelayanan Terpadu/Central Service Unit
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YCHS	Youth Care Health Services
YHC	Young Health Cadre





CHAPTER I

Global Early Adolescent Study (GEAS)

1.1. Background

The current young generation are living in societies facing rapid social transformations including globalization, urbanization, access to mass communication. This changing social environment complicates development and affects social norms which in turn shape behaviors. In many countries of the world especially low and middle income countries social stability has been constant for millennia; children grew up knowing exactly what their roles will be as wage earners and parents. But today's social change creates both new opportunities and uncertainty. Today the social contexts and supports will determine the potential of young people (10-24 years) to realize new aspirations to which they are exposed through media and greater contact with the outside world.

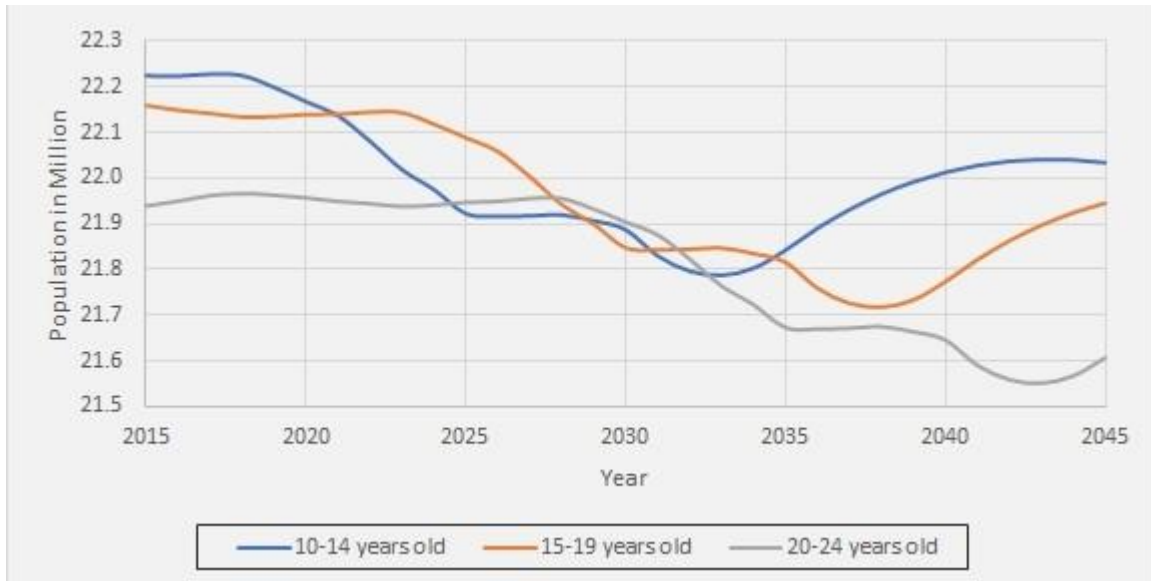
In the Asia Pacific region, young people aged 10-24 years account for more than a quarter of the population. In Indonesia, National Census Bureau predicted young people aged 10-24 years will reach 67,6 million by 2020 which is 25% from the total population. If one in four Indonesians is a young age group, the health and welfare issues of this age group will bring significant effect on the larger population.

Young people (10-24 years) face many challenges through their growth and transition to adulthood. It might come from social media, urbanization, unhealthy diets, climate change and migration. UNICEF data estimate 1.2 million adolescents die every year, mostly due to preventable causes. In poor and middle-income countries, where more than 90% of adolescents currently live, young people are the most vulnerable group infected by HIV. At the same times they also

have the least opportunity to access HIV services. It explains why the trend of HIV mortality rate in this age group is increasing.

During puberty, the risks for girl is increase due to poverty and discrimination that comes from norms and culture. This condition limits women's life choices and opportunities to get education and participate in social and economic. Puberty also opens opportunities for unwanted pregnancy. Every year it is estimated 23 million teenagers become pregnant. In many cases early pregnancy, which is related to child marriage, resulting maternal death which is the leading cause of death among girls aged 15-19 years.

During puberty adolescent also experience increase of self autonomy, peer pressure and exploration of sexuality. These factors combine with exposure of poverty, abuse or violence, media influence and unequal gender norm can make adolescent vulnerable to mental health problem. WHO data suggest that half of mental health problem start at age 14 but most of them are undetected and untreated. This condition makes mental health problem, which is account of 16%, becoming leading cause of the global burden of disease and injury among people aged 10-19 years. Moreover, problem behaviours such as smoking, drinking, or drug abuse that arise during adolescent cause premature death account for 70%. Failure on addressing the consequences of adolescent mental health problem will result enormous lost both physical and mental health and limiting opportunities to lead fulfilling lives during adulthood.



Source: Population projection from Central Statistics Bureau

Figure 1. Trend of adolescent and young age group in Indonesia.

In the early stage (10-14 years), adolescents experience a dramatic transition due to their interrelated brain, cognitive, social, and sexual development. Interactions between these factors will greatly determine their lifelong abilities and aspirations, as well as their current and long-term health and well-being, including their sexual and reproductive health (Blum *et al.*, 2017, McCarthy *et al.*, 2016). Puberty changes the physical appearance of adolescents from young children to mature adults (Blum *et al.*, 2015). These physical changes are accompanied by the emergence of different social expectations from family, peers, school, and the surrounding environment regarding the roles and responsibilities of young adolescents (Blum *et al.*, 2017). In addition to physical, social and emotional changes, in this period with brain development their cognitive ability of abstract thinking increases as does the ability to think about the future (Sawyer *et al.*, 2012).

Over the past 20 years there has been a growing interest in adolescent health and development; however, the primary focus has been on those 15 to 24 years of age. The

Global Early Adolescent Study (GEAS) aims to fill the void in our knowledge and understanding by starting with young people 10-14 years old and following them across adolescence. Adolescence (defined by the WHO as between 10 and 19 years) is divided into three stages: early, middle, and late adolescence (Blum *et al.*, 2015). GEAS specifically explores the development of unequal social norms and the consequences for boys and girls especially related to: sexual and reproductive health, mental health, school retention and completion and interpersonal and gender based violence.

The GEAS 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. There were two phases, the first of which concluded at the end of 2017 and involved qualitative data collection from young adolescents and a parent or guardian in 15 countries and in addition the development of measures to be used across sites. In the longitudinal phase of the project, which started in 2018, there is an interest in exploring how gender norms impact

adolescent health outcomes and concurrently in selected sites such as the three communities in Indonesia the goal is to explore how gender transformative and comprehensive sex education interventions impact adolescent outcomes across time. In 2018, Indonesia joined the longitudinal phase of the GEAS as a collaboration between: JHU, WHO, Rutgers Indonesia and the Centre for Reproductive Health, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada and the Karolinska Institute in Stockholm, Sweden. As currently structured young people will be followed over 4 years and three rounds of data collection starting in 2018.

In addition to the aforementioned objectives, GEAS also seeks to measure the impact of the SETARA curriculum. SETARA is a CSE curriculum for junior high school students (12-14 year-olds) in Indonesia. SETARA aims to equip students with a comprehensive understanding of sexuality, reproductive health, as well as preparing young people to become peer educators. SETARA's curriculum was based on the World Starts with Me (WSWM) global program developed by Rutgers which follows the International Technical Guidance

on Sexuality Education (ITGSE) set by the UNESCO, adapted to the Indonesian context and specific age group, involving feedbacks from the national workshop with teachers and students who have received the past materials and sessions.

On this study we collect information on contextual variable that might influence adolescent health and well being such as socio-economic, family, peer, school and neighborhood factors. Adolescent health and well being were measured through various dimension such as perceive on gender norm, empowerment, bullying and adverse childhood experiences (ACEs), mental health, sexual and reproductive health, and their media access and use. The data collection was limited at school level in urban setting in three cities, Bandar Lampung, Denpasar and Semarang. These sites were chosen to represent different cultural-religious and globalization influences including print, electronic and social media as well as tourism and contact with non-indigenous cultures. s including print, electronic and social media as well as tourism and contact with non-indigenous cultures.

1.2. Objectives

The objective of this report is to:

- 1) Provide baseline data on socioeconomic characteristics of early adolescent involved in SETARA and GEAS in Indonesia.
- 2) Exploring profile of gender norm specifically relates to sexuality among early adolescent in Indonesia.
- 3) Provide baseline knowledge prior SETARA intervention related to pregnancy prevention, HIV, contraception, media use and reproductive health services.
- 4) Provide information on early adolescent behavior on violence (such as bullying, teasing, ACEs), romantic relationship and access to reproductive health services.
- 5) Provide early adolescent health profiles that can be used by stakeholders to navigate the direction of health interventions for them.



CHAPTER II

How is GEAS carried out?

2.1. Organization

The GEAS Indonesia is carried out by the Center for Reproductive Health (CRH), Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada (FKKMK UGM), with technical supports from Rutgers WFP and the Johns Hopkins University (JHU). This study has been approved by the Ethics Committee of FKKMK UGM and

received approval from the relevant national and local authorities. Local data collectors are trained, supported, and monitored by the CRH and the site research teams. Data quality checking, data cleaning and management, and analysis are conducted in collaboration between the CRH and the GEAS Coordinating Center at JHU.

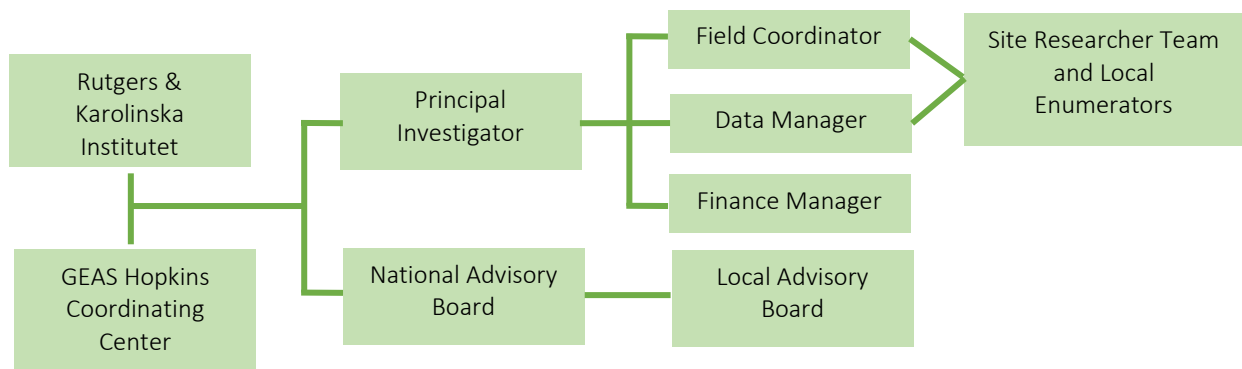


Figure 2. The organizational structure of GEAS Indonesia

2.2. Research Design

GEAS Indonesia is a component of Explore4Action, a research and advocacy program that aims to build evidence to support the implementation and scale-up of comprehensive sexuality education (CSE) and age-appropriate strategies to improve Adolescent Sexual and Reproductive Health (ASRH) in Indonesia. In addition to observational research, GEAS Indonesia evaluates the impact of a CSE implemented by Rutgers Indonesia and PKBI (Indonesia Planned Parenthood Association) called SETARA (Semangat Dunia Remaja or Teens' Aspirations, "SETARA" also means "equal" in Indonesian language).

Therefore GEAS Indonesia uses longitudinal quasi-experimental design among adolescents aged 10-14 years, who were in 7th grade in the selected schools at the

beginning of the study. The study compares adolescent knowledge, attitudes, and behaviors between those who are enrolled in intervention schools and those enrolled in control schools. The outcomes examined among students include:

- 1) Interpersonal and gender-based violence
- 2) Perceptions of gender norms
- 3) Empowerment: voice, freedom of movement and decision making
- 4) Self efficacy
- 5) Body image and body comfort
- 6) Mental Health (depressive symptoms, anxiety, adverse child experiences)
- 7) Sexual and reproductive health including:
 - a. Sexual and reproductive health knowledge and communication
 - b. Romantic experiences

- c. Sexual behaviors, contraception utilization where appropriate

This report presented the results from the baseline data collection in August-October 2018 prior to SETARA implementation.

The Intervention

SETARA is a CSE curriculum for junior high school students (12-14 year-olds) in Indonesia. SETARA aims to equip students with a comprehensive understanding of sexuality, reproductive health, as well as preparing young people to become peer educators. SETARA's curriculum was based on the World Starts with Me (WSWM) global program developed by Rutgers which follows the International Technical Guidance on Sexuality Education (ITGSE) set by the UNESCO, adapted to the Indonesian context and specific age group, involving feedbacks from the national workshop with teachers and students who have received the past materials and sessions.

SETARA consists of two sets of guidelines, one for the teachers and another for students. SETARA 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. SETARA is implemented in collaboration with Perkumpulan Keluarga Berencana Indonesia (Indonesian Planned Parenthood Association) and involving the local government for permission and support.

Rutgers Indonesia conducted the national master training for educators to prepare and deliver SETARA. Rutgers Indonesia established the guideline on teacher characteristics deemed optimal for delivering SETARA. Local chapters of PKBI organized the training of teachers from the intervention schools, the teachers workshop to develop teaching plans and for microteaching¹. Rutgers Indonesia developed the monitoring and evaluation (M&E) tools for SETARA implementation; the M&E data collection is organized by the local chapters of PKBI.

In the intervention schools in Semarang and Bandar Lampung, SETARA is delivered during the dedicated "guidance and counseling" (bimbingan dan konseling (BK)) instructional time by the BK teacher. But intervention schools in Denpasar decided to insert SETARA sessions into biology or civic studies classes. Regardless of the delivery channel, the intervention schools all deliver 15 sessions and common topics.

¹ Micro-teaching is a teacher training facilitates development of technique and provide constructive feedback from peers and/or students about what has worked and what improvements can be made to their teaching technique.

2.3. Study Population & Sample

Rutgers WFP Indonesia lead the city and school selection from the cities that are implementing SETARA. School selection in each city was based on consultation with the sub-district Public Health Center and local chapter of Perkumpulan Keluarga Berencana Indonesia (PKBI), by reviewing the demographic, health, social indicators of sub-district, the health program that are currently running in which school, the strategic value of the school/location based on the strength or history of partnership, and the willingness of the school to participate in the research. The school were also selected on the basis of type of school (only public, non religious-based schools were selected) and their agreement to implement SETARA as integrated course under counseling subject – rather than as extracurricular or under natural science/sports – to aim for uniformity and high quality of the implementation.

Three public junior high school in selected subdistrict was assigned as intervention school, and three nearby public junior high school with similar demographic and school characteristics was selected as the control school. There are 9 intervention and 9 control schools for a total of 18 schools in three cities.

We obtained permission from the Ministry of Home Affair (for national level permit), The Development Planning Agency (Bappeda) at provincial and distric level and the City Office of Education before asking for the schools' participation. In Bandar Lampung, the participating schools are geographically spread across five subdistricts, while in Denpasar and Semarang, the participating school are spread across three subdistricts and five subdistricts, respectively.

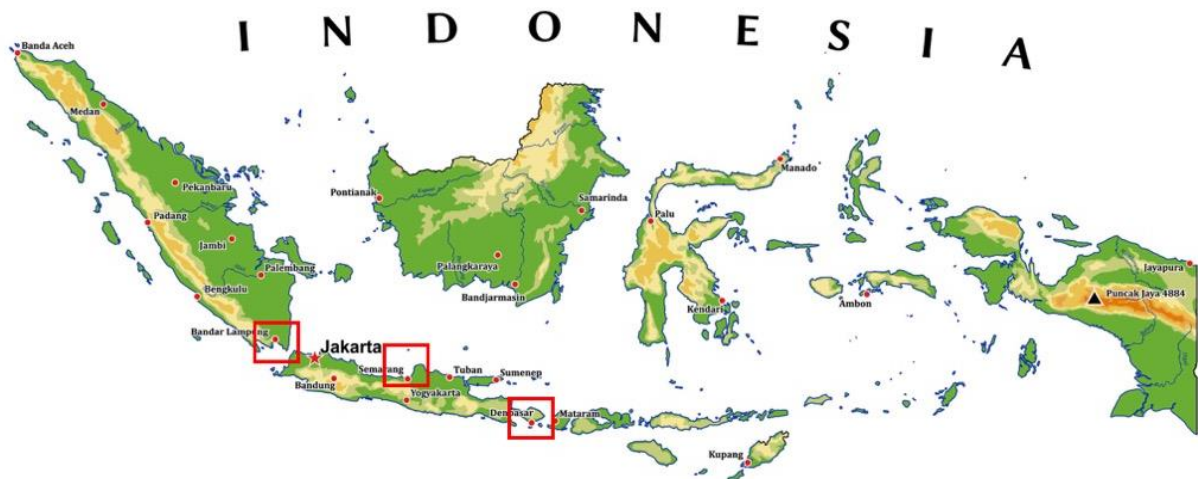


Figure 3. The sites of GEAS Indonesia and SETARA implementation in three provinces (Indonesia map).

2.3.1. Sampling

Sample location

GEAS Indonesia is conducted in three different geographical sites (Lampung, Semarang, Denpasar) with the aims to a) analyze how the diverse local context affects gender norms and behavior, b) discover interesting/different cases so that counseling, information and education (CIE) can be applied in various contexts, and c) identify how the local context affects the implementation of SETARA. The three study sites have different cultural-religious (e.g. more conservative Islam in Sumatra compared to Java, and a more open Hindu culture in Bali) and globalization influences including print, electronic and social media as well as tourism and contact with non-indigenous cultures.

Eligibility criteria

Eligibility criteria for adolescents include: 10-14 years old at the time of the interview, enrolled in 7th grade in the selected schools, live within the study sites (city of Bandar Lampung, Denpasar, or Semarang), assented to participate, and their parents consented to their child's participation.

With the school's permission, at the start of the 2018-2019 academic year, we invited the parents or guardian of all 7th graders to the school to seek informed consent for their and their child's participation (in the survey and in the SETARA program) and to collect the basic sociodemographic and household information of consenting parents.

On a subsequent day, all 7th graders whose parents consented for their participation were given presentation about the study and asked for their assent to participate. A total of 1,414 students consented to participate in the GEAS survey in Bandar Lampung (75.7% response rate); with 751 in intervention group and 663 in control group or 670 boys and 744 girls. In Denpasar, 1,753 students consented to participate (92.8% response rate); with 992 in intervention group and 761 in control group or 854 boys and 899 girls. In Semarang, 1,517 students assented to participate (99.3% response rate), with 760 intervention group and 757 in control group or 683 boys and 834 girls.

Table I. GEAS Indonesia sample, by site and study arm.

Sites	Study arm				Total N of schools	Total N of students	Total response rate
	Intervention		Control				
	N of schools	N of students	N of school	N of students			
Denpasar	3	992	3	761	6	1,753	92.8%
Bandar Lampung	3	751	3	663	6	1,414	75.7%
Semarang	3	760	3	757	6	1,517	99.3%
TOTAL	9	2,503	9	2,181	18	4,684	

Note: N = Number of sample

2.3.2. Characteristic of Program Sites

The three Explore4Action communities are predominantly urban, young (30-34% are ≤19 year olds), densely populated, and bustling with economic activities. The sites are located in three different islands and are substantially different in their ethnic and religious composition and economic structures. The Denpasar population is mostly Balinese (65%) and Javanese (26%) and unlike the rest of the country, Hindu is the main religion. As a popular international travel destination, tourism and its associated service industry dominate Denpasar's economy. Bandar Lampung is a Muslim majority, multi ethnic city (with 41% Javanese and 16% Lampungnese) and its main economic sectors are farming/forestry/mining/fishing, processing industry, and retail-wholesale sales. Semarang is a Muslim and Javanese majority city with and its main economic sectors are processing industry, retail-wholesale sales, and construction (BPS, 2010).

Gender development

Compared to the other GEAS sites, Semarang's Gender Development Index (GDI) is higher than Bandar Lampung but lower than Denpasar. Semarang's Gender Empowerment Measure (GEM) is also higher than the national average score while Denpasar's and Bandar Lampung's scores are much lower than it. In 2015, Lampung is one of the five provinces with the lowest GEM in Indonesia. In Denpasar, low GEM score was contributed by low proportion of parliamentary seats occupied by women while in Bandar Lampung is likely due to gender inequalities in types of work (BPS, 2016). In Semarang, the GEM continues to increase since 2012 due to the increase of two components, i.e. the income contribution by women and the share of

women in the workforce, but the gaps between men and women in their representation in the parliament and their income contribution are substantial.

The Ministry of Women's Empowerment and Child Protection categorized Bali in the quadrant II of gender-based development suggesting that gender equality is high, but gender empowerment is not yet optimal. While gender development in this group exceed the national averages, women's involvement in decision making remain low. Lampung is categorized to be in the quadrant III of gender-based development, for a group of provinces with GDI and GEI below the national score. It means that Lampung has been able to improve human quality and reduce the gap between the development of men and women, but the rate is relatively lower than other provinces. Therefore, more effort is needed to catch up with the other provinces (National Gender Development Report, 2018). While Bali and Lampung need to improve their gender development agenda, Semarang which is located in Jawa Tengah is categorized as quadrant I along with other four provinces. It indicates an ideal gender development setting.

Health services for adolescent

Adolescent Health Services (AHS) is a government program coordinated by the Provincial Health Office and administered by the City Health Office to serve adolescents. Each district/city is expected to have at least 4 YCHS provided in Community Health Center (CHC). In Denpasar, all CHCs include adolescent health services. YCHS programs include:

- a. Counseling services for adolescents
- b. Providing health education in at least one school and conducting Communication, Information and Education (CIE) twice a year

- c. Training of the (YHC) Young Health Cadre or peer counselor, who are students of the targeted schools who will be trained to provide information about health to their peers

In 2015, Bandar Lampung has 30 CHCs and 50 satellite CHCs. Unfortunately, there is no official data about the availability of health services for young people or the health status of Bandar Lampung's youth. In 2017, Bandar Lampung chapter of PKBI and Rutgers Indonesia have started reproductive health programs for youth that include training on integrated youth friendly service providers and comprehensive sexuality and reproductive health education for youth.

In Semarang, adolescent health services are provided by several institutions, such as Pelayanan Kesehatan Peduli Remaja (PKPR - AHS) by the Ministry of Health through CHCs, Griya ASA clinic by PKBI, and Pusat Informasi dan Konseling Remaja (PIK-R - Youth Information and Counseling Center) by BKKBN. PKPR is provided by five CHCs in Semarang. The service includes counseling, contraception, antenatal care, STI test, VCT, and safe abortion (Sobatask, 2018). Griya ASA Clinic is organized by PKBI Semarang. The clinic offers several services, such as screening and treatment for STIs including HIV, contraception services, family planning counseling, teen sexuality counseling, and premarital counseling (Sobatask, 2018). There are also 42 PIK-R in 16 subdistricts.

2.3.3. Characteristic of the schools participating in GEAS Indonesia

The schools selected to participate in GEAS Indonesia are generally located in safe neighborhoods but in diverse urban settings, ranging from the center of densely populated Denpasar city to the outer ring of the Bandar Lampung city. All participating schools are A-accredited public junior high schools, except for one control school in Denpasar that has "B" accreditation score². Based on their accreditation status, the characteristics of the schools are similar between intervention and control in terms of curriculum, standard of competence, educational processes, educator resources, infrastructure, governance, funding and assesment standards (BANSM, 2017). Except for the four schools in Semarang, all other schools have met the criterion of the ideal students-teacher ratio of 20:1.

² The score represents quality of the school compared to government standard. It is calculated from a set of criteria that measure curriculum, standard of competence, educational processes, educator resources, infrastructure, governance, funding and assesment standards. Standarization process is conducted by High School National Accreditation Agency (Badan Akreditasi Nasional Sekolah Menengah (BANSM)).

2.4. Questionnaire

The GEAS survey measure is comprised of three cross-cultural components: a 10-module health instrument, a vignettes-based measure of gender equality and assessment of gender norms. Together, these instruments assess a range of socio-ecological influences at the family, peer, school and neighborhood level, as well as behaviors and outcomes related to adolescent health and wellbeing, including school retention, adolescent empowerment; violence and adverse experiences; mental health, sexuality and sexual health.

The first wave of GEAS data collection included two questionnaires, one for parents and the other for the adolescents. The parent questionnaire collects data on marital status, education level, and employment status of the head of household and the parent/main caregiver, household assets ownership to generate a wealth index, household composition, expectation about their child's education, and whether they would approve if their child had a boy/girlfriend now.

The adolescent questionnaire collects data on (1) family level characteristics: connectedness and closeness to the parents, communication with parents, their

perception of parents' expectation about their education; (2) peers characteristics: the number of close male or female friends; perception about peers' norms and behaviors regarding school, popularity, romantic relationships and sexual activities; and drugs/alcohol abuse; (3) school and neighborhood characteristics: perception of neighborhood social cohesion and control, perception of school and neighborhood safety; (4) measure of gender equality and assessment of gender norms using vignettes and statements; (5) health literacy and information: knowledge of pregnancy & HIV/AIDS, knowledge of contraceptive access and youth health services; (6) health: general health status, mental health status (depression and anxiety), body image and comfort, puberty, substance use, (7) sexual health and behaviours: experience of romantic relationships, power dynamics and violence in the relationship, experiences of sexual activity (8) bullying and violence as witness, victim or perpetrator; (9) media: access to and use of media. Additionally, Indonesia-specific questions include: feelings about own sexuality, confidence in obtaining information and services on SRH, comfort discussing SRH issues, planfulness for life goals, knowledge and experience of Female Genital Cutting (FGC).

2.5. Data Collection and Processing

Data collection

The GEAS Indonesia study has been approved by the Ethics Committee of FKMK UGM and received permission from the regional Development Planning Agency (Bappeda) and the City Office of Education

before we contacted the selected schools. Rutgers Indonesia and CRH developed a Child Protection Policy, Principles and Guidelines of Conducts, and reporting protocol to promote awareness of child safety protection, prevent harmful and

unethical conducts, and to investigate and address reports of child abuse and exploitation.

Site research team which includes a site supervisor and two junior researchers were recruited with the help from the local chapters of PKBI. The master training, that included discussion on the questionnaire wording and purpose to ensure correct understanding, was conducted by Johns Hopkins, UGM and Rutgers together in April 2018. A total of 18 site data collectors (6 data collectors for each site) were recruited by CRH and received information and training on the background and goals of GEAS, ethical conduct of the study, informed consent and protection of confidentiality, interview process, use of mobile device to administer the questionnaire and submit the completed interviews, the walk-through of the questionnaire, and data quality supervision in August 2018. Data collection was conducted in August – October 2018 in the 3 sites.

Data collection for both adolescents and parents were conducted in 2 ways: computer assisted personal (face-to-face) interview (CAPI) using tablet and computer-assisted self-interview (CASI). While the questions are identical, the difference in survey mode, including the presence of an interviewer allowed inclusion of respondents with low literacy levels. In wave 1, most surveys were conducted using CASI for adolescents, and CAPI or CASI for parents.

Data processing and analysis

Parent and child data were immediately uploaded to the UGM server at the end of each data collection day. The UGM based data manager regularly checked data and confirmed any errors or discrepancies reported by data collectors. Johns Hopkins provided the data analysis programs to monitor data quality and generate the results and the initial tables for the baseline report. The CRH tabulated the results and interpreted and elaborated the findings into the full baseline report with support from Johns Hopkins (see Figure 4 for data management flow).

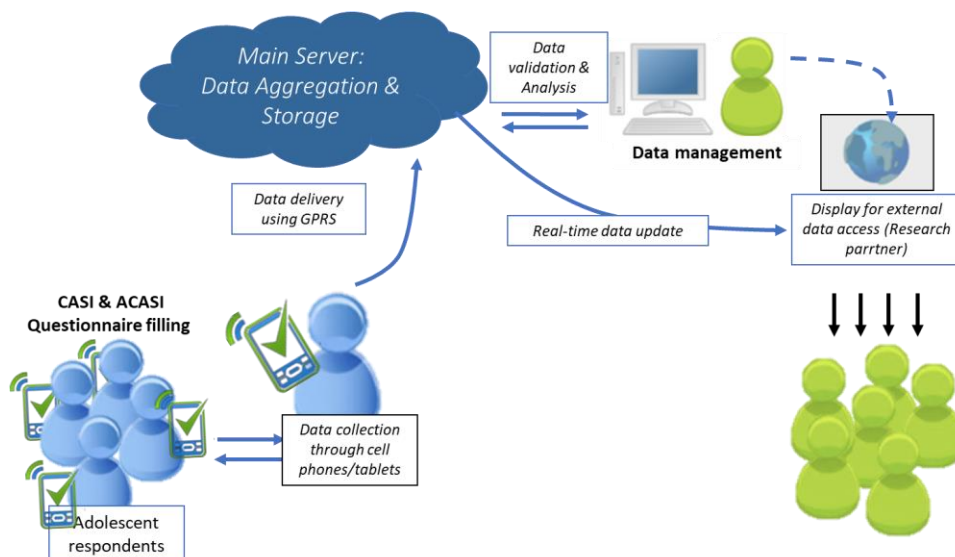


Figure 4. Flow of GEAS data management.



CHAPTER III

Results

3.1. Sociodemographic Characteristics

This section presents the demographic, social, and economic characteristics of the students and their parents or main caregivers who have consented to participate in GEAS Indonesia in Bandar Lampung, Denpasar, and Semarang. Social, economic, and demographic characteristics provide context that can influence gender norms and adolescents' attitudes and behaviors on their health and wellbeing.

Snapshot of students' and their caregivers' or households' sociodemographic characteristics

74%

Students whose main caregivers are their mother; 62% of main caregivers are employed and 86% have secondary or university education

85%

Students who self-reported that they are very or somewhat devout to their religion

50%

feel comfortable talking with their caregiver; 75% believe that their caregiver cares about what they think, and 63% feel close to their caregiver.

84%

aspire to go to college/university; most of the caregivers also have high educational aspiration for their children.

3.1.1. Adolescent Characteristics

Table 2 displays the students' individual and family characteristics. In GEAS Indonesia, we targeted seventh-grade students in junior high school; therefore, the majority (72%) are 12 years old. Nearly 9 in 10 students were born in the city where they lived, but a significant proportion ranging from 38% in Bandar Lampung and Semarang to 56% in Denpasar reported their caregivers were born in a different location.

More than two thirds (65%) of the adolescents were Muslim and one third were Hindu (predominantly in Denpasar). Eighty percent of the students reported that they often attended a religious service in the past month. This percentage was higher in Denpasar than Bandar Lampung and Semarang probably because many Balinese Hindu ceremonies and rituals are performed collectively.



Students in Denpasar also reported higher perception of devoutness than students in other sites. Boys were more likely than girls to report that they attended religious services frequently (84% vs 76%). The percentage reported that they are very or somewhat religiously devout is also higher in boys (88%) than girls (83%). The sex difference in devoutness is also seen in all three cities studied. The level of literacy is higher in boys than girls.

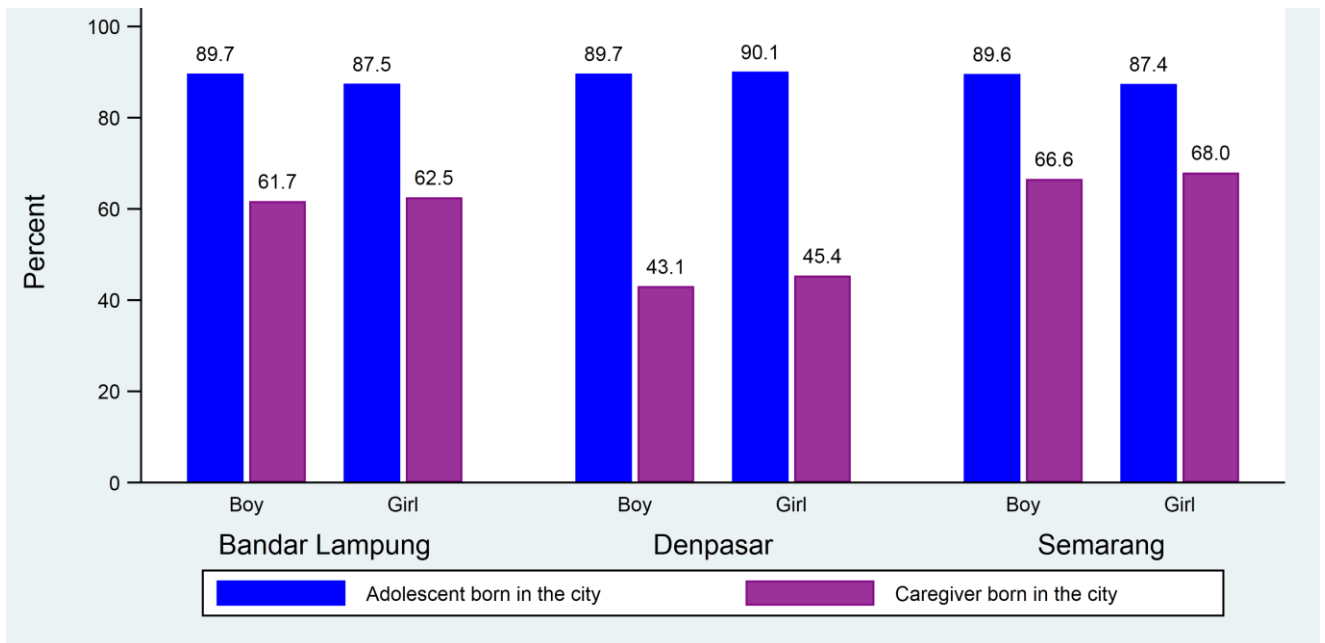


Figure 5. Migration status of the adolescents and their parent/caregiver by site.

Table 2. Characteristics of students in the Indonesia GEAS, by sex.

Socio-demographic characteristics	Total %	Boys %	Girls %	P-value
N	4684	2207	2477	
Age mean + SD (range)	12.2+0.5	12.3+0.6	12.1+0.5	<0.001
10 years	0.1	0.1	0.1	<0.001
11 years	5.4	4.2	6.6	
12 years	72.1	69.2	74.6	
13 years	20.8	23.7	18.2	
14 years	1.6	2.8	0.6	
Migration				
Adolescent born in the city	89.0	89.7	88.4	0.19
Caregiver born in the city	56.9	55.8	57.9	0.14
Religion				
Islam	64.7	63.6	65.7	0.45
Christian/Catholic	2.1	2.1	2.1	
Hinduism	32.9	34.0	31.9	
Buddhism	0.3	0.3	0.3	
Other	0.04	0.1	0.0	
Religiosity				
Self report about religious obedience or devoutness				<0.01
Very/somewhat devout	85.2	87.5	83.2	
Not very much/not at all devout	14.8	12.5	16.8	
Frequency of attending a religious service in the past month				<0.01
Often	79.8	83.6	76.4	
Not often	20.2	16.4	23.6	
Literacy				
Able to read simple sentence	98.7	98.0	99.3	<0.01

Tabel 3 also displays students' connectedness to their caregivers, their perception about their caregivers' expectation about school and marriage. Half of the students felt 'very comfortable' or 'somewhat comfortable' talking to their caregiver about the following: (1) the things that worry them, (2) changes with their body, and (3) problem with their boyfriend or girlfriend (if they have one). Forty two percent of adolescents conferred with their mothers or female caregivers when they had worries or concerns while 38% usually conferred with their friends. Less than 3% said they usually talk to their father or male caregiver, and only 2% identified their teacher as a confidant. While comfort in talking to caregiver was similar for boys and girls, girls were more likely to confide in their mothers (43% versus 40%) while boys were more likely to confide in their brothers (5% versus 1%).

Girls were significantly more likely to consider that their caregiver cared about them or that they felt close to their caregiver than boys (77% vs. 74% and 66% vs. 60%, respectively). Gender difference in the belief of caregiver carelessness is not observed in Denpasar and Semarang, and gender difference in feeling of closeness to caregiver is not observed in Semarang.

Parent monitoring was assessed by asking adolescents if their caregiver was aware of: (1) their friends name, (2) their grades/how they are doing in school, and (3) where they usually were. Parental monitoring varied from 67% in Denpasar to 57% in Bandar Lampung. Parental monitoring was higher for girls than boys (66% versus 57%).

Most adolescents believed that their caregiver cared about what they were thinking or feeling and they said they felt

close to their caregiver. The percentage of adolescents who felt comfortable talking with their caregivers was higher in Denpasar (55%) and lowest in Bandar Lampung (44%); however, nearly half or more young people in each site did not feel comfortable talking with their caregivers about personal issues. Students in Denpasar and Semarang were more likely to confer with their mothers or female caregivers than with their friends when they had worries or concern; while students in Bandar Lampung were more likely to talk to their friends.

Eighty-five percent of adolescents reported that they believe their caregiver expects them to go to university. Gender

differences were noted in adolescent's perception of parental expectations, as a higher percentage of girls indicated their parents expected them to go to university than boys (92% versus 76%) and a higher percentage of girls believed their parents would let them decide about the timing of their marriage (90% versus 78%). Differences between sites emerged with higher percentage of adolescents in Denpasar indicated their parents expected them to go to university than in other sites. More than 8 in 10 adolescents said they could decide when to marry, while few (12%) believed their parents expected them to marry after high school. This proportion however rose to 16% in Semarang.

Table 3. Parent-child relationship from the child's perspective, by sex.

Family Characteristics	Total	Boys %	Girls %	P-value
N	4,682	2,206	2,476	
Parental/caregiver connectedness				
Comfortable talking with caregiver	2347 (50.1%)	1093 (49.5%)	1254 (50.6%)	0.44
Believes caregiver cares about what adolescent thinks	3529 (75.4%)	1624 (73.6%)	1905 (76.9%)	0.008
Feels close to caregiver	2939 (62.8%)	1314 (59.5%)	1625 (65.6%)	<0.001
Parental awareness	2895 (61.8%)	1252 (56.7%)	1643 (66.4%)	<0.001
The person whom the child usually talks to about their worries and concerns				<0.001
Mother/caregiver	1893 (41.6%)	841 (39.6%)	1052 (43.3%)	
Father/caregiver	117 (2.6%)	72 (3.4%)	45 (1.9%)	
Brother	142 (3.1%)	121 (5.7%)	21 (0.9%)	
Sister	318 (7.0%)	77 (3.6%)	241 (9.9%)	
Friends	1728 (38.0%)	820 (38.6%)	908 (37.4%)	
Grandparents	60 (1.3%)	39 (1.8%)	21 (0.9%)	
Teacher	79 (1.7%)	42 (2.0%)	37 (1.5%)	
Other	3 (0.1%)	3 (0.1%)	0 (0.0%)	
Parental Expectations				<0.001
<i>Education from caregiver</i>				
Primary or secondary school	58 (1.4%)	38 (1.9%)	20 (0.9%)	
Vocational high school	272 (6.4%)	199 (10.1%)	73 (3.2%)	
General high school	298 (7.0%)	208 (10.5%)	90 (3.9%)	
University	3635 (85.3%)	1535 (77.5%)	2100 (92.0%)	
<i>Marriage from caregiver</i>				<0.001
After primary or secondary school	18 (0.6%)	16 (1.2%)	2 (0.1%)	
After I graduate high school	322 (11.6%)	221 (16.0%)	101 (7.3%)	
When I decide I want to marry	2326 (83.9%)	1080 (78.3%)	1246 (89.4%)	
They don't expect me to marry	107 (3.9%)	63 (4.6%)	44 (3.2%)	

3.1.2. Main Caregiver and Household/ Family Characteristics

We collected information about the household's asset, household head's and main caregiver's education and marital status from the parents' interview. The majority (87%) of the main caregiver had a secondary education or higher and 62% were employed

(Table 4). However, education and employment status varied by site, with a higher percentage of caregivers with a college education in Denpasar (42%) than Bandar Lampung (14%). Likewise, main caregivers' employment was highest in Denpasar (73%) and lowest in Bandar Lampung (46%).

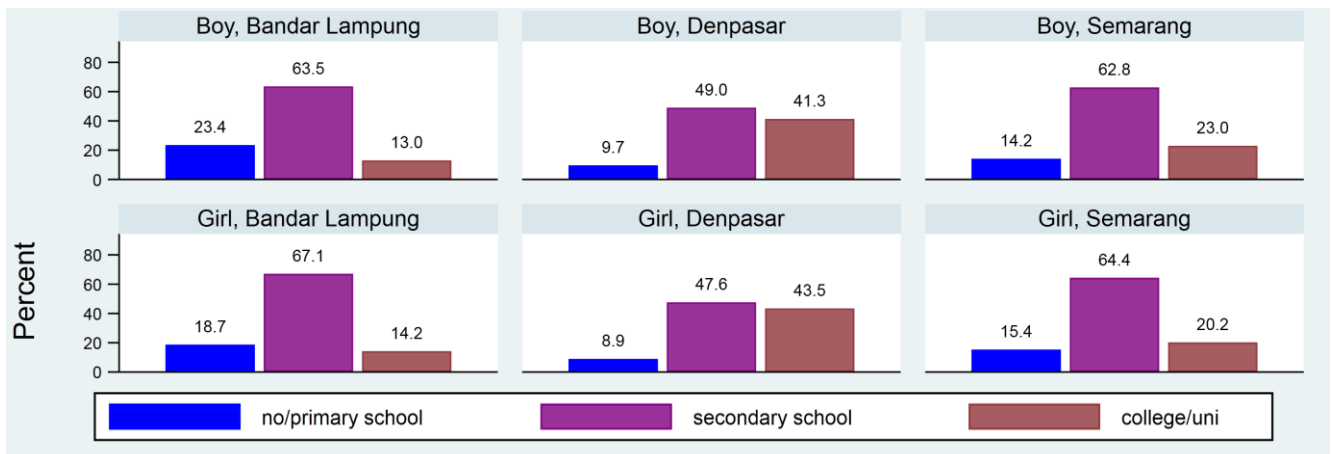


Figure 6. Distribution of main caregiver's education, by sex and site.

Wealth index distribution does not differ by sex but differs by site. The percentages of students' households categorized as 'very poor' or 'poor' were higher in Bandar Lampung (60%) than in Denpasar (27%) and Semarang (38%). Three quarters of adolescents' main caregiver was the mother, approximately one-in-five was the father while only 1% to 2% depending on site was another family member. Approximately 90% of adolescents lived with both parents, 8% lived in a single parent

household and less than 1% lived with neither parent (Table 5). The percentage of adolescents who lived with neither parent was higher in Bandar Lampung (1.1%) than in other sites (0.3% in Denpasar and 0.7% in Semarang). The percentage of fathers identified to be adolescents' primary caregiver is higher in Denpasar (25%) and Semarang (26%) compared to Bandar Lampung (15%).

Table 4. Characteristics of parent/main caregivers of the student participants, by sex.

Socio-demographic characteristics	Total %	Boys %	Girls %	P-value
N	4504	2117	2387	
Caregiver Education				0.55
No school	34 (0.8%)	14 (0.7%)	20 (0.8%)	
Primary school	605 (13.6%)	298 (14.2%)	307 (13.0%)	
Secondary school	2592 (58.1%)	1203 (57.4%)	1389 (58.8%)	
College/university	1228 (27.5%)	580 (27.7%)	648 (27.4%)	
Caregiver Employment				0.35
Employed	2708 (62.1%)	1286 (62.9%)	1422 (61.5%)	
Unemployed	1611 (37.0%)	745 (36.4%)	866 (37.4%)	
Has retired	40 (0.9%)	15 (0.7%)	25 (1.1%)	
Wealth				0.98
Very poor	932 (20.7%)	438 (20.7%)	494 (20.7%)	
Poor	871 (19.3%)	411 (19.4%)	460 (19.3%)	
Middle	881 (19.6%)	406 (19.2%)	475 (19.9%)	
Rich	1028 (22.8%)	488 (23.1%)	540 (22.6%)	
Very rich	792 (17.6%)	374 (17.7%)	418 (17.5%)	
Main Caregiver's Relationship with the Child				0.47
Mother	73.6	72.8	74.2	
Father	22.8	23.2	22.5	
Brother	0.1	0.1	0.1	
Sister	0.6	0.6	0.7	
Uncle/Aunt	0.6	0.5	0.7	
Grandparents	1.7	2.1	1.4	
Other	0.6	0.6	0.5	

There were no significant differences in caregiver characteristics between boys and girls across sites, but a number of gender differences emerged in terms of family structure, family relations and expectations. More than 8 in 10 adolescents had siblings, in most cases of both sexes. Sex composition of siblings does not differ by site but differs by sex. Specifically, boys were more likely to live in large families (6 siblings or more) and more likely to report having brothers and sisters, while girls were more likely to only have sisters.

About 90% of parents indicated that they want their children to complete university education. The percentage of

parent's expectation for university degree is higher in Denpasar (93%) than in Bandar Lampung (91%) and Semarang (87%). In Denpasar and Semarang, parent's expectation on their child's education is similar for boys and girls.

The vast majority of parents (84%) strongly disapproved of their child dating at their current age, although this percentage was lower in Denpasar than in other sites. Parents were less likely to approve their girl's dating than their boy's dating behaviors (5% approved for boys versus 3% for girls). Boys and girls in Bandar Lampung and Semarang were equally disapproved from dating by their parent.

Table 5. Family characteristics and parent's expectation on education and dating, by sex.

Family Characteristics	Total	Boys %	Girls %	P-value
N	4,682	2,206	2,476	
Household composition				0.66
Both parents*	4075 (90.5%)	1918 (90.6%)	2157 (90.4%)	
Single parent				
Mother only	258 (5.7%)	113 (5.3%)	145 (6.1%)	
Father only	91 (2.0%)	48 (2.3%)	43 (1.8%)	
Grandparents	49 (1.1%)	24 (1.1%)	25 (1.0%)	
Other only (no parents or grandparents)	29 (0.6%)	13 (0.6%)	16 (0.7%)	
Sibling				
<i>Number of siblings</i>				<0.001
Have no siblings	351 (7.8%)	151 (7.2%)	200 (8.4%)	
1-2 siblings	2358 (52.6%)	987 (47.3%)	1371 (57.3%)	
3-5 siblings	1064 (23.8%)	543 (26.0%)	521 (21.8%)	
6 or more siblings	707 (15.8%)	405 (19.4%)	302 (12.6%)	
<i>Gender of Siblings</i>				<0.001
Brothers only	1180 (27.2%)	513 (25.0%)	667 (29.3%)	
Sisters only	804 (18.6%)	336 (16.3%)	468 (20.6%)	
Both brothers & sisters	2349 (54.2%)	1207 (58.7%)	1142 (50.2%)	
Parent's (main caregiver) expectation on child education				0.020
Primary school	11 (0.2%)	2 (0.1%)	9 (0.4%)	
Junior high school	23 (0.5%)	9 (0.4%)	14 (0.6%)	
Senior high school	222 (5.0%)	125 (6.0%)	97 (4.1%)	
Diploma	155 (3.5%)	72 (3.5%)	83 (3.6%)	
Higher education	3994 (90.6%)	1859 (89.9%)	2135 (91.3%)	
Parent's (main caregiver) opinion about dating				<0.001
Very much approve	35 (0.8%)	17 (0.8%)	18 (0.8%)	
Approve	124 (2.8%)	76 (3.7%)	48 (2.1%)	
Disapprove	545 (12.4%)	292 (14.1%)	253 (10.9%)	
Very disapprove	3687 (84.0%)	1680 (81.4%)	2007 (86.3%)	

Note: *married or cohabiting, includes parents and stepparents

3.2. Contextual Factors

This section provides information about factors outside the individual and family/household level i.e. peers, school, and environment/neighborhood that affect adolescents. The social ecological theory model approach used in GEAS is able to explain the role of parents, peers, family structures and institutions (both school, government and others) towards adolescent attitudes and behavior. This theory also provides an explanation of how models, opportunities and reinforcement occur in their behavior. The four levels of information gathered are family, peers, school and environment.

Snapshots of the environment and context where adolescents are growing up

27% and **17%**

feel unsafe in their neighborhood and in school, and about 60% perceive that their neighborhood has positive social cohesion.

Boys

more often than girls report having friends who have ever used tobacco/alcohol/drugs.

Boys

more often than girls report having friends who have ever dropped out of school;

Boys

also more often than girls report having friends who have engaged in sexual activities.

3.2.1. Peers Factor

Many studies have shown that peers are an important factor in young people's life. The GEAS also examined several peer characteristics, including peer structure and peer attitudes and behaviors related to school, substance use (tobacco/vapor/ alcohol/drugs), and sexual activity.

Fifty-eight percent of the students have more than three close friends (i.e. a

friend with whom one can talk about feelings and share secrets) of the same sex, but a majority also had at least one friend of the opposite sex (70% of boys and 60% of girls). Most adolescents saw their friends once or twice a week while a third saw their friends every day. There was no notable difference in these indicators by site, except that students in Bandar Lampung (42%) were more likely to spend time with their friends nearly every day than those in Denpasar (33%) and Semarang (33%).

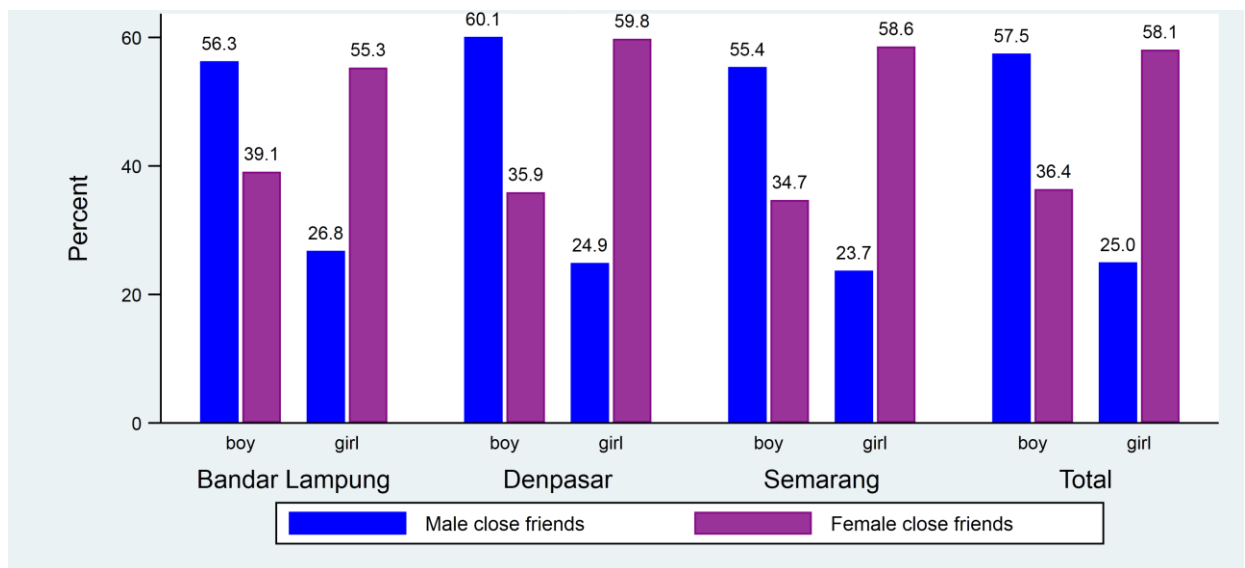


Figure 7. Percentage of adolescents who had more than three male/female close friends, by sex and site.

Students were asked about their close friends' attitudes indicating how important it was for their friends to (1) attend school regularly, or (2) be popular with people their age, (3) study hard, or (4) pay attention to their appearance, (5) be good in sport, (6) have a boyfriend or girlfriend, or (7) have sexual intercourse. Most adolescents reported school attendance and studying hard was important to their friends (91% and 84%). More than half also believed being good in sports and appearance were important to their friends (67% and 58%) while 47% thought being popular was important to their peers and fewer (28%)

indicated that having a boyfriend or girl friend was important to their friends. Only 4% thought sexual relations were important for their friends. Peers attitudes varied across sites, with a greater percentage of adolescents in Denpasar reporting education, sports, appearance and being popular were important for their close friends than in other sites. For example, 53% of the students in Denpasar reported that all or most of their close friends thought that being popular was important, compared to 44% in Bandar Lampung and 45% in Semarang.

Adolescents also reported on their friends' behaviors related to substance use and sexual relations. According to these perceptions, smoking was prevalent, particularly in Semarang where 41% indicated that their close friends smoked compared to 16% in Denpasar and 27% Bandar Lampung. Altogether, 10% thought their friends drank alcohol, rising slightly to 14% in Semarang. Few (7%) indicated that their friends had dropped out of school, with a higher percentage in Bandar Lampung (9%). Few peers were perceived to have engaged in kissing or petting and fewer than 4% thought their friends had ever had sexual relations. Students in Semarang were more likely to perceive that their peers have engaged in kissing or petting than students in other sites. However, students in Bandar Lampung were more likely than those in other sites to believe that their peers have had sexual intercourse.

A number of peer indicators differed between boys and girls. Boys' peer network was larger than girls and more likely to include both sexes. Boys were also more likely to spend time with their friends than girls (46% spent time every day versus 26% of girls).

Peer attitudes were also different between boys and girls, with greater importance devoted to studying hard and greater attention to appearance among girls' peers while a greater percentage of boys

indicated that being good in sports, having romantic relations and having sexual relations were important to their friends.

Perception on peer attitude toward risk taking behaviors among boys is higher than girls suggests gendered behaviors encouraging risk taking among boys.

Boys were more likely to indicate that their close friends smoked or consumed alcohol, or drugs or had ever kissed, fondled or has sexual relations than girls. For example, 36% of boys versus 19% of girls reported their close friends smoked cigarettes and 13% of boys versus 8% of girls reported their friends consumed alcohol. Additionally, 10% of boys and 4% of girls had close friends who had dropped out of school. Seven percent of boys versus 1% believed a close friend had had sex. While these results reflect perceptions rather than actual behaviors, they nevertheless suggest gendered behaviors encouraging risk taking among boys.

Table 6. Characteristics of close friends and peers of GEAS participants, by sex.

Peer Characteristics	Total	Boys %	Girls %	P-value
N	4,521	2,160	2,361	
Number of male close friends				<0.001
0 friend	1053 (23.3%)	101 (4.7%)	952 (40.3%)	
1 - 3 friends	1635 (36.2%)	817 (37.8%)	818 (34.6%)	
> 3 friends	1833 (40.5%)	1242 (57.5%)	591 (25.0%)	
Number of female close friends				<0.001
0 friend	665 (14.7%)	620 (29.9%)	45 (1.8%)	
1 - 3 friends	1681 (37.2%)	700 (33.7%)	981 (40.1%)	
> 3 friends	2177 (48.1%)	757 (36.4%)	1420 (58.1%)	
Average time spent with friends weekly				<0.001
Never	391 (8.6%)	153 (7.2%)	238 (9.8%)	
1 – 2 times/week	2068 (45.6%)	743 (35.1%)	1325 (54.7%)	
3 – 4 times/week	467 (10.3%)	241 (11.4%)	226 (9.3%)	
Nearly every day	1613 (35.5%)	981 (46.3%)	632 (26.1%)	
Close friends think that it is important to...				
Attend school regularly	4151 (90.9%)	1923 (90.2%)	2228 (91.5%)	0.15
Study hard	3858 (84.5%)	1752 (82.2%)	2106 (86.5%)	<0.001
Be good in sport	3097 (67.8%)	1581 (74.2%)	1516 (62.2%)	<0.001
Be popular with people your age	2179 (47.7%)	1019 (47.8%)	1160 (47.6%)	0.89
Pay attention to their appearance	2629 (57.6%)	1176 (55.2%)	1453 (59.6%)	0.002
Have a boyfriend or girlfriend	1298 (28.4%)	649 (30.5%)	649 (26.6%)	0.004
Have sexual intercourse	109 (2.4%)	89 (4.2%)	20 (0.8%)	<0.001
Having friends with experience in...				
Smoke cigarette/vapor	1242 (27.2%)	775 (36.4%)	467 (19.2%)	<0.001
Drink alcohol	486 (10.6%)	286 (13.4%)	200 (8.2%)	<0.001
Use drugs	85 (1.9%)	52 (2.4%)	33 (1.4%)	0.007
School dropout	308 (6.7%)	206 (9.7%)	102 (4.2%)	<0.001
Perceived peer behaviors				
Close friends have had kissed	670 (14.7%)	386 (18.1%)	284 (11.7%)	<0.001
Close friends have had petting	519 (11.4%)	353 (16.6%)	166 (6.8%)	<0.001
Close friends have had vaginal sex	179 (3.9%)	150 (7.0%)	29 (1.2%)	<0.001
Close friends have had anal sex	161 (3.5%)	138 (6.5%)	23 (0.9%)	<0.001

3.2.2. School factor

Table 7 displays the indicators related to the student's school environment; 58% of the students went to school with a low

resource index., this percentage rising from 49% in Denpasar, to 63% in Bandar Lampung and 65% in Semarang.

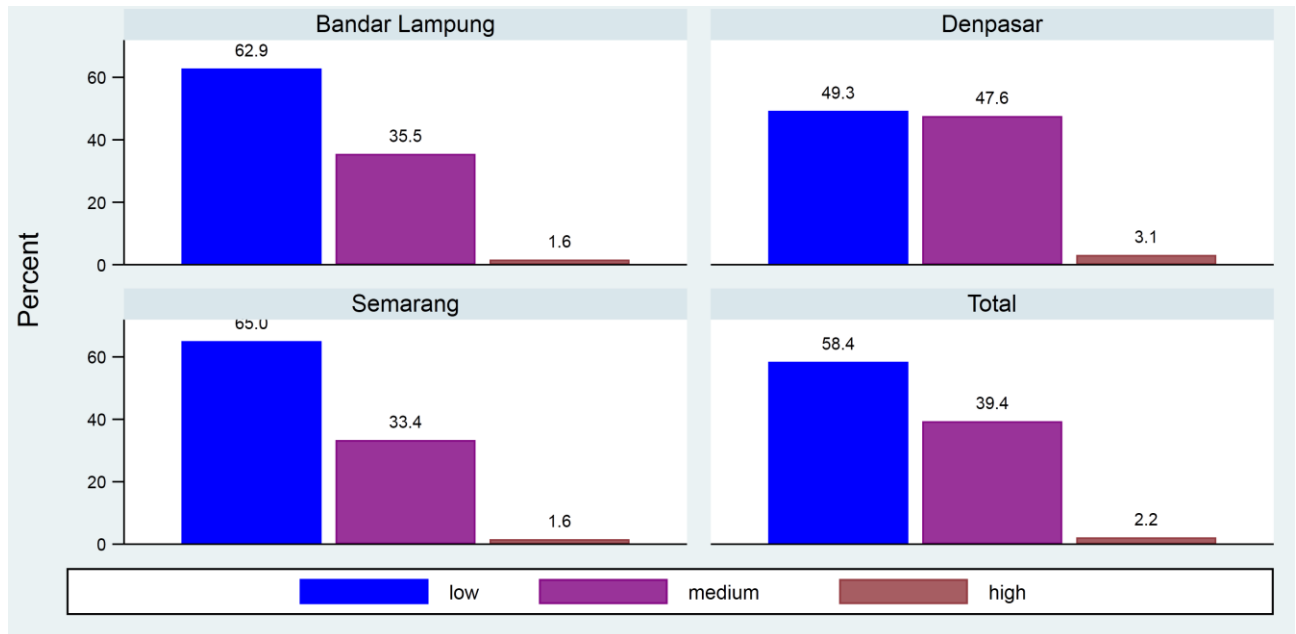


Figure 8. Distribution of school resources index, by site.

School absence was uncommon with 70% never missing a day of school in the past month, but students in Bali were more likely to report school absence. The most common reason for missing school was sickness, followed by hanging out with their friends.

A significant percentage of students (17%) indicated they had felt unsafe or threatened in school in the last year, mostly by classmates or other students (77%) and in 17% of cases by teachers or other adults. Issues of safety were more often reported in Denpasar and Semarang (18%) than in Lampung.

Adolescents had high educational aspirations in line with their caregiver's expectations; 84% expected to go to university. Conversely, few (8%) had ever thought about dropping out of school. Students in Denpasar had higher educational aspirations than elsewhere, with 88%.

School experiences and aspirations differed between boys and girls, with a greater percentage of boys who missed school (34% versus 27%), and a greater percentage of boys who had ever thought of dropping out of school (11% versus 6%). Boys were also more likely to have felt threatened in the school environment (20% versus 15% of girls). The educational aspirations of boys were also lower with 78% hoping to attend university compared with 91% of girls.

Boys are more likely to report missing school days and thinking about dropping out of school. Boys' educational aspiration to attend university is also lower than girls.

Table 7. The indicators related to school environment and attitude about school of GEAS participants, by sex.

School Context	Total	Boys %	Girls %	P-value
N	4,681	2,206	2,475	
School Grade				
7th grade	100.0	100.0	100.0	
Attends Co-ed School	4353 (94.5%)	2040 (94.1%)	2313 (94.8%)	0.30
Average number of school days missed				
				<0.001
0 day	3170 (69.9%)	1407 (66.4%)	1763 (73.0%)	
1-2 days	1196 (26.4%)	619 (29.2%)	577 (23.9%)	
3-5 days	116 (2.6%)	67 (3.2%)	49 (2.0%)	
6 or more days	51 (1.1%)	26 (1.2%)	25 (1.0%)	
Most common reasons for missing school				
Sickness	1054 (22.5%)	543 (24.6%)	511 (20.6%)	0.001
Hanging out with friends	52 (1.1%)	29 (1.3%)	23 (0.9%)	0.59
Other reason*	65 (1.4%)	43 (2.0%)	22 (0.9%)	
The percentage of boys/girls who) ever thought about dropping out of school this year				
Yes	378 (8.1%)	233 (10.6%)	145 (5.9%)	<0.001
I expect to complete				
				<0.001
Primary or secondary school	132 (2.9%)	95 (4.5%)	37 (1.5%)	
Vocational or high school	606 (13.4%)	424 (19.9%)	182 (7.5%)	
Graduate degree (university, licensure, or doctorate)	3795 (83.6%)	1607 (75.5%)	2188 (90.8%)	
School Resource Index³				
				0.42
Low	2371 (58.4%)	1134 (58.7%)	1237 (58.2%)	
Medium	1599 (39.4%)	751 (38.9%)	848 (39.9%)	
High	89 (2.2%)	48 (2.5%)	41 (1.9%)	
Student's knowledge about Healthy School Indicators⁴				
Non-smoking area	3571 (76.2%)	1740 (78.8%)	1831 (73.9%)	<0.001
No drugs area	3375 (72.1%)	1675 (75.9%)	1700 (68.6%)	<0.001
Non-violence area	3232 (69.0%)	1589 (72.0%)	1643 (66.3%)	<0.001
Healthy life skill education	3519 (75.1%)	1694 (76.8%)	1825 (73.7%)	0.015
Felt unsafe or threatened in the school				
	803 (17.1%)	432 (19.6%)	371 (15.0%)	<0.001
Felt unsafe or threatened in the school because of...				
Adults or teachers	136 (17.2%)	76 (17.8%)	60 (16.4%)	0.60
Classmates or other students	606 (76.6%)	331 (77.7%)	275 (75.3%)	0.43
Other (e.g. animals, car accidents)	191 (24.1%)	91 (21.4%)	100 (27.4%)	0.048

Note: *Lack of school fees, due to period, help out at home, babysit, work to earn money, study for exam.

³ Calculated through availability of toilets with doors, running water, soap, computer, trash can, and sports club or team.

⁴ Healthy School Indicator is a set of indicator provided by Indonesia Ministry of Health.

3.2.3. Neighborhood Environment

Table 8 displays the indicators related to the student's neighborhood environment. The students generally had positive perceptions of their neighborhoods although their assessment of social control was lower than their perceptions of social cohesion.

60% considered they lived in a neighborhood with high social cohesion, responding positively to all of the following statements: (1) People in my neighborhood look out for and help their neighbors, (2) People in my neighborhood can be trusted, (3) People in my neighborhood know who I am, and (4) People in my neighborhood care about me.



Figure 9. Perception of neighborhood social control and cohesion, by sex and site.

Fewer adolescents (44%) responded positively to the social cohesion questions: (1) Adult in your neighborhood would intervene if children or teenagers were damaging property, (2) Adult in your neighborhood would intervene if children or adult were spraying paint on walls (graffiti),

(3) Adult in your neighborhood would intervene if children or adult were bullying or threatening. Students in Denpasar had more positive perceptions of their neighborhood's social cohesion compared to other sites; but perception of social control was highest in Semarang.

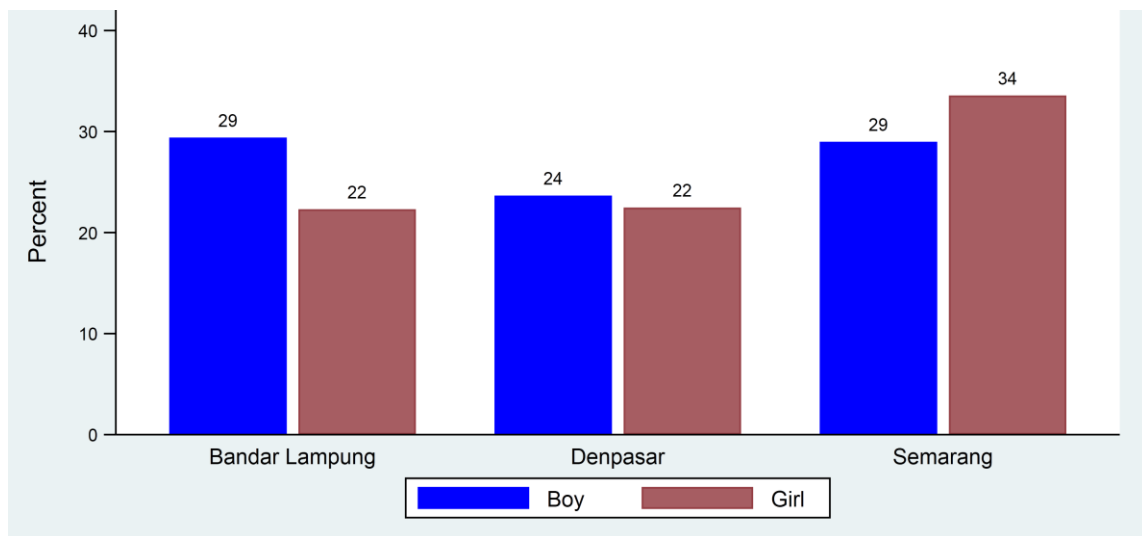


Figure 10. Percentage of adolescents feeling threatened/unsafe in their neighborhood, by sex and site.

A significant proportion of adolescents (27%) indicated they had felt unsafe or threatened in their neighborhood in the last year, and 10% currently felt unsafe. Up to 21% of adolescents carried some kind of weapon for protection; only 36% had someone to turn to if they felt unsafe. Feelings of insecurity in the last year were more common in Semarang (32%) than in Bandar Lampung (26%) and Denpasar (23%).

Perceptions of the community environment differed between boys and girls, as boys had higher perceptions of social cohesion but lower perceptions of social

control. While perceptions of safety were similar among boys and girls, boys were more likely to have something to protect themselves (23% versus 19%) while girls were more likely to have someone to turn to if they felt threatened (39% versus 34%).

Boys had higher perceptions of social cohesion but lower perceptions of social control.

Table 8. Characteristics of the neighborhood of GEAS participants, by sex.

Neighborhood Characteristics	Total	Boys %	Girls %	P-value
N	4684	2207	2477	
Neighborhood Social Cohesion (% who agree with)				
"People in my neighborhood look out for and help their neighbors"	4145 (88.5%)	1978 (89.6%)	2167 (87.5%)	0.022
"People in my neighborhood can be trusted"	3487 (74.4%)	1762 (79.8%)	1725 (69.6%)	<0.001
"People in my neighborhood know who I am"	4258 (90.9%)	2031 (92.0%)	2227 (89.9%)	0.012
"People in my neighborhood care about me"	3524 (75.2%)	1677 (76.0%)	1847 (74.6%)	0.26
<i>Positive neighborhood perception</i>	2791 (59.6%)	1396 (63.3%)	1395 (56.3%)	<0.001
Perceived Social Control (% who agree with)				
"Adult in your neighborhood would intervene if children or teenagers were damaging property"	2926 (62.5%)	1326 (60.1%)	1600 (64.6%)	0.001
"Adult in your neighborhood would intervene if children or adult were Spraying paint on walls (graffiti)"	2683 (57.3%)	1220 (55.3%)	1463 (59.1%)	0.009
"Adult in your neighborhood would intervene if children or adult were Bullying or threatening"	2806 (59.9%)	1255 (56.9%)	1551 (62.6%)	<0.001
"Adult in your neighborhood would intervene if children or adult were Fighting with another person"	3082 (65.8%)	1424 (64.5%)	1658 (66.9%)	0.082
<i>Strong social control (agreed to all statements above)</i>	2083 (44.5%)	914 (41.4%)	1169 (47.2)	<0.001
<i>Summary Score (Mean +/- SD)</i>	2.82 (0.96)	2.76 (0.98)	2.88 (0.94)	<0.001
<i>Cronbach's Alpha</i>	0.911	0.903	0.917	
Neighborhood Danger				
Felt threatened in neighborhood	1245 (26.6%)	597 (27.1%)	648 (26.2%)	0.49
Felt unsafe or threatened in the neighborhood because of...				
Adults	65 (5.3%)	34 (5.8%)	31 (4.8%)	0.46
Boys or girls your age	163 (13.3%)	90 (15.3%)	73 (11.4%)	0.004
Other (e.g. animals, car accidents)	72 (5.9%)	34 (5.8%)	38 (5.9%)	0.91
Someone to turn to when feeling unsafe	1696 (36.2%)	742 (33.6%)	954 (38.5%)	<0.001
Feels unsafe now	451 (9.6%)	212 (9.6%)	239 (9.6%)	0.96
Carry something for protection	969 (20.7%)	504 (22.8%)	465 (18.8%)	<0.001

3.3. Gender Norms

This section describes gender norms collected through closed questions and vignettes⁵. Gender norms are collective and often unequal expectations about how women and men should behave, feel, think and interact in a given society (Doyal, 2000, Connell, 2012). Differential gender expectations intensify during early adolescence (ages 10-14 years) because self-perceptions and social expectations change when boys and girls experience puberty (Hill J.P., 1983). Teenagers learn and internalize appropriate or inappropriate behavior from various socialization agents such as family, peers and the media. In this process adolescents are not only passively accepting but actively engage in building their systems of beliefs and their gender identity through interactions with others (Basu et al., 2017). GEAS explores this process by examining young people's perceptions of gender norms and how those perceptions affect adolescents' health and well being as well as their inclusiveness in their social interactions.

Snapshots of gender norms among young people

Boys

are more direct than girls in their communication style; but girls are more socially inclusive than boys.

Boys

have higher acceptance to heteronormative romantic relationship than girls; but boys also agree with sexual double standard more often than girls.

Boys

generally agree with stereotypical gender traits and roles more often than girls; but girls agree with stereotypical gender roles for women (i.e. of women to take care of the family) more often than boys.

A majority

of adolescents endorse male toughness over female vulnerability, and many recognize a division of roles and power between the sexes within the household.

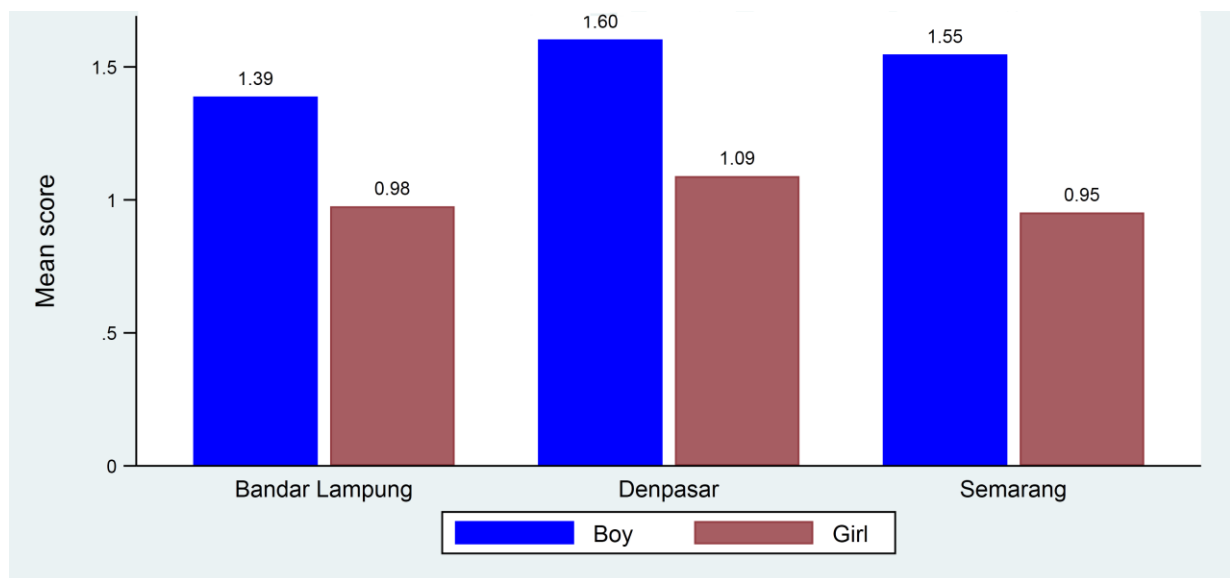
⁵ The vignette tool is form of stories or narratives about people or situations that has been used to assess attitudes, values, norms and perceptions, particularly regarding sensitive topics in the health and social sciences. These stories are presented to participants who are asked how they or the central character (protagonist) might respond to the situation.

The students were presented with four vignettes about romantic interest, gender conformity and bullying, puberty, and adolescent pregnancy and were asked to respond to the situations described in the vignettes to measure several domains of gender equality. Table 9 displays the two indicators from the vignettes, i.e. communication style and social inclusion.

Compared to girls, boys are more likely to have a direct communication style when they are romantically attracted to someone and want to get their attention.

Gender conformity was assessed using a scenario about an atypical gender adolescent boy/girl who wants to play with opposite sex peers. A score of peer social

inclusion indicators ranging from 0-2 with higher scores signaling higher levels of inclusion was used to explore young people’s perceptions of social acceptance of atypical gender behaviors. The results show moderate levels of perceived acceptance of atypical behavior, with an average score of 1.12, which was higher in Denpasar than in the two other sites (1.34 versus 1.05 in Lampung and 0.94 in Semarang). Adolescent girls were more likely to perceive social inclusiveness than boys, scoring 1.17 versus 1.06 for boys .The findings above are in line with the results of a qualitative study of Lanscaping Adolescent Reproductive Health in 2017 which showed that adolescents considered that playing games/activities that are perceived to belong to the opposite sex was strange; adolescents who engage in gender atypical behavior were often accused of homosexuality (CRH, 2017). Such perceptions are likely influenced by gender norms which define a set of rules of what typical boys or girls could or could not do (Blackstone, 2003).



Note: Score range is 0-2; 0 = avoidance style; 1 = indirect style; and 2 = direct style

Figure 11. Mean score of communication style (direct or indirect), by sex and site.

Communication style was examined by asking students how they would act if they were romantically interested in

someone and wanted to get their attention. A communication score from 0 to 2 was defined, 0 corresponding to a situation of

avoidance if they choose to 'do nothing and just wait', 1 related to an indirect style of communication (if they choose to 'ask a friend to tell (the person) that you like her/him'; and 2 corresponding to a direct style of communication if they choose 'pass X a note' or 'go up and talk to X directly'. On average, adolescents were more likely to

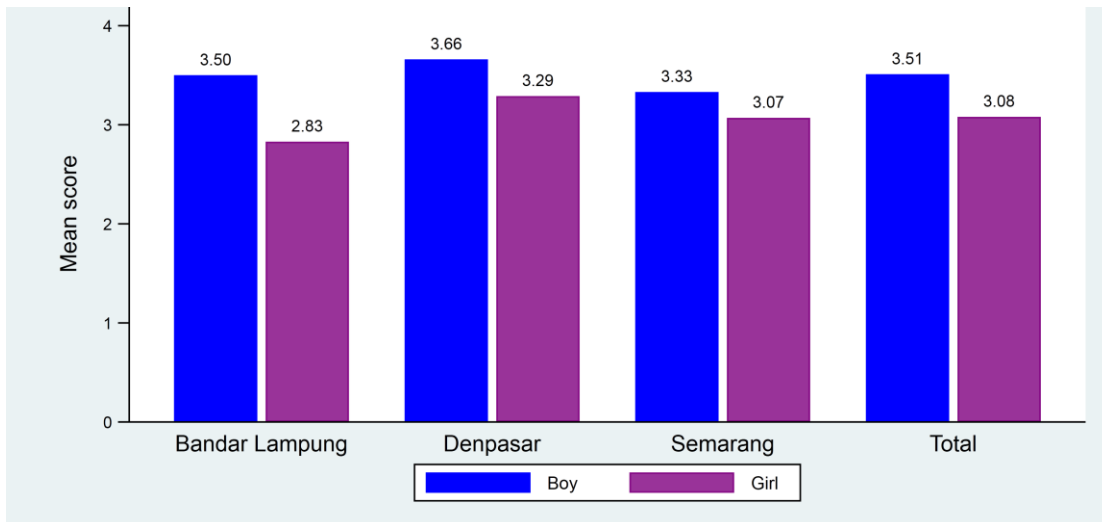
have an indirect style of communication, with a score of 1.25, although higher in Denpasar than in the two other sites (1.34 versus 1.17 in Bandar Lampung and 1.22 in Semarang). Boys' were more likely to have a direct mode of communication than girls; scoring higher at 1.52 versus 1.01 for girls.

Table 9. Communication style and peer social inclusion for gender atypical peers of GEAS participants, by sex.

Vignettes	Indonesia			P-value
	Total	Boys %	Girls %	
Communication style* <i>(How would you approach a romantic interest)</i>	4414	2083	2331	
Mean score	1.25 (0.86)	1.52 (0.74)	1.01 (0.88)	<0.001
Peer social inclusion for gender a-typical peers** <i>(Acceptance of peer wanting to play with opposite gender group)</i>	4483	2100	2383	
Mean score	1.12 (0.88)	1.06 (0.87)	1.17 (0.97)	<0.001

The students were presented with 44 statements on gender norms and asked whether they agreed or disagreed with the statements. Table 10 displays two specific domains of gender norms regulating adolescent boy/girl relationships i.e. acceptance of heteronormative relationship and sexual double standard. Four statements related to perceived acceptability of heteronormative romantic relationship during adolescents. The four statements

were combined into a single indicator averageing responses to the four questions, after verifying the internal reliability of the measure (Cronbach alpha=0.83). Levels of acceptance of romantic relationships were relatively widespread, with a mean score of 3.17 with greater perceived acceptance in Denpasar (score=3.37) than Bandar Lampung and Semarang (scores =3.04 and 3.07 respectively).

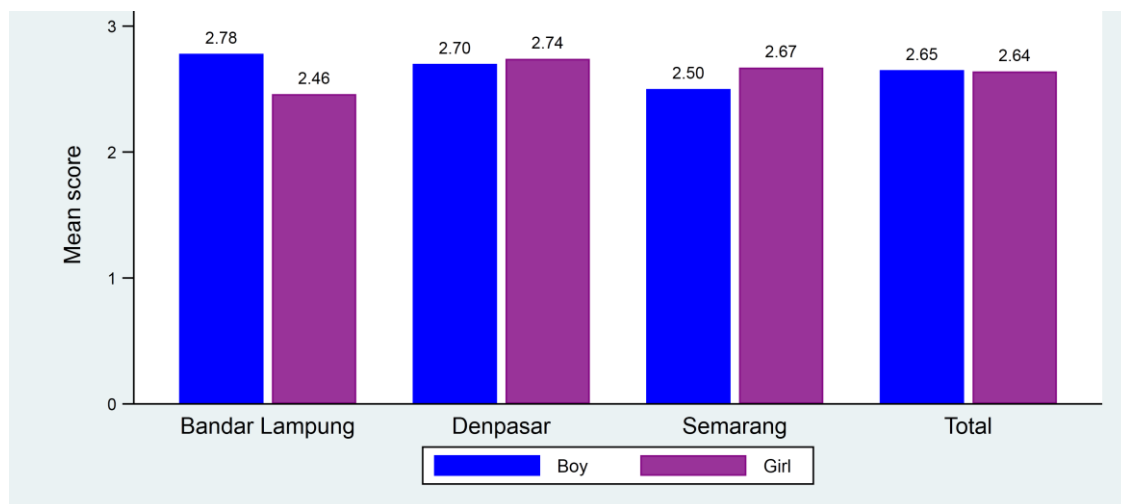


Note: Greater score indicates greater perceive of acceptance for heteronormative romantic relationship

Figure 12. Mean score of acceptance of heteronormative relationship, by sex and site.

Six statements related to the concept of sexual double standard, suggestive of differential values assigned to boys' versus girls' romantic involvement. Such values encourage boys to have relationships to gain social status while restrain girls who risk their social reputation by engaging in relationships. They were summarized in a measure ranging

from 1 to 5, with high internal reliability (Cronbach 0.89). Less than half of adolescents ascribed to the sexual double standard with a mean score of 2.78, although variation was noted between sites, with higher acceptance of the double standard in Bandar Lampung and Semarang (scores =2.71 and 2.74 respectively) compared to Denpasar (score=2.88).



Note: Greater score indicates stronger endorsement on sexual double standards norms.

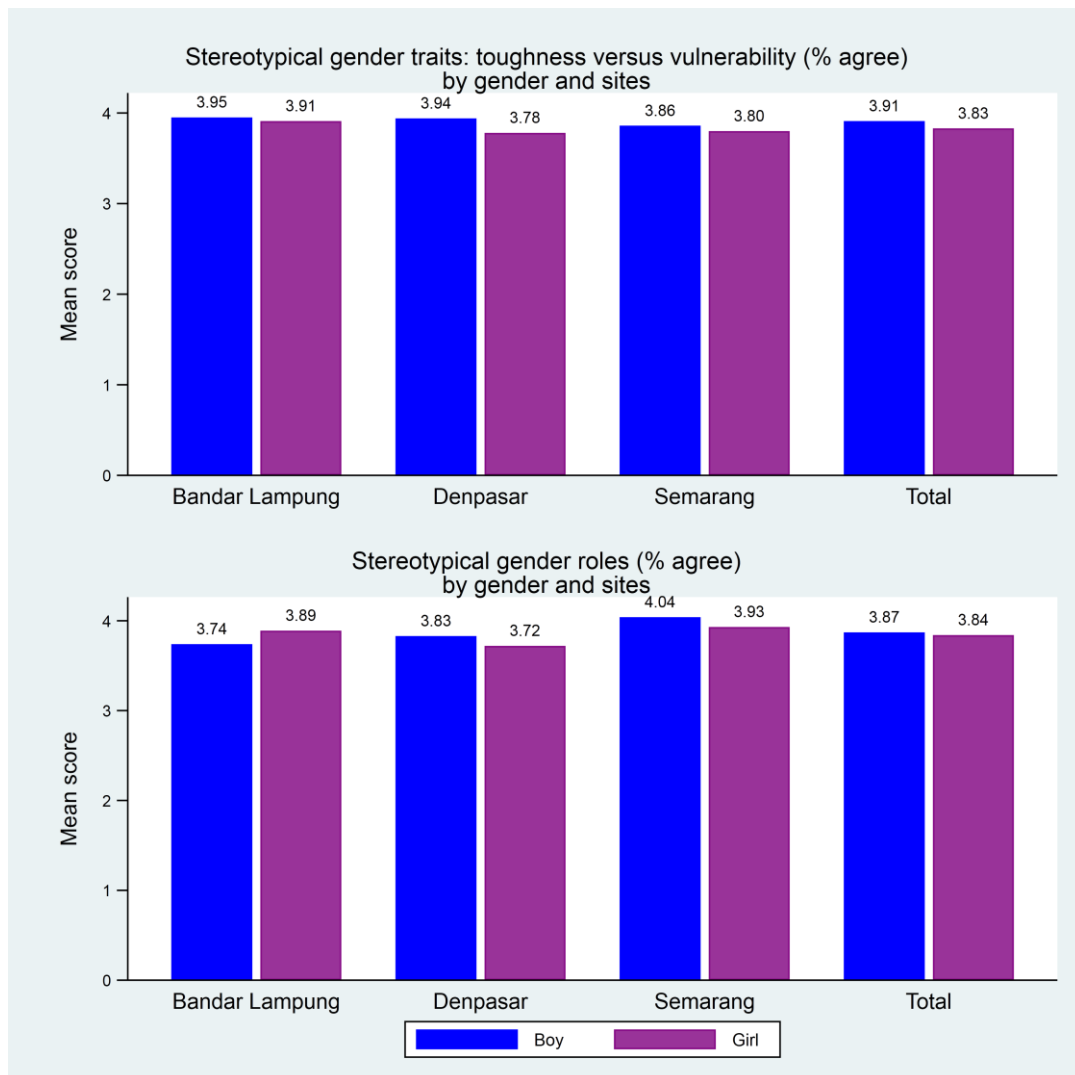
Figure 13. Mean score of sexual double standard, by sex and site.

Gender differences were noted in perceptions of the sexual double standard as well as the perceived acceptability of romantic relations between boys and girls in early adolescence. Boys were more likely

than girls to embrace the sexual double standard (2.84 versus 2.72) and more likely to believe romantic relations to be normative during early adolescence (3.42 versus 2.95).

Table 10. Acceptance of heteronormative relationship and sexual double standard of GEAS participants, by sex.

Gender Norms	Total	Indonesia		P-value
		Boys %	Girls %	
Adolescent Acceptance of Romantic Relationships (% who agree with...)	4622	2172	2450	
It's normal for a boy your age to want a girlfriend	54.9	60.1	50.3	<0.001
It's normal for a girl to want a boyfriend at your age	51.5	54.1	49.1	0.001
A girl should be able to have a boyfriend if she wants to	37.4	48.1	27.9	<0.001
A boy should be able to have a girlfriend if he wants to	41.3	54.4	29.6	<0.001
<i>Mean Score*</i>	3.28 (1.04)	3.51 (1.05)	3.08 (1.00)	<0.001
<i>Cronbach's Alpha</i>	0.87			
Sexual Double Standard (% who agree with...)	4682	2171	2457	
Adolescent boys fool girls into having sex	15.0	17.4	12.9	<0.001
Adolescent girls should avoid boys because they trick them into having sex	43.9	37.4	49.7	<0.001
Girls are the victims of rumors if they have boyfriends	36.0	35.6	36.3	0.606
Boys have girlfriends to show off to their friends	25.0	23.8	26.0	0.081
Adolescent boys lose interest in a girl after they have sex with her	23.7	25.3	22.4	0.019
Boys tell girls they love them when they don't	22.7	23.7	21.8	0.140
<i>Mean Score**</i>	2.64 (0.98)	2.65 (0.98)	2.64 (0.99)	0.71
<i>Cronbach's Alpha</i>	0.84			



Note: Greater score indicates stronger endorsement on stereotypical gender norms and gender traits.

Figure 14. Mean score of agreement to stereotypical gender trait and gender roles, by sex and site.

Other dimensions of gender norms, including stereotypical gender traits and stereotypical roles are presented in Table II.

Stereotypical gender traits were examined in a series of questions contrasting boys' toughness with girls' vulnerabilities. More than half of the students agreed with the statements on stereotypical gender traits, except with 'boys should always defend themselves even if it means fighting' (48% agreed) and 'boys who behave like girls are considered weak' (43% agreed).

Boys show higher endorsement on norms that indicate boys' toughness over girls' vulnerabilities, as well as males' authority in the household.

A summary measure across all items (with high internal reliability Chronbach alpha=0.80) indicates an average score of 3.87, which varied from 3.83 to 3.93 across sites, suggesting more traditional norms in Bandar Lampung than other sites.

endorsing the series of items portraying the division of gender roles as well as male authority in the household. A summary score ranging from 1 to 5 with high internal reliability (Cronbach alpha=0.87) shows an average score of 3.85, higher in Bandar Lampung than in the 2 other sites.

The majority of students endorsed stereotypical gender roles, with 52% to 68%

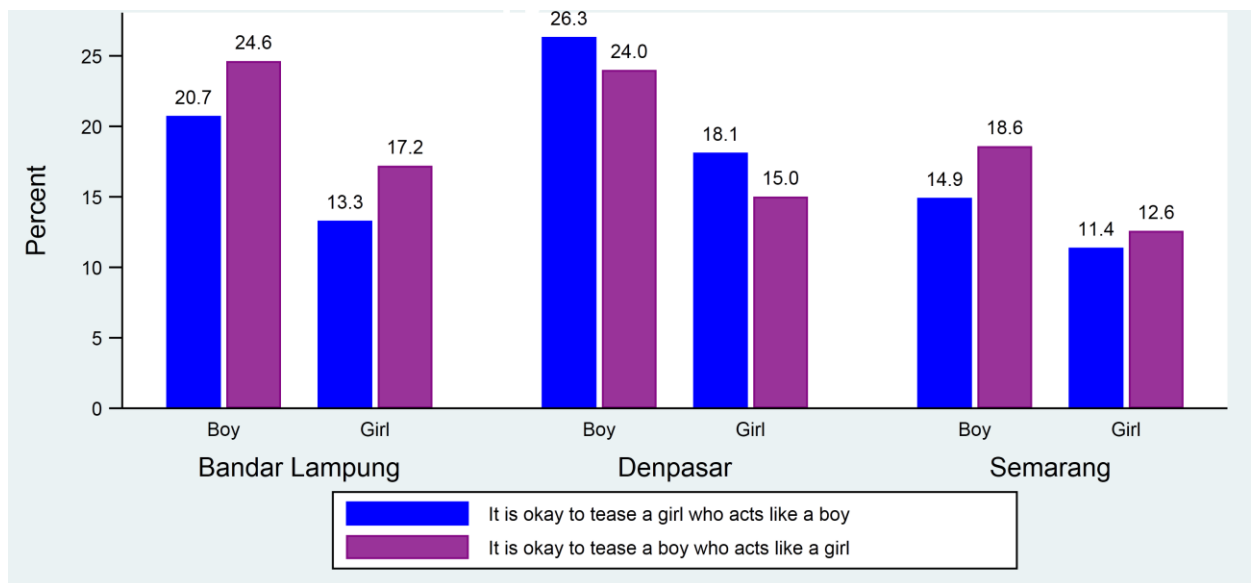


Figure 15. Acceptance to gender-based teasing by sex and site.

Finally, 18% of students agreed that it was okay to tease a girl who acted like a boy or a boy who acted like a girl. Perceptions of stereotypical gender traits were consistently higher among boys than girls (scores 3.91 versus 3.83, respectively) while no

differences were noted with respect to stereotypical gender roles. Likewise, boys were more likely to approve of teasing behaviors against adolescents with atypical gendered behavior.

Table 11. Agreement with stereotypical gender traits and roles and social sanction for challenging stereotypical gender roles among GEAS participants, by sex.

Gender Norms Concept	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Stereotypical gender traits: toughness versus vulnerability (% agree)				
Boys should always defend themselves even if it means fighting.	47.8	55.6	41.0	<0.001
It's important for boys to show they are tough even if they are nervous inside.	50.6	55.6	46.1	<0.001
Boys who behave like girls are considered weak.	42.9	46.4	39.9	<0.001
Boys should be raised to be tough so can overcome any difficulties in life	77.3	77.2	77.4	0.86
Girls are expected to be humble.	72.0	71.4	72.6	0.39
Girls should avoid raising their voice to be lady like.	61.6	65.4	58.2	<0.001
Girls need their parents' protection more than boys.	75.5	71.6	78.9	<0.001
Mean Score	3.87 (0.72)	3.91 (0.78)	3.83 (0.67)	<0.001
Cronbach's Alpha	0.80			
Stereotypical gender roles (% agree)				
A woman's role is taking care of her home and family.	64.5	60.9	67.7	<0.001
A man should have the final word about decisions in the home.	51.7	56.0	47.9	<0.001
A woman should obey her husband in all matters.	55.1	56.6	53.7	0.040
Men should be the ones who bring money home for the family, not women.	68.3	67.1	69.4	0.098
Mean Score*	3.85 (0.99)	3.87 (1.05)	3.84 (0.93)	0.27
Cronbach's Alpha	0.87			
Sanctions for challenging gender roles				
It is okay to tease a girl who acts like a boy.	17.6	21.1	14.4	<0.001
It is okay to tease a boy who acts like a girl.	18.5	22.5	14.9	<0.001

Table 12. Gender norms indicators by sex and sites.

Gender Norms Concept	Bandar Lampung		Denpasar		Semarang	
	Boys	Girls	Boys	Girls	Boys	Girls
Communication style	1.39(0.78)	0.98 (0.89)	1.60 (0.70)	1.10 (0.89)	1.55 (0.74)	0.95 (0.87)
Peer social inclusion for gender a-typical peers	1.02 (0.87)	1.07 (0.88)	1.24 (0.84)	1.40(0.81)	0.87 (0.87)	1.00 (0.88)
Acceptance of Romantic Relationships	3.50 (1.20)	2.83(1.14)	3.65(0.96)	3.29 (0.92)	3.33 (0.99)	3.0 (0.91)
Sexual Double Standard	2.75 (1.12)	2.46 (1.03)	2.70 (0.93)	2.74 (0.95)	2.49 (0.88)	2.67 (0.97)
Stereotypical gender traits						
Mean Score	3.95(0.94)	3.91 (0.73)	3.94 (0.71)	3.78 (0.66)	3.86 (0.68)	3.80 (0.61)
Stereotypical gender roles						
Mean Score*	3.74 (1.23)	3.89 (1.10)	3.83 (0.97)	3.72 (0.87)	4.04 (0.94)	3.93 (0.83)
Sanctions for challenging gender roles						
It is okay to tease a girl who acts like a boy.	20.7%	13.3%	26.3%	18.1%	14.9%	11.4%
It is okay to tease a boy who acts like a girl.	24.6%	17.2%	24.0%	15.0%	18.6%	12.6%

Conclusion

- In early adolescence, boys and girls already perceive a number of gender unequal norms related to gender relations, stereotypical norms and traits.
- Acceptability of romantic relationships is split in early adolescence, and a significant percentage of adolescents recognize a sexual double standard rewarding boys but penalizing girls for engaging in romantic relations.
- A majority of adolescents endorse male toughness over female vulnerability, and many recognize a division of roles and power between the sexes within the household.
- Perceptions of gender norms depend on the social context and are generally more traditional in Bandar Lampung and Semarang than in Denpasar. These perceptions also differ by sex, as boys typically embrace more unequal norms about relationships and gender traits.
- Gender is also manifested in different behaviors between boys and girls as boys are more direct than girls in communicating their romantic interest, while girls are more socially inclusive and less likely to sanction atypical gender behaviors.

3.4. Empowerment

This section describes empowerment which is measured through three components, namely freedom of movement, voice and decision-making. In Indonesia, The GEAS also measured teenagers' aspirations regarding education, marriage and reproduction as well as their ability to plan their future. This information provides valuable points for stakeholders to formulate steps that can help youth to realize their dreams in the future.

Snapshots of young people's empowerment

Boys

have greater freedom of movement than girls; but girls are able to voice their opinion or concern and to offer advice more often than boys.

Girls

have identified their goals and value their goals more than boys.

Intentions

to marry, to have a child, and to work are almost universal in both boys and girls; and the majority intend to do so after age 20, as most of the students aspire to go to university.

Only a few students feel confident

about discussing contraception, about obtaining information on pregnancy prevention, and about obtaining contraception if needed; boys are more confident to do so than girls.

Table 13 and Table 14 displays the three empowerment subscales as well as planfulness for the future, and a measure of self-confidence. Each empowerment component forms a subscale comprising

several questions. Internal reliability of each subscale ranged from 0.69 for the freedom of movement and decision making subscales to 0.84 for the voice subscale.

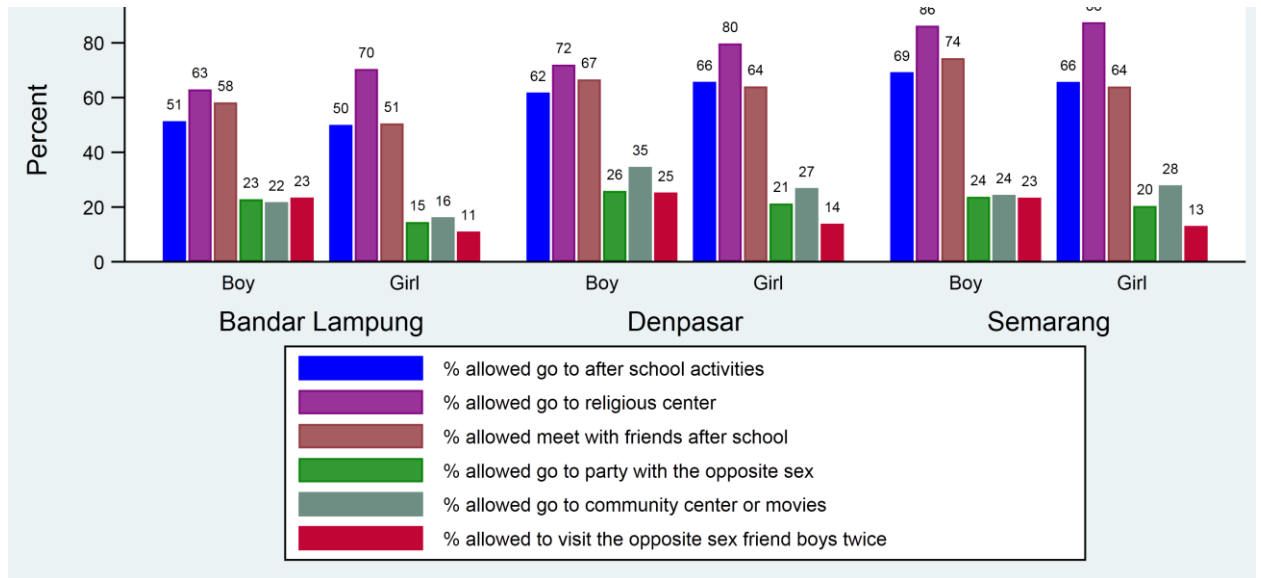


Figure 16. Adolescents’ perception of their freedom of movement by sex and site.

The students were asked how often they are allowed to meet with friends after school, go to a party with friends, visit a friend from the opposite sex, go to the community center or movies without adult supervision, or go to a religious center without adult supervision. A majority of adolescents were free to do school and religion-related activities, but few indicated they could meet or do activities with opposite sex friends. As a result, the freedom of movement score averaged 2.45, with higher scores noted in Semarang (2.51) compared to Denpasar (2.43) and Bandar Lampung (2.40). However, students in Denpasar were more likely to meet opposite sex friends and go to parties than in other sites. These results need careful interpretation based on local context, as restricted mobility may also signal lack of neighborhood safety.

A majority of adolescents were free to do school and religion-related activities, but few indicated they could do recreational activities or meet with opposite sex friends. The percentages were lower among girls compared to boys.

Adolescents scored higher on the voice than the freedom of movement subscale suggesting greater capacity to be heard than to circulate freely. The voice subscale included 7 items exploring young people ability to express their thoughts with peers, family members or at school and their ability to be heard. Voice scores were higher in Denpasar and Semarang (2.91 and 2.92, respectively) than in Bandar Lampung (2.79).

Adolescents ability to decide on daily activities (eat, clothing activities and friends) were summarized in a 4 items subscale, averaging 2.80 across sites. Decision making over daily activities was higher in Denpasar

and Semarang (2.84 and 2.82 versus 2.72 in Bandar Lampung, respectively).

Approximately a third (37%) of students reported that they were able to decide on clothing outside of school (or workplace); while up to 66% indicated they could decide who could be their friend. Other decisions related to education, who and when to marry were mostly in the hands of adults with a little more than 1 in 10 adolescents indicating that they would be able to influence these decisions. Control over economic decisions were low in terms of decision to work (30%) but higher with respect to spending money (70%).

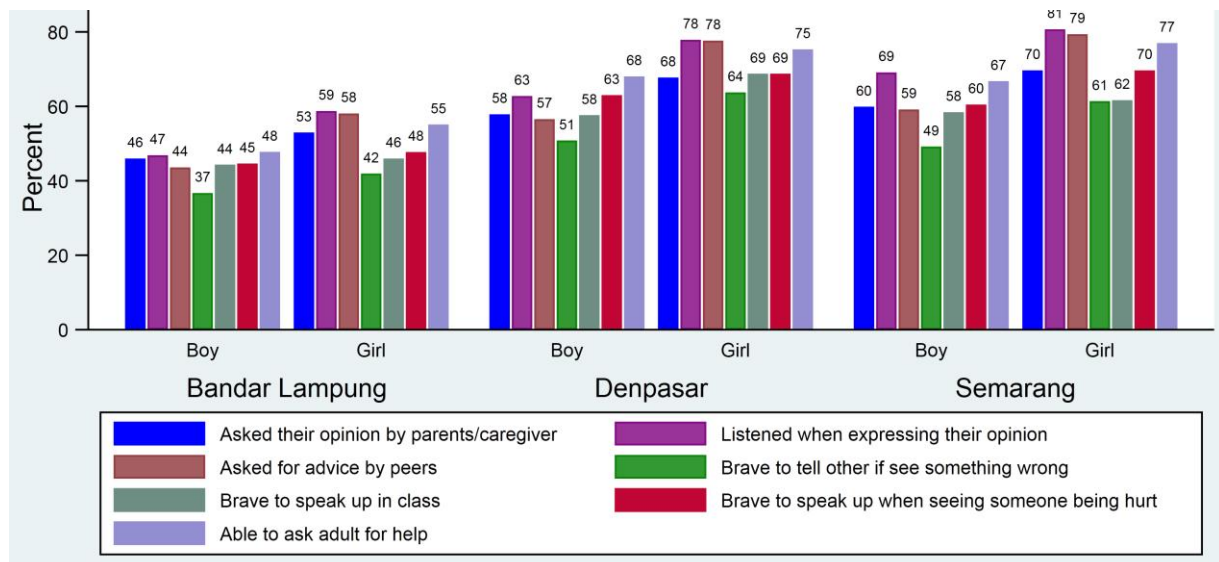


Figure 17. Adolescents’ perception about their ability to voice their opinion/thought, by sex and site.

In all three dimensions of empowerment, a number of gender differences were noted, with lower freedom of movement but higher voice and decision making among girls compared to boys. Boys, on the other hand, were more likely to believe they could influence decisions about marriage or education although their decision-making power remained low.

The questions about student’s planfulness and confidence were specific to

Indonesia. The mean score of planfulness was the highest in Semarang (3.60) compared to Bandar Lampung and Denpasar (3.32 and 3.46, respectively). Only a small percentage of students thought they would feel confident talking to a boyfriend or girlfriend about contraception (7%), obtaining information on pregnancy prevention (12%), or getting contraception if they needed it (10%); Only 22% of adolescents thought they would be confident telling someone that they liked them while

45% thought they would be confident telling someone no if they were doing something that they did not want to do. Adolescents in

Bandar Lampung were notably different than their peers with lower confidence levels than Denpasar or Semarang.

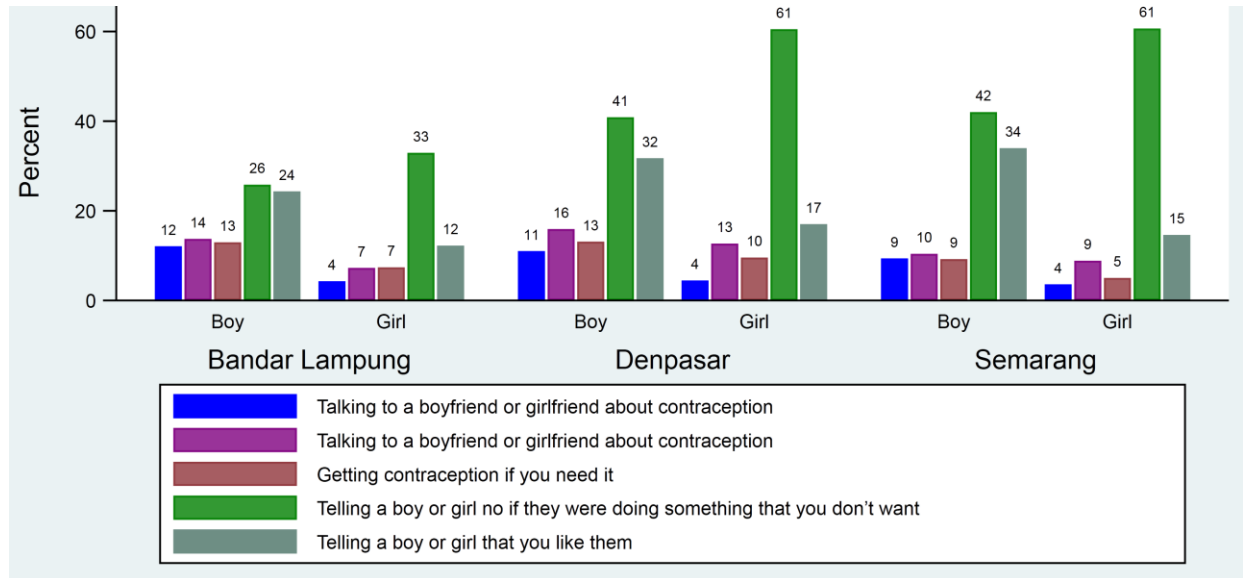


Figure 18. Adolescents’s confidence to talk about reproductive issues and obtain reproductive service, by sex and site.

Gender difference were also notable, with boys reporting greater confidence in discussing, obtaining information about or obtaining contraception than girls. Boys were also more confident in telling a girl about their feelings while girls had a higher mean score of planfulness and felt more confident in saying no when someone was doing something they didn’t like.

more prevalent in Denpasar (at 52% and 71% respectively, versus 38% and 53% in Bandar Lampung and 40% and 66% in Semarang), while marriage and childbearing before the age of 21 was more commonly expected in Bandar Lampung (12% and 11% respectively, versus less than 4% for both variables in Denpasar and Semarang).

Adolescent aspirations to marry and have children are presented in Table 14. These aspirations were almost universal with 96% hoping to marry and 93% intending to have children. More than half of adolescents expected to marry by the age of 25 and 35% expected to have children by the same age. Marriage and childbearing after 25 years was

Almost all adolescents expected to be employed starting between 21 and 25 years, an age at which two thirds indicated they would be finished with school. Expectations of early school leaving before 18 was very uncommon (5%), although more frequently expected in Bandar Lampung (12%) than in Denpasar (4%) and Semarang (1%).

Table 13. Empowerment related to their freedom of movement, freedom of speech, and freedom of decision making of GEAS participants, by sex.

Empowerment	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Freedom of Movement				
% allowed go to after school activities	2856 (61.0%)	1345 (60.9%)	1511 (61.0%)	0.97
% allowed go to religious center	3597 (76.8%)	1626 (73.7%)	1971 (79.6%)	<0.001
% allowed meet with friends after school	2953 (63.0%)	1467 (66.5%)	1486 (60.0%)	<0.001
% allowed go to party with the opposite sex	1005 (21.5%)	536 (24.3%)	469 (18.9%)	<0.001
% allowed go to community center or movies	1205 (25.7%)	609 (27.6%)	596 (24.1%)	0.006
% allowed to visit the opposite sex friend	849 (18.1%)	533 (24.2%)	316 (12.8%)	<0.001
Mean Score (Mean +/- SD)	2.45 (0.65)	2.54 (0.69)	2.38 (0.61)	<0.001
Cronbach's Alpha	0.687	0.703	0.660	
Freedom of Speech				
Asked their opinion by parents/caregiver	2795 (59.7%)	1211 (54.9%)	1584 (63.9%)	<0.001
Listened when expressing their opinion	3132 (66.9%)	1322 (59.9%)	1810 (73.1%)	<0.001
Asked for advice by peers	2971 (63.4%)	1179 (53.4%)	1792 (72.3%)	<0.001
Brave to tell other if see something wrong	2413 (51.5%)	1016 (46.0%)	1397 (56.4%)	<0.001
Brave to speak up in class	2662 (56.8%)	1188 (53.8%)	1474 (59.5%)	<0.001
Brave to speak up when seeing someone being hurt	2804 (59.9%)	1250 (56.6%)	1554 (62.7%)	<0.001
Able to ask adult for help	3086 (65.9%)	1357 (61.5%)	1729 (69.8%)	<0.001
Mean Score (Mean +/- SD)	2.88 (0.72)	2.76 (0.77)	2.99 (0.65)	<0.001
Cronbach's Alpha	0.838	0.852	0.815	
Freedom of Decision Making				
<i>Able to decide.... without adult intervention</i>				
Type of clothes to wear outside school	1750 (37.4%)	814 (36.9%)	936 (37.8%)	0.52
Activity during free times	2648 (56.5%)	1211 (54.9%)	1437 (58.0%)	0.030
Food to eat outside home	2720 (58.1%)	1216 (55.1%)	1504 (60.7%)	<0.001
Having friends	3085 (65.9%)	1419 (64.3%)	1666 (67.3%)	0.033
<i>Able to influence decision about....</i>				
Leave school	564 (12.0%)	302 (13.7%)	262 (10.6%)	0.001
When to marry	587 (12.5%)	313 (14.2%)	274 (11.1%)	0.001
Who to marry	643 (13.7%)	334 (15.1%)	309 (12.5%)	0.008
<i>Working and earn money</i>				
Make decision to work	1544 (34.8%)	794 (37.8%)	750 (32.1%)	<0.001
Decide how to use the money	2354 (70.7%)	1133 (70.2%)	1221 (71.1%)	0.56
Mean Score (Mean +/- SD)	2.80 (0.80)	2.75 (0.84)	2.85 (0.77)	<0.001
Cronbach's Alpha	0.694	0.707	0.679	
Overall Empowerment				
Mean Score (Mean +/- SD)	2.65 (0.59)	2.62 (0.64)	2.68 (0.55)	<0.001

Table 14. Planfulness and aspiration for education, marriage and reproductive life of GEAS participants, by sex.

Planfulness	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Planfulness (very like me or exactly like me)				
I made a step plan to achieve my goals	1488 (31.8%)	685 (31.0%)	803 (32.4%)	0.31
I have goals in my life	3034 (64.8%)	1298 (58.8%)	1736 (70.1%)	<0.001
I will do what it takes to achieve my goals	2910 (62.1%)	1266 (57.4%)	1644 (66.4%)	<0.001
It is important to achieve my goals	3119 (66.6%)	1323 (59.9%)	1796 (72.5%)	<0.001
I know how to realize my plan	1847 (39.4%)	849 (38.5%)	998 (40.3%)	0.20
Mean score	3.46 (0.92)	3.34 (1.01)	3.57 (0.82)	
Cronbach's Alpha	0.87	0.89	0.85	
Age at which will end school				<0.001
<18 years old	136 (5.3%)	121 (9.2%)	15 (1.2%)	
18-20 years old	498 (19.6%)	315 (24.0%)	183 (14.9%)	
21-25 years old	1065 (41.8%)	485 (36.9%)	580 (47.1%)	
>25 years old	847 (33.3%)	393 (29.9%)	454 (36.9%)	
Intends to get married	2490 (96.1%)	1184 (94.1%)	1306 (98.0%)	<0.001
Intended Age at marriage				<0.001
<18 years old	12 (0.6%)	12 (1.3%)	0 (0.0%)	
18-20 years old	89 (4.8%)	55 (6.1%)	34 (3.6%)	
21-25 years old	929 (50.0%)	440 (48.7%)	489 (51.2%)	
>25 years old	829 (44.6%)	397 (43.9%)	432 (45.2%)	
Intend to have children	1947 (93.4%)	967 (90.7%)	980 (96.2%)	<0.001
Intended age at first birth				<0.001
<18 years old	31 (2.2%)	28 (3.8%)	3 (0.4%)	
18-20 years old	35 (2.4%)	27 (3.7%)	8 (1.1%)	
21-25 years old	437 (30.4%)	219 (30.1%)	218 (30.7%)	
>25 years old	934 (65.0%)	454 (62.4%)	480 (67.7%)	
Intended number of children				<0.001
<=2 children	1187 (76.2%)	550 (71.5%)	637 (80.8%)	
3-5 children	349 (22.4%)	202 (26.3%)	147 (18.7%)	
>5 children	21 (1.3%)	17 (2.2%)	4 (0.5%)	
Intend to get a job	2657 (97.1%)	1305 (95.5%)	1352 (98.7%)	<0.001
Intended Age at first employment				0.007
<18 years old	68 (3.4%)	44 (4.5%)	24 (2.4%)	
18-20 years old	483 (24.2%)	256 (26.0%)	227 (22.4%)	
21-25 years old	971 (48.6%)	452 (45.8%)	519 (51.2%)	
>25 years old	477 (23.9%)	234 (23.7%)	243 (24.0%)	
<i>Additional indicators from Indonesia specific question</i>				
Felt confident				
Talking to a boyfriend or girlfriend about contraception	341 (7.3%)	239 (10.8%)	102 (4.1%)	<0.001
Obtaining information on prevention of pregnancy	541 (11.5%)	299 (13.5%)	242 (9.8%)	<0.001
Getting contraception if you need it	445 (9.5%)	262 (11.9%)	183 (7.4%)	<0.001
Telling a boy or girl no if they were doing something that you don't want	2104 (44.9%)	809 (36.7%)	1295 (52.3%)	<0.001
Telling a boy or girl that you like them	1032 (22.0%)	666 (30.2%)	366 (14.8%)	<0.001

Conclusion

- Girls have a higher overall empowerment score than boys, although these gender differences complexify when examining empowerment in different spheres of adolescent lives.
- Young people have freedom to pursue school activities or religion-related activities but have less freedom to attend recreational activities and to interact with opposite sex peers without adult supervision. Girls are more restricted in this matter than boys.
- On the other hand, girls are able to voice their opinion and concern, to offer advice to other people, and to make daily decisions on their own more often than boys.
- Few early adolescents think that they can influence decisions about their future education and marriage.
- Girls are more likely to set goals, value their goals, and determined to achieve their goals than boys. However, both sexes seldom have concrete plans to achieve their goals.
- Both boys and girls have high educational and family aspirations, hoping to find a job and marry mostly between 21 and 25 years. Two thirds of adolescents hope to delay age at first birth after the age of 25.
- Adolescents in Bandar Lampung were less likely to freely move, voice their opinion, and participate in decision-making about their daily activities and their future, compared to their peers in Denpasar and Semarang.

3.5. Bullying and Adverse Childhood Experiences (ACEs)

This section describes adverse childhood experiences (ACEs), which are stressful or traumatic experiences including violence, neglect, family dysfunction, domestic violence, and family drug abuse. Such experiences have a significant impact on future victimization and violence perpetration, and more broadly on the health and lifetime opportunities of adolescents.

Snapshots of adverse childhood experiences

78%

have experienced at least one adverse experience such as child abuse or neglect, household economic challenges, and exposure to other adult behavioral challenges in their lifetime.

16%

have ever experienced physical bullying by their peers, and 11% and 12% have ever perpetrated verbal and physical bullying against their peers, respectively, in the last 6 months.

54%

have ever experienced verbal abuse and teasing by an adult. Twenty-one percent of students experienced five or more ACEs and the percentage is much higher in boys (27%) than girls (16%).

Boys

consistently reported verbal and physical abuse and violence more often than girls.

Adolescent's experience of adverse child events are reported in Table 15. Results indicate that almost 2 in 5 had been exposed to at least three adverse experiences, while one in five adolescents reported five or more ACEs which is extremely high. These estimates varied by site. Experience of at least an ACEs was less common in Bandar Lampung (61% versus 81% in Denpasar and 82% in Semarang). The percentages who reported five or more ACEs are similar in the three sites (19-23%).

The most frequently reported adverse events related to verbal abuse by an adult (54%) or feelings of not being loved or cared for (45%). About a third of students reporting having felt scared as a child of being physically abused by a parent or adult

and the same percentage had ever feel have no one to protect. Over one in five adolescents reported they had not had enough food (23%) at some point in their lives. Additionally, 12% indicated that they had been touched by an adult in their private parts and 4% said had been invited or forced to have sexual intercourse by adults. Other experiences such as parent incarceration or house eviction were rare. Experiences of economic hardship (not having enough food, house eviction) and parent incarceration were more common in Bandar Lampung while physical physical violence victimization and witnessing domestic violence were more common in Denpasar. Feelings of neglect (feeling unloved or having no one that protects them) were highest in Semarang.

Exposure to at least three adverse experiences will significantly influence adolescent health and wellbeing. Results indicate that almost 2 in 5 adolescents had been exposed to at least three ACEs, while one in five adolescents reported five or more ACEs.

Girls were more likely to report any adverse experience, but boys were more likely to report 5 or more ACEs (27%) compared to 16% of girls. Girls were more likely to indicate they felt not loved or cared about while boys were more likely to report any other adverse event, except feeling like they have no one protecting them which was equally reported by boys and girls. We found noticeable gender differences in sexual abuse, more commonly reported by boys than girls: 18% had ever been touched versus 6% of girls and 7% reported a forced sex versus 2% of girls. Overall findings on adverse events are in line with research conducted by Duker et al. (2010) which states that male adolescents are more likely to be victim of physical abuse, carry weapons more

frequently and are more likely injured. However, results related to sexual abuse are surprising as prevalence is generally higher among girls than among boys.

Peer aggression and bullying are also presented in Table 15. A little more than one in ten adolescents (12%) reported in the last 6 months to have ever been slapped or kicked by a peer and 11% bullied or threatened someone. These experiences were notably different in the three sites. Teasing and physical violence perpetration or victimization were most common in Semarang. Boys were more likely to engage in these behaviors or be the victims of violence compared to girls.

Table 15. Adverse childhood experiences (ACEs) and experience of being the victim or perpetrator of bullying and physical violence among GEAS participants, by sex.

Abuse, Interpersonal Violence Experience	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
ACEs				<0.001
No Experiences	1022 (21.8%)	446 (20.2%)	576 (23.3%)	
History of 1-2 ACEs	1538 (32.8%)	659 (29.9%)	879 (35.5%)	
History of 3-4 ACEs	1151 (24.6%)	514 (23.3%)	637 (25.7%)	
History of 5 or more ACEs	973 (20.8%)	588 (26.6%)	385 (15.5%)	
The ACEs items (ever):				
Feeling unloved	2103 (44.9%)	923 (41.8%)	1180 (47.6%)	<0.001
Feeling have no one that protects them	1392 (29.7%)	663 (30.0%)	729 (29.4%)	0.65
Experience of physical violence victimization by drunk adults/caregiver	423 (9.0%)	315 (14.3%)	108 (4.4%)	<0.001
Experience of having not enough food	1097 (23.4%)	637 (28.9%)	460 (18.6%)	<0.001
Experience of witnessing your mother beaten, threaten, and hurt	533 (11.4%)	302 (13.7%)	231 (9.3%)	<0.001
Having jailed father/mother	163 (3.5%)	135 (6.1%)	28 (1.1%)	<0.001
Experience of expelled from home	196 (4.2%)	150 (6.8%)	46 (1.9%)	<0.001
Experience of touched in private body by adults	542 (11.6%)	402 (18.2%)	140 (5.7%)	<0.001
Experience of invited or forced for having sexual intercourse by adults	203 (4.3%)	159 (7.2%)	44 (1.8%)	<0.001
Afraid will be hurt by parents or other adult	1520 (32.5%)	751 (34.0%)	769 (31.0%)	0.030
Experience of verbal violence and teasing by adult	2541 (54.2%)	1232 (55.8%)	1309 (52.8%)	0.041
Teasing				
Ever been teased during the last six months by girls	1361 (29.1%)	571 (25.9%)	790 (31.9%)	<0.001
Ever been teased during the last six months by boys	1974 (42.1%)	1000 (45.3%)	974 (39.3%)	<0.001
Ever been teased during the last six months	2253 (48.1%)	1114 (50.5%)	1139 (46.0%)	0.002
Reason to be teased				
Due to their sex	766 (33.8%)	417 (37.1%)	349 (30.6%)	0.001
Behave like the opposite sex	357 (15.8%)	157 (14.0%)	200 (17.5%)	0.024
Bullying (ever)				
In the last 6 months...				
Experience of witnessing friend/peer bullying	2112 (45.1%)	1130 (51.2%)	982 (39.6%)	<0.001
Experience of witnessing friend/peer physical fight	2139 (45.7%)	1185 (53.7%)	954 (38.5%)	<0.001
Experience of physical violence victimization by peers	751 (16.0%)	527 (23.9%)	224 (9.0%)	<0.001
Engaged in physical violence perpetration with peers	581 (12.4%)	372 (16.9%)	209 (8.4%)	<0.001
Engaged in bullying or threatening peers	517 (11.0%)	367 (16.6%)	150 (6.1%)	<0.001
Bystander intervention				
Tried to intervene peer bullying	1513 (61.2%)	666 (60.1%)	847 (62.0%)	0.34
Self-Defense				
Ever carry a weapon for protection	969 (41.0%)	504 (43.2%)	465 (38.8%)	0.031

Note: Gender Based Violence (GBV)

Conclusion

- The majority of adolescents have ever experienced at least an adverse experience during childhood, mostly in the form of neglect and poverty.
- Many students also have ever been verbally teased or abused by an adult, or have been teased by their peers in the last six months.
- Polyvictimization is more common among boys who are also more likely to be the subject of sexual abuse.
- While the majority of girls do not experience or engage in peer bullying and physical violence, a substantial percentage of boys have been the victim or perpetrator of peer bullying and physical violence.

3.6. Adolescent Health

3.6.1. Self-Rated Health, Body Image, and Body comfort

This section describes young people's perceived health, and their levels of comfort with their own bodies and pubertal development. These perceptions are shaped by gender norms and are associated with health-related behaviors including nutrition (such as diet, eating disorders, obesity, malnutrition, anemia, anxiety and others) and sexual behaviors. In many situations, the norms regarding body size are related to the incidence of bullying and victimization.

Snapshots of adolescent health

68%

reported that their health is excellent or good.

Boys

are more likely to report excellent or good health than girls.

Majority

of students are not satisfied with their current weight or height and many are uncomfortable with their body image.

Majority

of students (74-80%) disagreed with the three negative statements about their body i.e. they were worried about the way their body looked, they often wished their body was different, and they were worried that their body was not developing normally.

Self-rated health (SRH) is a component of the GEAS that assesses self-rating of individual’s physical health. This tool is a measure commonly used in adolescent research and has been found to be a reliable and valid indicator of physical and mental function. In addition, this tool is sensitive enough to measure public health in terms of

monitoring the effects of large-scale socio-economic events (Lachytova et al., 2017). Adolescents' perceptions of how healthy they are had been shown to be related to many medical related factors (eg. physical activity), psychological, social and lifestyle of adolescents (Granger et al., 2017, Lachytova et al., 2017).

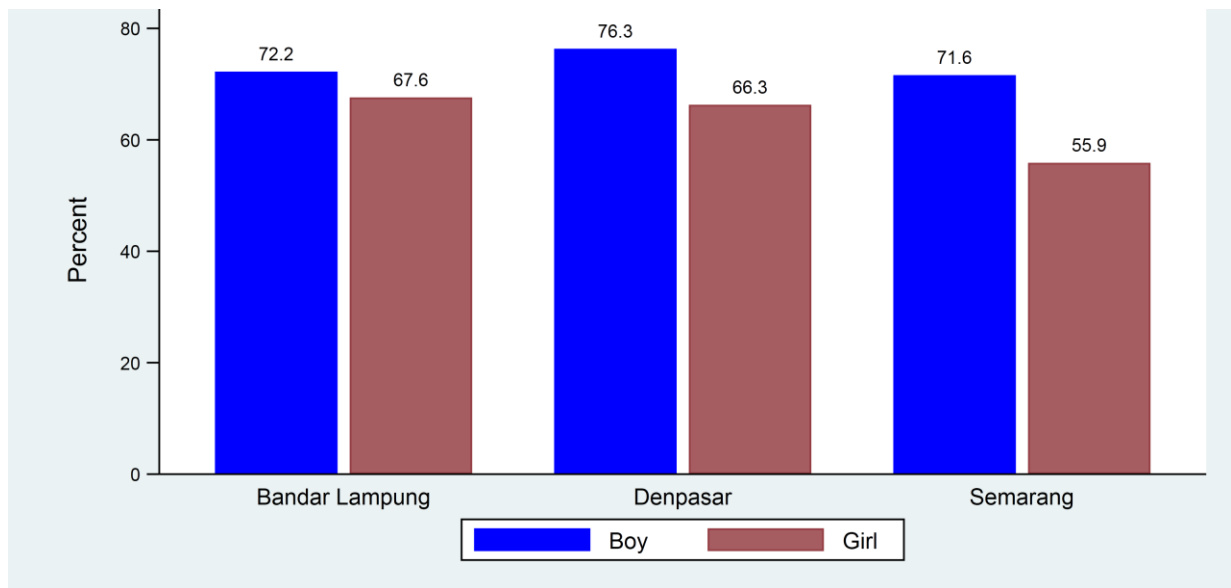


Figure 19. Percentage of adolescents who self-reported excellent or good health, by sex and site.

Table 16 displays the findings related to self-rated health, body image, and body comfort. Sixty-eight percent of students reported that their health was excellent or good (which by international comparisons is quite low); 37% thought they were the right weight, 33% thought they were the right height, and 54% thought they were growing at the same rate as their peers. More than half of students agreed with the three positive statements about their body i.e. they were satisfied with their body, they liked the way they look, and they felt like they were beautiful/handsome.

Majority of students disagreed with the three negative statements about their body. But boys were more likely than girls to report good/excellent health and agree with the positive statements about their body.

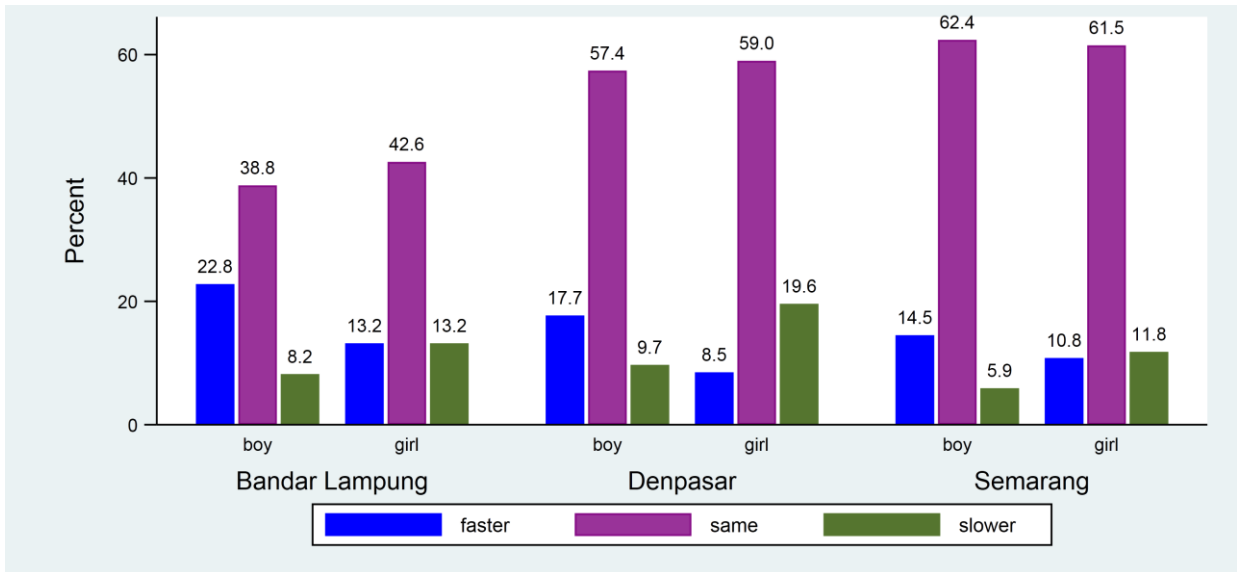


Figure 20. Adolescents’ perception about their body maturation/changes compared with peers by sex and site.

Conversely, the majority of students (74-80%) disagreed with the three negative statements about their body i.e. they were worried about the way their body looked, they often wished their body was different, and they were worried that their body was not developing normally. Positive perceptions about body image was similar across sites while adolescents in Bandar Lampung were more likely to be concerned about their body growth and height/weight.

Boys were more likely than girls to report good/excellent health and agree with the positive statements about their body. Boys were also more likely to think that they

are too thin, too tall, or grew faster than their peers.



Table 16. Adolescents' perception about their health, body comfort and body image by sex.

Perception	Total	Boys %	Girls %	P-value
N	6,184	2,207	2,477	
Overall perception of own health (good or excellent)	3 190 (68.1%)	1 625 (73.6%)	1 565 (63.2%)	<0.001
Body image				
Self perception about body weight				<0.001
Think they are too thin	1 478 (32.6%)	752 (35.4%)	726 (30.2%)	
Right weight	1 670 (36.8%)	755 (35.5%)	915 (38.0%)	
Think they are too fat	1 385 (30.6%)	619 (29.1%)	766 (31.8%)	
Self perception about body height				<0.001
Think they are too tall	2 240 (49.0%)	1 120 (52.1%)	1 120 (46.2%)	
Right height	1 484 (32.5%)	672 (31.3%)	812 (33.5%)	
Think they are too short	846 (18.5%)	356 (16.6%)	490 (20.2%)	
Self perception about the development of the body				<0.001
Faster than peers	667 (14.2%)	403 (18.3%)	264 (10.7%)	
Same with peers	2 536 (54.1%)	1 176 (53.3%)	1 360 (54.9%)	
Slower than peers	550 (11.7%)	178 (8.1%)	372 (15.0%)	
Body Comfort				
% positivity (agree) towards "I am satisfied with my body"	2 583 (55.1%)	1 407 (63.8%)	1 176 (47.5%)	<0.001
% positivity (agree) towards "I like the way I look"	2 748 (58.7%)	1 448 (65.6%)	1 300 (52.5%)	<0.001
% positivity (agree) towards "I like looking at my body"	1 725 (36.8%)	949 (43.0%)	776 (31.3%)	<0.001
% positivity (agree) towards "I feel like I am beautiful/handsome"	2 543 (54.3%)	1 289 (58.4%)	1 254 (50.6%)	<0.001
% negativity (disagree) towards "I worry about the way that my body looks"	3 745 (80.0%)	1 731 (78.4%)	2 014 (81.3%)	0.014
% negativity (disagree) towards "I often wish my body was different"	3 471 (74.1%)	1 726 (78.2%)	1 745 (70.4%)	<0.001
% negativity (disagree) towards "I am worried that my body is not developing normally"	3 451 (73.7%)	1 551 (70.3%)	1 900 (76.7%)	<0.001
Indicated body comfort (positive responses on all above items)	77 (1.6%)	46 (2.1%)	31 (1.3%)	0.025

3.6.2. Depression Symptoms and Substance Abuse

Adolescence is a period of dramatic physical, psychological, and social changes which can prove stressful. According to WHO, mental health problems account for 16% of the disease burden for the 10-19 year age group. Globally, depression is one of the main causes of illness and disability among adolescents. Unfortunately, adolescent mental health problems are often neglected due to lack of data and/or available services. Mental health during adolescence not only affects their health and well being but also impedes their social development and thus affects health and well-being throughout their lives. In this section, we report the prevalence of adolescent depressive symptoms. In addition, we also describe substance use including tobacco/cigarettes, alcohol and drug use.

Snapshots of adolescent mental health

50%

of students worry for no good reason; 32% are so unhappy they can not sleep at night and 20% are so unhappy they think of harming themselves.

Boys

were generally more likely to report depressive symptoms compared to girls.

16%

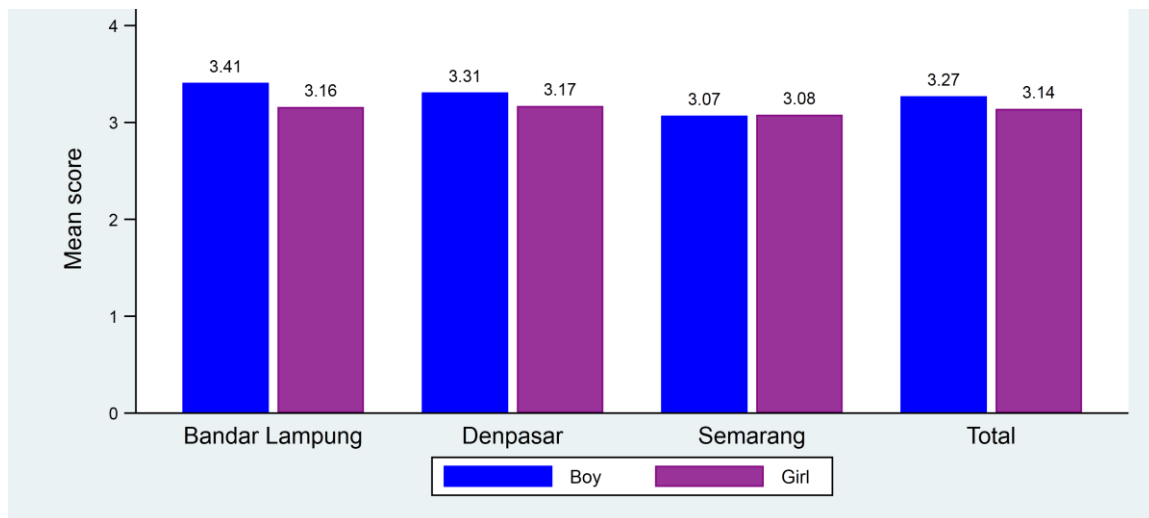
of boys have ever smoked tobacco cigarettes; only 1% of girls have smoked cigarettes.

Alcohol, marijuana, and other drugs

use are very low among the students.

The GEAS included 6 statements related to depressive symptoms presented in Table 17. Depressive symptoms were prevalent with half of the students indicating that they were worried for no good reason and almost a third reporting they felt sad or felt so unhappy they could not sleep at night.

Almost one in five adolescents indicated that they felt so unhappy they had thought of harming themselves. A summary score of these symptoms from 0 to 4, showed relatively high score of 3.20 with higher scores in Bandar Lampung (2.93) than in Denpasar (2.89) and Semarang (2.72).



Note: Score range is 1-5, 5 indicating strongest affirmation for symptoms.

Figure 21. Mean score of self-reported depressive symptoms (from 4 question items), by sex and site.

Boys were generally more likely to report depressive symptoms compared to girls with 36% indicating that they so unhappy they can not sleep at night versus 28% of girls. Similarly, one-in-four boys felt so unhappy they had thought of harming themselves compared to 16% of girls. As a result, boys mean scores for depressive symptoms were significantly higher than girls (3.27 versus 3.14).

Substance use was a highly gendered behavior with greater consumption among boys compared to girls.

Substance use was relatively uncommon ranging from 2% who indicated ever using drugs to 8% indicating that they

had ever smoked. Three percent of adolescents reported ever consuming alcohol; These behaviors varied widely across the three sites, with a greater proportion of smokers in Semarang than Bandar Lampung and Denpasar (28% versus 18% and 5% respectively). Alcohol consumption was more prevalent in Denpasar.

Substance use was a highly gendered behavior with greater consumption among boys compared to girls. For example, 16% of boys ever smoked compared to 1% of girls, 6% used alcohol versus 1% of girls and 2% used other drugs versus 0.5% of girls. These gender differences were consistent across sites, with male smoking reaching 28% in Semarang.

Table 17. Self-reported mental health problems and substance use among GEAS participants, by sex.

Mental Health	Total	Boys %	Girls %	P-value
N	4,526	2,125	2,401	
Depression symptoms (% agree with)				
"In general, I see myself as a happy person"	3275 (71.6%)	1626 (76.0%)	1649 (67.8%)	<0.001
"I blame myself when things go wrong"	2830 (62.2%)	1350 (63.5%)	1480 (61.2%)	0.108
"I worry for no good reason"	2275 (50.3%)	1037 (48.8%)	1238 (51.6%)	0.064
"I am so unhappy I can't sleep at night"	1435 (31.7%)	768 (36.3%)	667 (27.7%)	<0.001
"I feel sad"	1419 (31.4%)	659 (31.2%)	760 (31.6%)	0.80
"I am so unhappy I think of harming myself"	924 (19.7%)	531 (24.1%)	393 (15.9%)	<0.001
Mean Score (Mean +/- SD)*	3.20 (0.77)	3.27 (0.82)	3.14 (0.71)	<0.001
Cronbach's Alpha	0.72	0.74	0.70	
Substance Use (ever)				
Cigarettes	379 (8.1%)	354 (16.0%)	25 (1.0%)	<0.001
Alcohol	151 (3.2%)	128 (5.8%)	23 (0.9%)	<0.001
Marijuana	54 (1.2%)	42 (1.9%)	12 (0.5%)	<0.001
Other Drugs	74 (1.6%)	59 (2.7%)	15 (0.6%)	<0.001

Note: Standard deviation (SD); *(1-5, 5 indicating strongest affirmation for symptoms)

Conclusion

- A substantial percentage of students are not satisfied with their weight or height and are uncomfortable with their body image.
- Anxiety and depressive symptoms are common among the students, including the thought of self-harming. Boys reported some symptoms more commonly than girls.
- A substantial percentage of boys are already exposed to tobacco smoke at young age; however, the use of other substances (alcohol, marijuana, other drugs) is low.

3.7. Sexual and Reproductive Health

3.7.1. Sexual and Reproductive Health Knowledge

This section describes adolescent's knowledge of sexual and reproductive health such as pregnancy and HIV prevention, contraceptive methods and youth-friendly service programs. Sexual and reproductive health information has a crucial role in helping adolescents negotiate matters related to their reproductive health and sexuality. Limited knowledge prevents adolescents from controlling their bodies and avoiding negative sexual health outcomes. This information is critical because knowledge, education and ASRH services attract little attention and mostly taboo as ASRH services are viewed as contrary to morality (IWHC, 2010). To protect virginity before marriage, especially for girls, parents tend to avoid any discussion about SRH, as they believe SRH knowledge may incentivize young premarital sexual experiences. Many parents do not see the need to discuss SRH with their children as they believe young people automatically acquire reproductive health and sexuality information as they age (CRH, 2017). These conceptions prevent adolescents from acquiring the necessary skills to navigate healthy transitions into reproductive life and sexuality.

Snapshots of students' knowledge of sexual health

45%

know that a girl can get pregnant the first time of sexual intercourse, and 33% know that someone can get HIV infection the first time of sexual intercourse.

23%

are aware of an injection to prevent pregnancy and 16% are aware of contraceptive pills. The knowledge about contraceptive methods is higher in boys than girls.

16%

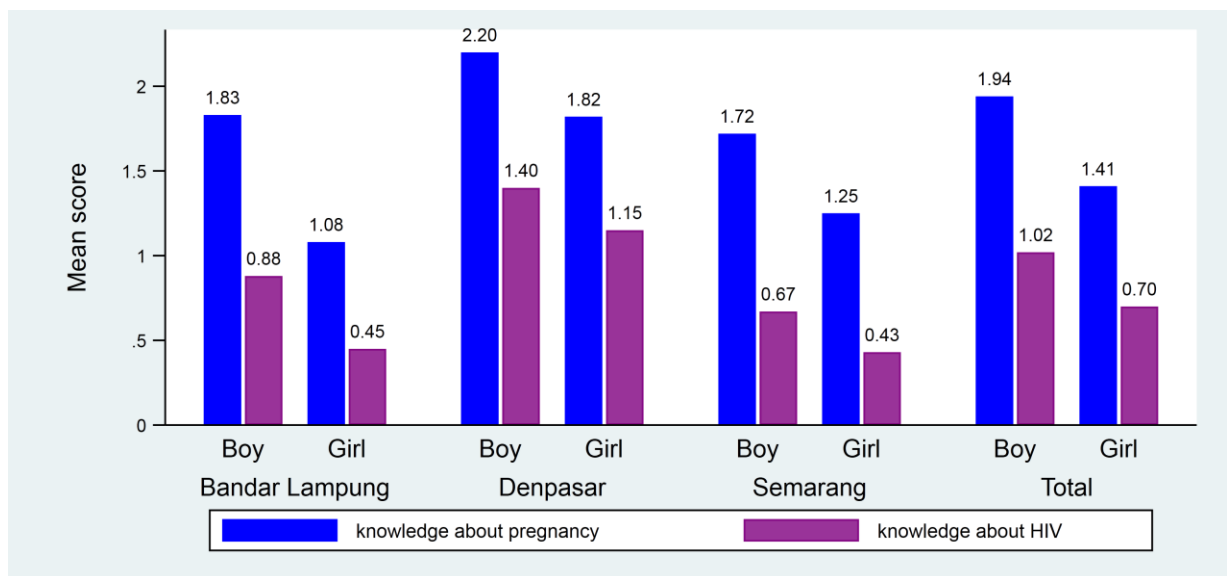
of students know the place to go to get a condom and 19% of girls know the place to get other contraceptive methods.

25%

know about Adolescent Information and Counseling Program (PIK-R), and 31% know about Adolescent Health Service (PKPR)

Students' knowledge of sexual health is presented in Table 18. Students had low levels of knowledge about pregnancy and HIV prevention. Only 45% of students thought a girl could get pregnant at first sexual intercourse; 62% knew girls could not get pregnant through kissing or fondling. Awareness about contraception was also low as only a third of adolescents believed

condoms could prevent pregnancy, 23% knew about injectables and 16% were aware of contraceptive pills as a way to prevent pregnancy. only 19% of girls knew where to get contraception if they needed it but up to a third indicated that they would feel too embarrassed to go to a clinic or health center to get contraception.



Note: Knowledge about Pregnancy range score 0-6; Knowledge about HIV range score 0-4.

Figure 22. Mean score of knowledge on pregnancy and HIV by sex and site.

Knowledge about HIV prevention was also low with a third of adolescents recognizing the risk of HIV at first sexual intercourse, 24% knowing condoms could protect against HIV and 13% believed that taking a pill before sex could protect against HIV. Levels of pregnancy and HIV knowledge varied by study site, with greater awareness in Denpasar than other sites (score of 2.01 for pregnancy knowledge and 1.27 for HIV knowledge versus 1.44 and 0.65 for Bandar Lampung and 1.47 and 0.54 for Semarang, respectively)

Gender differences were also evident as boys had better information about pregnancy and HIV prevention than girls. Differences were particularly striking with respect to knowledge of condom use for

pregnancy and HIV prevention, which was twice as high among boys than girls. Likewise, boys were more likely to know where to get a condom than girls (22.4% versus 8%).

Students had low levels of knowledge about pregnancy and HIV prevention, as well as adolescent-friendly services at center for community health service (PKPR) and youth center (PIK-R).

Girls had lower knowledge about pregnancy, HIV, and contraception than boys.

Consistent with low levels of awareness about condom or contraceptive services, only a quarter of students knew about PIK-R (Center of Information and Counseling for Youth), despite the Indonesian government’s effort to offer these services at more public health centers and in the youth communities (often times in school-based or university-based

organizations). Among who knew about these services, 32% have ever visited PIK-R. More students (31%) were aware of PKPR (Youth Friendly Health Services), offered by the public health center, and 61% of those who knew about PKPR had ever visited it. Students in Denpasar were better informed about PIK-R and PKPR services than their peers in other sites.

Table 18. Knowledge about pregnancy, HIV, contraceptive methods and reproductive health programs among GEAS participants, by sex.

Sexual Health Knowledge	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Knowledge (% correct response to...)				
A girl can get pregnant the first time of sexual intercourse	2096 (44.7%)	1066 (48.3%)	1030 (41.6%)	<0.001
A girl can get pregnant after kissing or hugging	2905 (62.0%)	1236 (56.0%)	1669 (67.4%)	<0.001
A girl can swallow a pill every day to protect against pregnancy	748 (16.0%)	420 (19.0%)	328 (13.2%)	<0.001
Using a condom can protect against pregnancy	1474 (31.5%)	945 (42.8%)	529 (21.4%)	<0.001
A girl can have a shot or injection to protect against pregnancy	1062 (22.7%)	559 (25.3%)	503 (20.3%)	<0.001
A girl can use herbs to prevent a pregnancy	612 (13.1%)	327 (14.8%)	285 (11.5%)	<0.001
Knowledge about Pregnancy (Mean +/- SD)*	1.66 (1.51)	1.94 (1.57)	1.41 (1.42)	<0.001
A boy/girl can get HIV the first time of sexual intercourse	1554 (33.2%)	784 (35.5%)	770 (31.1%)	0.001
Using a condom can protect against HIV	1104 (23.6%)	718 (32.5%)	386 (15.6%)	<0.001
You can get HIV through kissing	3963 (84.6%)	1824 (82.6%)	2139 (86.4%)	<0.001
A girl or boy can swallow a pill before sex that will protect against HIV	589 (12.6%)	360 (16.3%)	229 (9.2%)	<0.001
Knowledge about HIV (Mean +/- SD)**	0.85 (1.05)	1.02 (1.12)	0.70 (0.95)	<0.001
I know where to go to get...				
...condoms	727 (15.5%)	538 (24.4%)	189 (7.6%)	<0.001
...contraception			459 (18.5%)	
I feel embarrassed or shy to...				
...go to a clinic or center for contraception (birth control)			807 (32.6%)	
...get a condom if I needed it		592 (26.8%)		
Adolescent supporting program				
I know about PIK-R	1185 (25.3%)	573 (26.0%)	612 (24.7%)	0.32
I have ever visited PIK-R center	115 (32.1%)	77 (38.7%)	38 (23.9%)	0.003
I know about PKPR	1463 (31.2%)	793 (35.9%)	670 (27.0%)	<0.001
I have ever visited PKPR	234 (60.8%)	167 (64.5%)	67 (53.2%)	0.033

Note: standard deviation (SD), Human Immunodeficiency Virus (HIV), Adolescent Information and Counseling Program (PIK-R), Adolescent Care Health Service (PKPR); *No. correct answer, 6 Qs in-total; ** (No. correct answer, 4 Qs in-total).

3.7.2. Puberty

Early adolescence which is defined as age between 10-14 years old, is one of the most critical stages of human development as marked by dramatic physical, social and cognitive changes. This period is one of the most neglected stages of development, yet resulted fewer knowledge especially on how it influences adolescent health and wellbeing in their current and adulthood life. The rapid changes during this period are also not followed by adequate transfer of knowledge from parents to their children which cause navigation failure during the transition. In this section, GEAS presents information about adolescent' onset of pubertal and their perception about those changes, uncluding their sexuality, to have better understanding about the transition and help children and parent pass it successfully.

Snapshots of puberty

93%

have started puberty.

only 49%

of the students have ever talked about puberty with someone – the majority talked to their mother (or female caregiver) or their friends.

95%

of girls used sanitation products during their menstruation and only 2% have ever missed school due to their menstruation.

Very few students

feel comfortable to talk about menstruation, pregnancy prevention, or sexual intercourse with their friends.

Adolescent’ information on the onset of puberty, menstrual hygiene sanitation, perceive of body changes during this periode and their sexuality, and their discussion related this topic are presented in Table 19.

Most adolescents had positive attitudes about puberty but comfort with emerging sexuality was relatively low.

Most of the students had started their puberty; Sixty-two percent of the girls had had their first menstruation and 65% of boys reported having wet dreams. Most adolescents had positive attitudes about puberty although with a majority agreeing that they liked that they were becoming a man/woman (78%), that they were treated more like an adult (67%), and that they were

proud of the pubertal changes they were going through (61%). However, a substantial proportion of girls who ever had a period felt ashamed of their body during menstruation (38%) and half of them (54%) felt it was important to keep their periods secret. However, half of the girls also felt proud that they had their periods. Most of the girls recognized that having a period was a sign of being a woman and two-thirds also agreed that periods were not a big deal for them. Substantial differences in girls’ feelings about menstruation were noted across sites, with fewer girls reporting feeling of shame in Denpasar compared to elsewhere.

Twenty-nine percent of the girls tracked their menstrual cycle and most had access to recommended products for menstrual hygiene management; most of the girls used feminine hygiene products to manage their menstruation and only 2% ever missed school due to their period.

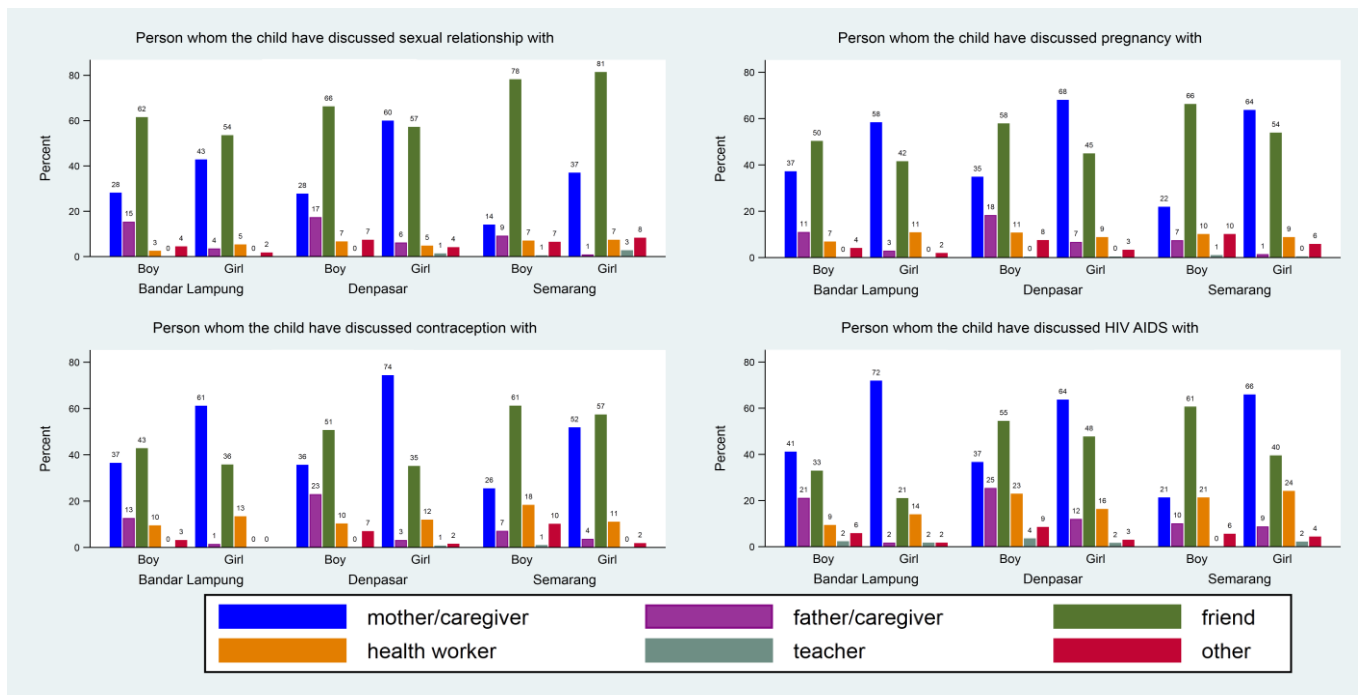


Figure 23. Adolescents’ discussion partner preferences on sexual relationship, pregnancy, contraception and HIV.

The majority of the girls knew where to get information about menstruation and had talked with other people (mostly their mothers and less often their friends or sisters) about self-care during menstruation, and 90% of the girls who talk with other people do so with their mother or female caregiver. Menstrual hygiene management and access to information about menstrual management seemed more problematic for girls in Bandar Lampung than in other sites.

Half of the students ever talked about puberty with someone; 70% of those who talk with someone do so with their mother or female while 47% talked to fewer talked to their siblings. However, most of the students reported not being comfortable discussing menstruation (8%), pregnancy prevention (6%), or sexual intercourse (3%) with their friends. The percentage reported feeling comfortable talking about being in love is higher at 23%. The percentage ever talked with someone about puberty is the lowest in Bandar Lampung. Discussions about pubertal development were different for boys and girls, as girls were more likely to solicit their mothers (84%) compared to boys (54%, while boys were more likely talk with their father or male caregiver (37%) compared to girls (11%).

More girls reported to have started puberty and talk about puberty with someone. However, fewer boys reported feelings of guilt around their sexuality development and more boys

reported greater acceptance of pubertal changes.



Comfort with emerging sexuality was relatively low as almost half of the students felt guilty for looking at themselves naked and about a third felt guilty for being romantically attracted to someone or for touching the private parts of their own body. The majority of students felt guilty for having sexual feelings or urges and 27% thought that being curious about love or sex was not normal. Discomfort with sexuality development was higher in Semarang than in the other sites.

Compared to boys, more girls reported to have started puberty and talk about puberty with someone. However, fewer boys reported feelings of guilt around their sexuality development and more boys reported greater acceptance of pubertal changes.

Table 19. Adolescents' onset of and attitudes about puberty, and communication about puberty.

Puberty	Total	Boys %	Girls %	P-value
N	6,184	2,207	2,477	
Puberty				
Onset				<0.001
Pre-Pubertal	326 (7.7%)	204 (10.6%)	122 (5.3%)	
Pubertal	3911 (92.3%)	1719 (89.4%)	2192 (94.7%)	
Age at first menstruation or wet dream				<0.001
< 9 years old	0.0	0.0	0.0	
9-10	273 (11.8%)	140 (17.3%)	133 (8.8%)	
11-12	1912 (82.5%)	595 (73.7%)	1317 (87.2%)	
13-14	133 (5.7%)	72 (8.9%)	61 (4.0%)	
Ever talked about puberty	2276 (48.6%)	1013 (45.9%)	1263 (51.0%)	<0.001
The person whom the child talk to about puberty				
Mother/caregiver	1599 (70.3%)	544 (53.7%)	1055 (83.5%)	<0.001
Father/caregiver	513 (22.5%)	370 (36.5%)	143 (11.3%)	<0.001
Sister	370 (16.3%)	94 (9.3%)	276 (21.9%)	<0.001
Brother	226 (9.9%)	183 (18.1%)	43 (3.4%)	<0.001
Relative	281 (12.3%)	151 (14.9%)	130 (10.3%)	<0.001
Friend	1060 (46.6%)	474 (46.8%)	586 (46.4%)	0.85
Health worker	75 (3.3%)	41 (4.0%)	34 (2.7%)	0.072
Teacher	82 (3.6%)	46 (4.5%)	36 (2.9%)	0.031
Other	41 (1.8%)	27 (2.7%)	14 (1.1%)	0.006
Menstruation				
Ever had menstruation			1535 (62.0%)	
Body comfort during menstruation				
Feel ashamed with my body			586 (38.2%)	
Having period is sign of being a woman			1436 (93.6%)	
Important to keep the period secret			830 (54.1%)	
Feel proud of the period			785 (51.1%)	
Period is not a big deal			1006 (65.5%)	
Tracking menstrual cycle			449 (29.3%)	
Menstrual Hygiene Management (using sanitation product)			1455 (94.8%)	
Absent from school due to period			27 (1.8%)	
Know where to get information about menstrual periods			1766 (71.3%)	
Ever talked about self take-care during period			1081 (70.4%)	
The person whom the child talk to about menstruation				
Mother/caregiver			974 (90.1%)	
Father/caregiver			62 (5.7%)	
Sister			203 (18.8%)	
Brother			12 (1.1%)	
Relative			72 (6.7%)	
Friend			402 (37.2%)	
Health worker			41 (3.8%)	
Teacher			1 (0.1%)	
Other			15 (1.4%)	
The percentage of boys/girls who feel comfortable discussing the following topic with their friends				
Menstruation	352 (7.5%)	145 (6.6%)	207 (8.4%)	0.021
Pregnancy prevention	272 (5.8%)	103 (4.7%)	169 (6.8%)	0.002

Puberty	Total	Boys %	Girls %	P-value
Sexual intercourse	141 (3.0%)	89 (4.0%)	52 (2.1%)	<0.001
Being in love	1084 (23.1%)	569 (25.8%)	515 (20.8%)	<0.001
Perception of body changes during puberty				
I like becoming a man/woman	3036 (77.6%)	1417 (82.4%)	1619 (73.9%)	<0.001
Treated like an adult	2629 (67.2%)	1236 (71.9%)	1393 (63.5%)	<0.001
Proud with pubertal changes	2368 (60.5%)	1148 (66.8%)	1220 (55.7%)	<0.001
Feeling about sexual desire				
Felt guilty for looking at themselves naked	2242 (47.9%)	988 (44.8%)	1254 (50.6%)	<0.001
Felt guilty for being romantically attracted to someone	1564 (33.4%)	653 (29.6%)	911 (36.8%)	<0.001
Felt guilty for touching the private parts of their body	1492 (31.9%)	675 (30.6%)	817 (33.0%)	0.079
Felt guilty for having sexual feelings/urges	3549 (75.8%)	1588 (72.0%)	1961 (79.2%)	<0.001
It's not normal for being curious about love and sex	1239 (26.5%)	491 (22.2%)	748 (30.2%)	<0.001

3.7.3. Romantic Experiences

This section describes adolescents' perceptions and experiences of dating or being in a relationship. Students were also asked about their perception of whether their parents allow them to date. The dynamics of relationship among those who were dating or in a relationship was examined using power imbalance and intimacy scores. This section also examines violence experienced by adolescents within a close relationship both as victims and perpetrators.

Snapshots of adolescents' experience of relationship

28%

of boys and 12% of girls thought that having boyfriend or girlfriend is important.

18%

of boys and 10% of girls currently have a girlfriend/boyfriend; and 22% have had a romantic relationship in the past but not currently dating.

Some students have experienced or engaged in dating violence. Most commonly, 20% have been thrown something by their romantic partner and 15% have thrown something to their partner.

Majority

of students have not discussed about sexual relationship, pregnancy, contraception, or HIV/AIDS with anyone.

Upon entering adolescence, individuals begin to have romantic interests. Previous studies suggest that the development of adolescent romantic relationships follow sequential phases, where the intensity, duration, and quality of romantic relations increase as adolescents become older (Collins, 2003, Seiffge-Krenke, 2003).



Adolescents were asked about their romantic relationship and the results are presented in Table 20. A majority did not think that their main caregiver would allow them to have a boyfriend/girlfriend at this time in their life. The percentage of those who get approval from their parent were dropping from 23% in Denpasar to 15% in Bandar Lampung and 13% in Semarang.

While parent approval was low, more than two thirds of adolescents reported that they had ever fallen in love

(including 5% who reported same sex interest) and almost half (46%) had ever had a romantic relationship and 14% were in a current dating relationship. Most adolescents who had ever had a relation kept it secret. A minority (5%) were engaged to be married. These experiences differed across sites with greater romantic involvement in Semarang (49% ever been in a romantic relationship and 16% currently had a boy/girlfriend, compared to 46% and 13% in Bandar Lampung and 42% and 12% in Denpasar, respectively).

Among adolescents who ever had a romantic relationship (n=1857), 26% spent time with their partner 1 to 4 times a week and 12% met every day. The quality of the current or last relationship was assessed with respect to power imbalance and intimacy. Specifically, *power imbalance* was a summary measure (scored 1 to 5) of the four following statements: (1) I sometimes do things because X (the partner) is doing them, (2) X often influences what I do, (3) I sometimes do things because I don't want to lose X's respect, and (4) X sometimes wants to control what I do. A *relationship intimacy* measure summarized (scored 1 to 5) responses across six statements: (1) X makes me feel good about myself in a way my friends can't, (2) I feel comfortable talking with X when I have a problem; (3) X cares about me, (4) I would rather be with X than anyone else, (5) X always seems to be on my mind, and (6) X and I are practically inseparable.

The development of adolescent romantic relationships follows sequential phases, where the intensity, duration, and quality of romantic relations increase as adolescents become older. Result suggests more than two thirds of students reported that they had ever fallen in love.

The average power score generally signaled a lack of power (3.13) in relationships while adolescents enjoyed a higher level of intimacy (3.57). A number of adolescents described violent behaviors in the context of their relationships with 20% indicating that they had ever been thrown something while 15% had thrown something at their romantic partner. Additionally, 11% had ever been pushed/shoved/grabbed, 9% had ever been slapped on the face or head,

and 11% had ever been hit. The percentages ever engaged in these behaviors (pushing/shoving/grabbing, slapping, hitting) are less than or equal to 10%. Those percentages related to dating violence are consistently highest in Bandar Lampung and lowest in Semarang. The average power score among those ever in a romantic relationship is lower in Semarang than in other sites (3.0 versus 3.2 in Bandar Lampung and 3.3 in Denpasar). However, the average score of intimacy is similar across 3 sites.

Romantic experiences differed by gender, with more restrictive views of parents about these relations for girls than boys (90% opposed girls dating versus 74% who opposed boys dating), which also translated in a higher percentage of boys indicating that having a boyfriend/girlfriend was very important to them and more boys having ever had a romantic relationship (53% versus 39% of girls). The nature of these relationships also differed by gender, with higher perceptions of power imbalance and higher levels of intimacy reported by boys compared to girls (3.37 versus 2.86 for power imbalance and 3.67 versus 3.46 for intimacy), meaning boys reported feeling of closeness, connectedness, and bonding in their relationship more often than girls. Violence victimization and perpetration in the context of the last relationship was also more commonly reported by boys than girls.

Table 20. Experience of romantic relationship, dating violence and communication about sexual and reproductive issues, by sex.

Relationship Factors	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Child's perception about having boy/girl friend				
Allowed by caregiver	817 (17.4%)	566 (25.6%)	251 (10.1%)	<0.001
Romantic Relationships				
Having boy/girl friend is important	915 (19.5%)	609 (27.6%)	306 (12.4%)	<0.001
Ever fall in love with the same sex	172 (3.7%)	122 (5.5%)	50 (2.0%)	<0.001
Ever fall in love with the different sex	2958 (63.2%)	1316 (59.6%)	1642 (66.3%)	<0.001
Ever fall in love with both sexes	66 (1.4%)	45 (2.0%)	21 (0.8%)	<0.001
Ever having secret relationship	1427 (45.6%)	663 (46.1%)	764 (45.2%)	0.59
Never had a romantic relationship	2213 (54.4%)	875 (47.1%)	1338 (60.5%)	<0.001
Past romantic relationship (none currently)	1030 (25.3%)	463 (24.9%)	567 (25.6%)	0.11
Current boyfriend/girlfriend	645 (13.8%)	403 (18.3%)	242 (9.8%)	<0.001
Engaged or married	215 (4.6%)	144 (6.5%)	71 (2.9%)	<0.001
Power Imbalance in Relationships *	3.13 (1.02)	3.37 (0.99)	2.86 (0.99)	<0.001
Intimacy in Relationships**	3.57 (0.90)	3.67 (0.93)	3.46 (0.87)	<0.001
Time spent with romantic partner				<0.001
Everyday	199 (11.6%)	135 (14.8%)	64 (7.9%)	
1-4 times a week	442 (25.7%)	286 (31.3%)	156 (19.3%)	
Dating violence (ever)				
<i>Experience of physical violence victimization by romantic partner</i>				
Thrown something	350 (20.3%)	237 (26.0%)	113 (14.0%)	<0.001
Pushed, shoved, grabbed	197 (11.4%)	155 (17.0%)	42 (5.2%)	<0.001
Slapped on face or head (161	161 (9.3%)	137 (15.0%)	24 (3.0%)	<0.001
Hitting	185 (10.7%)	144 (15.8%)	41 (5.1%)	<0.001
<i>Engaged in physical violence perpetration with romantic partner</i>				
Throwing something	255 (14.8%)	147 (16.1%)	108 (13.3%)	0.11
Pushing, shoving, grabbing	147 (8.5%)	97 (10.6%)	50 (6.2%)	<0.001
Slapping on face or head	146 (8.5%)	94 (10.3%)	52 (6.4%)	0.004
Hitting	173 (10.0%)	94 (10.3%)	79 (9.8%)	0.71
Ever discussed the following topic with anyone				
Sexual relationship	19.6	27.6	12.5	<0.001
Pregnancy	24.6	27.6	21.9	<0.001
Contraception	14.6	19.8	9.9	<0.001
HIV/AIDS	27.7	28.0	27.5	0.675
Person whom the child have discussed sexual relationship with				
Mother/caregiver	296 (32.2%)	145 (23.8%)	151 (48.9%)	<0.001
Father/caregiver	100 (10.9%)	88 (14.4%)	12 (3.9%)	<0.001
Sister	65 (7.1%)	27 (4.4%)	38 (12.3%)	<0.001
Brother	75 (8.2%)	73 (12.0%)	2 (0.6%)	<0.001
Relative	56 (6.1%)	42 (6.9%)	14 (4.5%)	0.16
Friend	620 (67.5%)	419 (68.7%)	201 (65.0%)	0.27
Health worker	53 (5.8%)	35 (5.7%)	18 (5.8%)	0.96
Teacher	6 (0.7%)	1 (0.2%)	5 (1.6%)	0.010
Other	55 (6.0%)	39 (6.4%)	16 (5.2%)	0.46
Person whom the child have discussed pregnancy with				
Mother/caregiver	543 (47.1%)	192 (31.5%)	351 (64.6%)	<0.001

Relationship Factors	Total	Boys %	Girls %	P-value
Father/caregiver	103 (8.9%)	81 (13.3%)	22 (4.1%)	<0.001
Sister	102 (8.8%)	25 (4.1%)	77 (14.2%)	<0.001
Brother	49 (4.2%)	43 (7.0%)	6 (1.1%)	<0.001
Relative	76 (6.6%)	40 (6.6%)	36 (6.6%)	0.96
Friend	617 (53.5%)	358 (58.7%)	259 (47.7%)	<0.001
Health worker	109 (9.5%)	59 (9.7%)	50 (9.2%)	0.79
Teacher	5 (0.4%)	3 (0.5%)	2 (0.4%)	0.75
Other	68 (5.9%)	46 (7.5%)	22 (4.1%)	0.012
Person whom the child have discussed contraception with				
Mother/caregiver	309 (45.2%)	147 (33.6%)	162 (65.9%)	<0.001
Father/caregiver	79 (11.6%)	72 (16.5%)	7 (2.8%)	<0.001
Sister	55 (8.1%)	21 (4.8%)	34 (13.8%)	<0.001
Brother	40 (5.9%)	38 (8.7%)	2 (0.8%)	<0.001
Relative	52 (7.6%)	43 (9.8%)	9 (3.7%)	0.003
Friend	321 (47.0%)	222 (50.8%)	99 (40.2%)	0.008
Health worker	82 (12.0%)	52 (11.9%)	30 (12.2%)	0.91
Teacher	2 (0.3%)	1 (0.2%)	1 (0.4%)	0.68
Other	32 (4.7%)	29 (6.6%)	3 (1.2%)	<0.001
Person whom the child have discussed HIV AIDS with				
Mother/caregiver	657 (50.6%)	217 (35.1%)	440 (64.7%)	<0.001
Father/caregiver	213 (16.4%)	140 (22.7%)	73 (10.7%)	<0.001
Brother	115 (8.9%)	38 (6.1%)	77 (11.3%)	0.001
Sister	62 (4.8%)	48 (7.8%)	14 (2.1%)	<0.001
Relative	119 (9.2%)	63 (10.2%)	56 (8.2%)	0.22
Friend	626 (48.2%)	324 (52.4%)	302 (44.4%)	0.004
Health worker	246 (19.0%)	129 (20.9%)	117 (17.2%)	0.092
Teacher	30 (2.3%)	18 (2.9%)	12 (1.8%)	0.17
Other	69 (5.3%)	48 (7.8%)	21 (3.1%)	<0.001

Note: *(1-5, 5 indicating strong imbalance in power) (Mean score +/- SD); **(1-5, 5 indicating strong feeling of intimacy/satisfaction) (Mean score +/- SD)

3.7.4. Sexual and Reproductive Health

This section describes the norms and experiences of teen sexuality including contraceptive use. To understand the nature of adolescents' various sexual activities, GEAS collected information about partnered behaviors and the relational context in which first partner experiences take place. The type of partnered behaviors extend from spending time together alone, holding hands, hugging, kissing, teasing, sending sexual images, sensual touches, and sexual intercourse.

Snapshots of sexual and reproductive health

The majority *of the students do not agree with stereotypical sexual norms, the most commonly agreed on is that it is girl's responsibility to prevent pregnancy, which is agreed on by 37% of boys and 47% of girls.*

The majority *of the students do not agree with abortion for a teenage pregnant girl if she is not yet married, too young to raise a child or to be able to continue their study.*

While a **substantial percentage** *of students have spent time together in private with someone they are romantically interested in, held hand, or flirted; 99% are not sexually active and do not plan to be sexually active in the next year.*

Being forced *for their first sexual experience (sexual touch, oral sex, sexual intercourse) were reported by many of those who ever had these experience.*

- a. Stereotypical sexual norms, attitudes on abortion, and sexual experience

Stereotypical views about teenage sexuality were prevalent with a third of adolescents endorsing the view that women who carry condoms are easy; and 42% agreed that pregnancy prevention is the girl's responsibility. Other stereotypes were less common, including masculine hypersexuality (15% agreed that men are always ready for sex and 10% agreed that a real man should have as many female partners as he can). Perceptions of hypersexual masculinity was notably higher in Bandar Lampung than in other sites.

Sexual attitudes and behaviors were highly gendered with a greater proportion of boys endorsing masculine hypersexuality than girls.

Less than 25% of students agreed that pregnant adolescent girls should have an abortion if they are not married or because they are too young to raise a child and 27% thought they should have an abortion to stay in school. Boys had more liberal views on

this matter than girls, with up to 31% agreeing an adolescent girl their age should get an abortion to continue studying.

Partnered behaviors were uncommon in early adolescence, as only a quarter indicated that they had spent time alone with a romantic partner, 18.9% had ever held hands and 9.5 had ever hugged or cuddled. Only 1% reported ever having had sexual intercourse or oral sex, while 2% have ever sent sexual pictures of themselves. Few adolescents anticipated engaged in sexual behavior in the following year. Partnered activities were more common in Bandar Lampung where 4% had ever kissed, 9% had ever cuddled and 2% had ever had vaginal or oral sex. These activities were least commonly reported in Semarang

Sexual attitudes and behaviors were highly gendered with a greater proportion of boys endorsing masculine hypersexuality than girls, and a greater proportion of boys reporting any form of partnered activity: 32% had ever spent time alone with a partner versus 18% of girls, 21% had ever held hands versus 17% of girls, 6% had ever touched in a sexual way versus 2% of girls and 2% had ever had sex. Four percent of boys and 0.3% of girls intend to have sex next year.

Table 21. Sexual norms, attitudes about abortion, and sexual experiences of GEAS participants, by sex.

Sexual Attitudes and Experiences	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Sexual norms (% agree with...)				
It's the girl's responsibility to prevent pregnancy	1976 (42.2%)	817 (37.0%)	1159 (46.8%)	<0.001
Women who carry condoms on them are easy	1539 (32.9%)	725 (32.9%)	814 (32.9%)	0.99
A real man should have as many female partners as he can	454 (9.7%)	331 (15.0%)	123 (5.0%)	<0.001
Men are always ready for sex	703 (15.0%)	511 (23.2%)	192 (7.8%)	<0.001
Intention for having sexual intercourse next year	86 (1.8%)	79 (3.6%)	7 (0.3%)	<0.001
Agree that pregnant teenage girl should get abortion if...				
Not yet married	1085 (23.2%)	584 (26.5%)	501 (20.2%)	<0.001
Too young to raise a child	1144 (24.4%)	609 (27.6%)	535 (21.6%)	<0.001
Continuing study	1271 (27.1%)	682 (30.9%)	589 (23.8%)	<0.001
Sexual History (ever)				
Spent time together in private without adult supervision	1163 (24.8%)	705 (31.9%)	458 (18.5%)	<0.001
Held hand with someone	884 (18.9%)	465 (21.1%)	419 (16.9%)	<0.001
Hugged and cuddled	445 (9.5%)	264 (12.0%)	181 (7.3%)	<0.001
Kissed	152 (3.2%)	113 (5.1%)	39 (1.6%)	<0.001
Flirted someone	874 (18.7%)	620 (28.1%)	254 (10.3%)	<0.001
Sent your sexual picture	106 (2.3%)	94 (4.3%)	12 (0.5%)	<0.001
Sexual touch	187 (4.0%)	143 (6.5%)	44 (1.8%)	<0.001
Sexual intercourse	58 (1.2%)	53 (2.4%)	5 (0.2%)	<0.001
Oral sex	62 (1.3%)	58 (2.6%)	4 (0.2%)	<0.001
Anal sex	71 (1.5%)	65 (2.9%)	6 (0.2%)	<0.001

b. Experience of sexual intercourse

Only 58 young people reported they ever had sexual intercourse, therefore the analysis of these experiences is limited. Forty-two percent (n=22) had sexual intercourse for the first time with their boyfriend/girlfriend and 13% (n=7) with another boy/girl. A third (n=20) did it with

an older person and 29% (n=17) indicated their first sexual intercourse was forced; 29% had first sexual intercourse under the influence of drugs or alcohol. A third of adolescents used a condom as first sex, and 12% used withdrawal. 29% (n=17) did not use any contraceptive method at first sexual intercourse.

Table 22. Experience of sexual intercourse among GEAS participants, by sex.

Coital-Sexual Experiences	Total	Boys %	Girls %	P-value
N	58	53	5	
First time sexual intercourse with...				
Boy/girl friend	22 (42%)	20 (42%)	2 (40%)	0.41
Husband/wife	4 (8%)	3 (6%)	1 (20%)	
Other boy/girl	7 (13%)	7 (15%)	0 (0%)	
Stranger	1 (2%)	1 (2%)	0 (0%)	
Sex worker	2 (4%)	2 (4%)	0 (0%)	
Father/mother	3 (6%)	2 (4%)	1 (20%)	
Brother/sister	2 (4%)	1 (2%)	1 (20%)	
Relative	0.0	0.0	0.0	
Teacher	3 (6%)	3 (6%)	0 (0%)	
Someone just met	0.0	0.0	0.0	
Paid	0.0	0.0	0.0	
<i>Older partner at first sexual intercourse</i>	20 (34%)	18 (34%)	2 (40%)	0.79
<i>Reason at first sexual intercourse</i>				
Expression of love	28 (48%)	25 (47%)	3 (60%)	0.58
Curiosity	20 (34%)	17 (32%)	3 (60%)	0.21
Obligation from boy/girlfriend	20 (34%)	19 (36%)	1 (20%)	0.48
Peer pressure / threatened	17 (29%)	16 (30%)	1 (20%)	0.63
Promised a gift/present	15 (26%)	14 (26%)	1 (20%)	0.75
I forced other	18 (31%)	17 (32%)	1 (20%)	0.58
Given drugs/alcohol	19 (33%)	18 (34%)	1 (20%)	0.52
Forced first time sexual intercourse	17 (29%)	14 (26%)	3 (60%)	0.88
Contraceptive experience at first sexual intercourse				
Did not use any contraceptive method	17 (29%)	14 (26%)	3 (60%)	0.11
Male condom	18 (31%)	17 (32%)	1 (20%)	0.58
Pill	5 (9%)	5 (9%)	0 (0%)	0.47
Injection	2 (3%)	2 (4%)	0 (0%)	0.66
Female condom	3 (5%)	3 (6%)	0 (0%)	0.58
Gel /foam	3 (5%)	3 (6%)	0 (0%)	0.58
Period abstinence	2 (3%)	2 (4%)	0 (0%)	0.66
Coitus interruptus	7 (12%)	6 (11%)	1 (20%)	0.57
Emergency contraception	0.0	0.0	0.0	
Intra Uterine Device (IUD)	1 (2%)	1 (2%)	0 (0%)	0.76
Implant	0.0	0.0	0.0	

Coital-Sexual Experiences	Total	Boys %	Girls %	P-value
Ever had first sexual intercourse under the influence of drugs/alcohol	17 (29%)	17 (32%)	0 (0%)	0.13
Sexual intercourse with current or last boyfriend/girlfriend				
<i>Ever had sexual intercourse with current/last boyfriend</i>	18 (40%)	16 (40%)	2 (40%)	1.00
<i>Worried about sexually transmitted disease</i>	17 (94%)	16 (100%)	1 (50%)	0.004
<i>Worried about getting pregnant/impregnate</i>	17 (94%)	16 (100%)	1 (50%)	0.004
Contraceptive experience with current or last boyfriend/girlfriend				
Did not use any contraceptive method	8 (44.4%)	8 (50%)	0 (0%)	0.18
Male condom	8 (44.4%)	8 (50%)	(0%)	
Pill	0.0	0.0	0.0	
Injection	0.0	0.0	0.0	
Female condom	0.0	0.0	0.0	
Gel /foam	0.0	0.0	0.0	
Period abstinence	0.0	0.0	0.0	
Coitus interruptus	0.0	0.0	0.0	
Emergency contraception	0.0	0.0	0.0	
Intra Uterine Device (IUD)	0.0	0.0	0.0	
Implant	0.0	0.0	0.0	
Reason for not using contraceptive method				
Too ashamed to talk about contraception	75.0	75.0	0.0	
Want to get pregnant	13.0	13.0	0.0	
Partner refusal	13.0	13.0	0.0	
Less pleasure	0.0	0.0	0.0	
Do not know where to find contraception	0.0	0.0	0.0	
Do not want to seem too eager for sex	0.0	0.0	0.0	
Thinking will not get pregnant or impregnate	0.0	0.0	0.0	
Never thought about contraception	0.0	0.0	0.0	
Not affordable	0.0	0.0	0.0	
Too ashamed/scared to get contraception	0.0	0.0	0.0	

c. Experience of sexual touch and oral sex

Sixty-two adolescents reported an experience of oral sex. Among them, 47% (n=29) did it the first time with their boyfriend/girlfriend and 11% (n=7) with another boy/girl. Thirty-five percent did it

with an older person and 56% were forced to do it the first time. Students who reported having experienced sexual touch also most commonly did it with their boyfriend/girlfriend; 35% were forced to do it the first time.

Table 23. Experience of sexual touch and oral sex among GEAS participants, by sex.

Non Coital-Sexual Experiences	Total	Boys %	Girls %	P-value
N	237	179	58	
First time sexual touch by...				0.052
Boy/girl friend	67 (28.3%)	54 (30.2%)	13 (22.4%)	
Husband/wife	10 (4.2%)	10 (5.6%)	0 (0.0%)	
Other boy/girl	56 (23.6%)	36 (20.1%)	20 (34.5%)	
Stranger	3 (1.3%)	3 (1.7%)	0 (0.0%)	
Sex worker	3 (1.3%)	3 (1.7%)	0 (0.0%)	
Father/mother	15 (6.3%)	12 (6.7%)	3 (5.2%)	
Brother/sister	7 (3.0%)	3 (1.7%)	4 (6.9%)	
Relative	5 (2.1%)	2 (1.1%)	3 (5.2%)	
Teacher	2 (0.8%)	2 (1.1%)	0 (0.0%)	
Someone just met	2 (0.8%)	2 (1.1%)	0 (0.0%)	
Paid				
Older partner at first sexual touch	67 (28.3%)	50 (27.9%)	17 (29.3%)	0.84
Reason at first sexual touch				
Expression of love	106 (44.7%)	83 (46.4%)	23 (39.7%)	0.37
Curiosity	91 (38.4%)	75 (41.9%)	16 (27.6%)	0.051
Obligation from boy/girlfriend	56 (23.6%)	50 (27.9%)	6 (10.3%)	0.006
Peer pressure / threatened	53 (22.4%)	47 (26.3%)	6 (10.3%)	0.011
Promised a gift/present	55 (23.2%)	50 (27.9%)	5 (8.6%)	0.002
Given drugs/alcohol	46 (19.4%)	44 (24.6%)	2 (3.5%)	<0.001
I forced other	53 (22.4%)	50 (27.9%)	3 (5.2%)	<0.001
Forced first time sexual touch	84 (35.4%)	72 (40.2%)	12 (20.7%)	0.007
N	62	58	4	
First time oral sex with...				0.66
Boy/girlfriend	29 (47%)	27 (47%)	2 (50%)	
Husband/wife	1 (2%)	1 (2%)	0 (0%)	
Other boy/girl	7 (11%)	7 (12%)	0 (0%)	
Stranger	3 (5%)	3 (5%)	0 (0%)	
Sex worker	2 (3%)	2 (3%)	0 (0%)	
Father/mother	3 (5%)	2 (3%)	1 (25%)	
Brother/sister	2 (3%)	2 (3%)	0 (0%)	
Relative	1 (2%)	1 (2%)	0 (0%)	
Teacher	0 (0%)	0 (0%)	0 (0%)	
Someone just met	0 (0%)	0 (0%)	0 (0%)	
Paid	0 (0%)	0 (0%)	0 (0%)	
Older partner at first oral sex	22 (35%)	20 (34%)	2 (50%)	0.53
Reason at first oral sex				
Expression of love	29 (47%)	27 (47%)	2 (50%)	0.89
Curiosity	29 (47%)	27 (47%)	2 (50%)	0.89
Obligation from boy/girlfriend	27 (44%)	25 (43%)	2 (50%)	0.79
Peer pressure / threatened	23 (37%)	23 (40%)	0 (0%)	0.11
Promised a gift/present	23 (37%)	22 (38%)	1 (25%)	0.60
Given drugs/alcohol	21 (34%)	20 (34%)	1 (25%)	0.70
I forced other	19 (31%)	17 (29%)	2 (50%)	0.39
Forced first time oral sex	35 (56%)	33 (57%)	2 (50%)	0.79

3.7.5. Female Genital Cutting

Female genital cutting (sometimes referred to female genital mutilation or female circumcision) are all actions that involve removing a small or large portion of the external female genital organs or other forms of injury to female genital organs for non-medical reasons. This section of the report describes the knowledge, experience, perceptions of benefits, motivations, procedures for female circumcision and those who assist in this process. The information was collected from the perspective of adolescents and parents.

Snapshots of Female Genital Cutting

23%

of students and 86% of main caregivers ever heard of or know about female genital mutilation.

9%

of girls reported to have been circumcised; 30% of caregivers have a daughter who was circumcised.

55%

of the caregivers whose daughter was circumcised reported that the genital area was nicked without flesh removal.

31%

of the girls and the caregivers who know about FGC think that FGC is required by their religion; 21% of the girls and 29% of the caregivers think that FGC should be continued

Female genital cutting (FGC) refers to all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. The nationally-representative 2013 Basic Health Survey found that 49% of girls under the age of 12 had undergone some form of FGC (2013 Basic Health Research (RISKESDAS)). The practice is strongly related to cultural and religious norms and therefore the prevalence varies greatly by province. FGC generally practiced in Indonesia generally refers to type I which consists of partial or total removal of the clitoris and/or its prepuce and type IV which is less invasive and consists of pricking, piercing, incising, scraping, and cauterization.

About third of students who know female genital cutting, they believe this practice is good for girl and required by their religion.

This survey asked both female students and parent/main caregiver about their knowledge of and attitude towards FGC. The majority of the girls (77%) had never heard about FGC. Among those who ever heard about FGC, 34% agreed that FGC is good for girls, 31% thought it was required by their religion, and 21% thought that FGC practices should be continued. Among those agreeing on the benefit of FGC for girls, 54% thought FGC had a health benefit, and 9% thought FGC could preserve a woman's virginity well 12% thought it

brought religious approval. Girls in Bandar Lampung were more likely to ever heard about FGC (36% compared to 21% in Semarang and 11% in Denpasar). Half of students in Bandar Lampung who know about FGC agreed that FGC is good for girls, also half thought that FGC is required by religion, compared to 20% and 40% in Denpasar and 8 and 33% in Semarang, respectively.

Only 9% of girls reported experiencing FGC: in 49% of cases a flesh was removed from the genital area (type I) and 32% reported that their genital area was sowed (type 3). In a majority of cases (91%); FGC was done by a medical professional (doctor, nurse, or midwives). FGC practices varied widely by site: 27% of girls in Bandar Lampung, but 2% of girls in Semarang and 0.8% in Denpasar.



Table 24. Attitude on and experience of female genital cutting, among girls.

Female Circumcision	Girls %
N	2,477
<i>Ever heard/know about female genital cutting (567)</i>	22.9
<i>Agree that FGC is good for girls (193)</i>	34.0
<i>Benefit of FGC for girls</i>	
Does not give benefit at all (9)	1.6
Health (299)	54.0
Social acceptance (27)	4.9
Easier to get married (17)	3.1
Keeping virginity (52)	9.4
Prevent premarital sexual intercourse (22)	4.0
Greater sexual pleasure for man (3)	0.5
Religious acceptance (68)	12.3
<i>FGC is required by their religion (174)</i>	30.7
<i>FGC should be continued (116)</i>	20.5
<i>Ever had FGC (221)</i>	8.9
<i>Circumcision procedure</i>	
A flesh removed from genital area (32)	49.2
A nick without flesh removal (12)	18.5
Genital area sewn closed (21)	32.3
<i>Person who performed circumcision</i>	
Traditional birth attendance (12)	6.8
Traditional circumcision attendance (3)	1.7
Doctor (81)	46.0
Nurse or midwives (79)	44.9
Other health professional (1)	0.6

In contrast to adolescents, 86% of parents or caregivers had heard of FGC. Among knowledgeable parents, less than a third thought it was religious obligation or thought FGC should be continued. Among those who agreed on the benefits of FGC, 40% thought FGC had health benefits and 18% thought FGC brought religious approval.

Almost a third of parents who knew about FGC had a daughter who was cut; the percentage was highest in Bandar Lampung (81%). Only 5% of parents in Denpasar and 17% of parents in Semarang reported FGC.

There is discrepancy between adolescents and parents report on FGC, which may be due to (1) the question is about any daughter's experience on FGC, not just the daughter who participated in GEAS, (2) adolescents were not aware about FGC because it was performed when she was small or it was a non-invasive (e.g. type IV FGC). The report about FGC procedure by parents/caregivers differed from adolescents. Only 5% of parents reported that their daughter's genital area was sewed, 41% reported that a flesh was removed from the genital area. Most FGC was performed by a nurse or midwives (73%).

Table 25. Attitude on and experience of female genital cutting among parent/main caregivers of GEAS participants, by sex of the students.

Female Circumcision	Total %	Boys %	Girls %	P-value
N	4,225	1,710	2,477	
<i>Ever heard/know about female genital cutting</i>	3637 (86.1%)	1710 (85.7%)	1927 (86.4%)	0.51
<i>Benefit of FGC for girls</i>				
Does not give benefit at all	137 (3.7%)	58 (3.4%)	79 (4.1%)	0.41
Health	1481 (40.3%)	684 (39.6%)	797 (40.9%)	<0.001
Social acceptance	184 (5.0%)	61 (3.5%)	123 (6.3%)	0.86
Easier to get married	33 (0.9%)	15 (0.9%)	18 (0.9%)	0.23
Keeping virginity	61 (1.7%)	24 (1.4%)	37 (1.9%)	0.43
Prevent premarital sexual intercourse	82 (2.2%)	35 (2.0%)	47 (2.4%)	0.86
Greater sexual pleasure for man	33 (0.9%)	15 (0.9%)	18 (0.9%)	0.049
Religious acceptance	657 (17.9%)	286 (16.5%)	371 (19.0%)	0.26
<i>FGC is required by their religion</i>	1127 (30.6%)	514 (29.7%)	613 (31.5%)	0.26
<i>FGC should be continued</i>	1052 (28.6%)	490 (28.3%)	562 (28.8%)	0.74
<i>Had a daughter who was circumcised</i>	1110 (29.6%)	385 (25.6%)	725 (32.3%)	<0.001
<i>Circumcision procedure</i>				0.19
A flesh removed from genital area	301 (40.9%)	114 (42.7%)	187 (39.9%)	
A nick without flesh removal	402 (54.6%)	137 (51.3%)	265 (56.5%)	
Genital area sewn closed	33 (4.5%)	16 (6.0%)	17 (3.6%)	
<i>Person who performed circumcision</i>				0.53
Traditional birth attendance	193 (17.4%)	65 (16.9%)	128 (17.7%)	
Traditional circumcision attendance	28 (2.5%)	12 (3.1%)	16 (2.2%)	
Doctor	68 (6.1%)	25 (6.5%)	43 (5.9%)	
Nurse or midwives	806 (72.6%)	281 (73.0%)	525 (72.4%)	
Other health professional	8 (0.7%)	2 (0.5%)	6 (0.8%)	

Conclusion

- A substantial percentage of students are uncomfortable with their romantic or sexual feelings. While the majority have positive perception of their body changes during puberty, a lot of students never talk about puberty with someone. For those who do, they most commonly talk with their mother or friends. Students feel uncomfortable to talk about menstruation, pregnancy prevention, and sexual intercourse with their friends.
- While most girls are able to use sanitation products and do not miss school during menstruation, many feel ashamed with their body and want to keep their menstruation secret.
- Most of the students have not talked about sexual relationship, pregnancy, contraception, and HIV/AIDS with someone. More people talked about HIV/AIDS than the other topics. Knowledge about pregnancy and HIV prevention was very low, particular among girls who are seem ill equipped to protect themselves once they become sexually active. The majority do not know where to go to get condom or other contraceptive methods or aware of the government's sexual health services available to young people.
- The majority do not agree with the stereotypical sexual norms. However, it seems that adolescents have mixed views about adolescent sexuality, rejecting hypersexual masculinity but at the same time endorsing female sexual shaming.
- The majority of the students have had romantic interest in someone, but most do not think that having a boyfriend/girlfriend is important and most are not currently dating. Romantic interest is common among young people despite parent's restriction and disapproval. Boys were more likely than girls to have experienced a romantic relationship. Boys experience romantic relationship differently than girls, with greater power imbalance but also greater feeling of intimacy.
- Almost all of the students are not yet sexually active and do not plan to be sexually active in the near future. Few had experienced any partnered activity, mostly in the form of spending time together in private, holding hands, and cuddling/hugging. Among those who have ever been dating, being thrown something and throw something at their partner is the most common form of dating violence. Boys experience and perpetrate dating violence more commonly than girls.
- The majority of the students do not know about FGC, but the majority of the caregivers know about FGC. FGC is not commonly practiced by the parents who have a daughter; the majority of the circumcision did not involve flesh removal. The majority of the students and caregivers do not think that FGC is required by their religion or that FGC should be continued.

3.8. Media Access and Use

Massive technological developments have transformed lives of adolescents globally. Today's integration of media and technology raises new patterns or ways for young people to find, share, create information, including information on sexuality, reproductive health and contraception. Technology and social media are ubiquitous in young people's lives. Teenagers use social media and the internet to connect with their peers, find entertainments and information. Therefore, technology and social media may significantly impact adolescents' identity and social development and have potential benefits and risks for their health and wellbeing. This section provides information about youth access to and use of several types of mass media and social media as well as consumption of pornographic content.

Snapshots of media access and use

84%

have access to mobile phone, and 91% and 75% have access to social media and computer, respectively.

29%

spend more than two hours per day on social media, 31% spend more than two hours per day watching TV/film/online videos.

68%

text their friend everyday, but only 19% call their friend everyday.

83%

have never watched pornography.

The majority of students have access to television, social media, and cellphones. Seventy-five percent had access to a computer and 45% had access to the radio. Access to social media, cellphones, and computers were highest in Denpasar and the lowest in Bandar Lampung. While most had access, most adolescents spend less than two hours per day on social media or watching TV/film/online videos.

A majority of adolescents used texting or other social media outlets to contact their friends daily while, 19% used cellphones or computers daily to communicate with friends. A majority of adolescents had never been exposed to pornography. Girls were greater consumers of social media than boys, while access to cellphones and computers were similar by sex. However, girls were less likely to report having been exposed to videos of sexual scenes.

Table 26. Media and technology access and pornography exposure of GEAS participants, by sex.

Media	Total	Boys %	Girls %	P-value
N	4,684	2,207	2,477	
Adolescent media access				
Television	4493 (95.9%)	2100 (95.2%)	2393 (96.6%)	0.012
Radio	2125 (45.4%)	1054 (47.8%)	1071 (43.2%)	0.002
Computer	3518 (75.1%)	1644 (74.5%)	1874 (75.7%)	0.36
Handphone	3940 (84.1%)	1854 (84.0%)	2086 (84.2%)	0.84
Social Media	4257 (90.9%)	1973 (89.4%)	2284 (92.2%)	<0.001
Time spend for access social media				
≤2 hours per day	3259 (70.7%)	1611 (74.2%)	1648 (67.5%)	<0.001
>2 hours per day	1351 (29.3%)	559 (25.8%)	792 (32.5%)	
Time spend for watching television/film/online video				
≤2 hours per day	3189 (69.1%)	1563 (72.0%)	1626 (66.6%)	<0.001
>2 hours per day	1426 (30.9%)	609 (28.0%)	817 (33.4%)	
Frequency of texting				
Everyday	3065 (68.1%)	1270 (60.7%)	1795 (74.5%)	<0.001
Every week	287 (6.4%)	158 (7.6%)	129 (5.4%)	
Less than weekly	799 (17.8%)	452 (21.6%)	347 (14.4%)	
Never	349 (7.8%)	212 (10.1%)	137 (5.7%)	
Frequency of calling friend using telephone or computer				
Everyday	822 (18.5%)	355 (17.2%)	467 (19.7%)	
Every week	562 (12.7%)	237 (11.5%)	325 (13.7%)	
Less than weekly	2518 (56.8%)	1145 (55.5%)	1373 (57.9%)	
Never	533 (12.0%)	326 (15.8%)	207 (8.7%)	
Experience of watching pornography				
No	3868 (82.6%)	1581 (71.6%)	2287 (92.3%)	<0.001
Yes	816 (17.4%)	626 (28.4%)	190 (7.7%)	

Conclusion

- The majority of the students have access to technology and media, and a substantial percentage spend a long time on them everyday.
- Texting is the main mode to communicate with friends.
- The majority of the students never been exposed to pornography.

GOALS

to understand how adolescents and young people experience growing up in relation to sexuality and what can support them in making the transition from childhood to adulthood



Appendices

Appendix I. The definition of selected gender development and education sector development indicators

Indonesia has adopted the UN Sustainable Development Goals (SDGs) in its national development agenda. Gender equality, as one of the main goal of the SDGs, is outlined in the national long-term development plan (RPJMN) 2005-2025. The following indicators are used by Indonesia government to evaluate the results of gender perspective development:

- a. **The Gender Development Index (GDI)** is used to measure gender gap in human development achievements, thus revealing disparities between men and women in basic dimensions of human development – health, knowledge, and living standard. The GDI is the ratio of the HDIs calculated separately for females and males, using indicators of life expectancy, average number of years of schooling, expected years of schooling, and income. The value of GDI ranges from zero and one.
- b. **The Gender Empowerment Measure (GEM)** shows whether women can play an active role in economic and political life. GEI focuses on participation, by measuring gender inequality in the fields of economy, political participation and decision making. The indicators used to measure GEM are the proportion of seats held by women in parliament, the proportion of women administrators and managers, the proportion of women professionals and technical workers, and the ratio of women and men earned income. The GEM

value also ranges from 0 (lowest) to 1 (highest).

The Development of The Education Sector

Participation in education is an important component in the development of human resources quality, as well as development and gender empowerment. The monitoring of school participation relies on several indicators, including:

- a) **School Participation Rate (SPR)** is the enrolment of a specific age group, expressed as a percentage of the population of a specific age group who are currently in school, regardless of level.
- b) **Gross Enrollment Ratio (GER)** is the total enrolment in a specific level of education, regardless of age, expressed as a percentage of the eligible official school-age population corresponding to the same level of education in a given school year. The GER shows the general level of participation in a given level of education.
- c) **Net Enrollment Ratio (NER)** is the enrolment of the official age group for a given level of education expressed as a percentage of the corresponding population.

The NER show the extent of coverage in a given level of education of children and youths belonging to the official age group corresponding to the given level of education.

Appendix 2. The types of interview administration

1. **Computer-assisted personal interview (CAPI) or face-to-face interview**

Computer-assisted personal interview (CAPI) is carried out when the enumerator/data collector sits face-to-face with the respondent and helps him participate in the survey together. When conducting a CAPI survey, the enumerator/data collector will be the one who holds the device/tablet, read aloud the questions (and answers if needed) to the respondent, and enter the respondent's answer into the device/tablet.

2. **Computer-assisted self-interview (CASI)**

When conducting a survey using computer-assisted self-interview (CASI), respondents are expected to read each question and answer it themselves. When using CASI, the enumerator/data collector can monitor several respondents at one time, as long as they work on the questionnaire

independently, and the enumerator/data collector will have to be ready to provide assistance if they encounter problems during the process. One of the advantages of CASI is that data collectors/data collectors can collect more data at one time, but this can be quite challenging for respondents who are too young to read and work on the questionnaire themselves for a long time.

3. **Audio Computer-Assisted Self-Interview (ACASI)**

Audio computer-assisted self-interview (ACASI) is similar to the combination of CAPI and CASI. In ACASI, respondent holds the device themselves, so the privacy is better. Respondents will also use headphones so that they can listen to the questions and answer choices that are read out loud. This method minimize 'headache' they could get after reading too many questions and allow the data collectors to monitor more respondents at one time.

Appendix 3: GEAS-Indonesia Team Profile

1. Principal investigator: Prof Siswanto Agus Wilopo, SU., M.Sc, ScD

Siswanto Agus Wilopo, is a Professor of Population Health and the Director of Center for Reproductive Health (CRH), Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Yogyakarta Indonesia. He is a medical doctor and received Master of Science degree from McMaster University, Canada in 1984 and Doctor of Science degree from the Johns Hopkins School of Public Health in 1990. He is a former Chair of Indonesia Public Health Physician Association (2011-2015) and the First Chairpersons of Indonesia Demographic Association (IPADI) from 2010-2017. He is also a former the Deputy Chairperson of National Family Planning Coordinating Board (BKKBN), Indonesia (2001-2008) and the Deputy Assistant Minister of Population and Environment and Population/FP from 1991-2000. He is currently working for Indonesia's FP2020 working group on Data and Monitoring Evaluation (a leader on Performance Monitoring Accountability for PMA2020). His research and publications are mainly in area of population health, especially in family planning and reproductive health issues.

2. Field Manager & Researcher: Anggriyani Wahyu Pinandari, SKM., MPH

Anggriyani Wahyu Pinandari is a researcher at the Center for Reproductive Health (CRH), Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Yogyakarta Indonesia. She studied public health and received her Master of Public Health degree from Gadjah Mada University. During her masters she took Maternal Child and Reproductive Health as her major with concentration on family and population health. She studied comprehensive sexual and reproductive health education at formal education and the

cohort effect on adolescent and young adult premarital sexual intercourse using the data collected through the nationally-representative Indonesia Adolescent Reproductive Health Survey. She is a former lecturer at Universitas Lambung Mangkurat, Kalimantan Selatan. She is currently working for CRH and was involved in several projects under Global Commitment FP2020 (PMA2020 and Track20), Landscaping Adolescent Reproductive Study, and Adolescent Mental Health Survey. Her research and publications are mainly in area of population health, especially in family planning and reproductive health issues.

3. Researcher: Agung Nugroho, MPH

Agung Nugroho is researcher at the Center for Reproductive Health (CRH), Faculty of Medicine, Public Health and Nursing The Universitas Gadjah Mada, Yogyakarta, Indonesia. He is a nutritionist and finished his master on Epidemiology and Public Health in 2001 from Umea University Sweden. He is involved in various quantitative and qualitative research projects conducted by CRH. Together with the CRH team, he became a consultant to draft a district-level legislation on HIV prevention for Magelang district, Central Java (2017). He also teaches research methodology, epidemiology and biostatistics for graduate and master students. He is currently pursuing his doctoral degree at UCD Dublin, starting in 2017.

4. Researcher and Data Analyst: dr. Ifta Choiriyah, MSPH., PhD

Ifta Choiriyah is a researcher for GEAS in Indonesia and obtained her PhD from John Hopkins University. She has a medical degree from Universitas Gadjah Mada (UGM) School of Medicine in Indonesia and a Master of Science in Public Health from the Johns Hopkins Bloomberg School of Public health. Before

coming to Baltimore for her doctoral degree, she worked as a lecturer at Department of Biostatistics, Epidemiology and Population Health, Faculty of Medicine, UGM and research assistant at the Center for Reproductive Health. She provides support for instrument adaptation, data management and analysis for GEAS in Indonesia.

5. **Researcher: Grhasta Dian P, MKes**

Grhasta Dian Perestroika became a lecturer in a midwifery diploma program (D3 Kebidanan) at the General Achmad Yani University (UNJAYA) from 2014 to 2016 after earning a Masters degree in health from the Epidemiology Study Program, Applied Health Science Concentration at the UNDIP Postgraduate School. The subjects she has taught include: Midwifery Concepts, Communication and Counseling, Midwifery Care for Postpartum Period. Currently she is pursuing her doctoral degree in the Doctorate Program, FK-KMK UGM with an interest on adolescent reproductive health. During her doctoral study, she has been involved in GEAS, with the supervision from her promotor.

6. **Data Manager: Althaf Setiawan, MPH**

Althaf Setyawan is GEAS Indonesia data manager, who is responsible in managing all incoming data, maintaining the survey databases and performing routine maintenance as needed to ensure high data integrity. He is also a biostatistician at the Center for Reproductive Health (CRH), Universitas Gadjah Mada, responsible for statistical data analysis. He is also an epidemiologist by training and earned his MPH on Field Epidemiology from Universitas Gadjah Mada. He is also very experienced in computer programming for data management, data analysis, development and design of research. He has consulted various research project and many students on

biostatistics and epidemiology methods. He is currently learning the machine algorithms, techniques and tools that are capable of handling, managing and analyzing Big Data.

7. **Field Research Team:**

a. Bandar Lampung

Field Coordinator: DR. Sindung Hartanto

Sindung Haryanto was born in Temanggung, Central Java, July 23, 1964. In 1987 he graduated cum laude from the Faculty of Sociology, UGM. Since 1988 he has devoted himself as a lecturer at the University of Lampung. In 1991-1995, he pursued his master degree in sociology at UGM. In addition to teaching, he is also active in several non-governmental organizations (NGOs) in Bandar Lampung as researcher and program coordinator. He has written several books, the titles are: Land of Lampung; Farmer Struggle and Movement, Economic Sociology, Spectrum of Social Theory: from classical to postmodern, World Symbol of Javanese, Edelweiss van Jogja, Religious Sociology, and Transformation of Masculinity. He is writing actively in several national and international scientific journals. He also graduated cum laude from the Doctoral Program in Social Sciences Study Program at Airlangga University, in 2012.

Young Researcher:

1) **Ines Sherly Zahrina, S.Tr.AK**

Ines Sherly Zahrina was born and raised in Bandar Lampung. She completed her undergraduate degree in health analyst program at the Tanjungkarang Polytechnic in 2017 as the best graduate. During her study, she was a teaching assistant of a course on health research. Ines realized that she has a lot of interests in health, women and social issues that she joins several social communities that focus on various issues as administrators and facilitators, such as Janis (Social Innovation Path) which focuses on

social and environmental issues; Empowomen which is directly supported by the Australian Grand Scheme to empower Lampungese women; and IMATELKI which is the Association of Students of medical laboratory technology program. In addition, Ines is also a medical volunteer of the National Gas Company and Zakat House which focuses on improving the health status of people in disadvantaged areas (2016-present). In 2017 she joined as a volunteer in Indonesian Family Planning Association (PKBI) Lampung's program addressing reproductive health and child protection in the. This activity introduced her to the Explore 4Action research program, and she was selected as a young researcher for the Bandar Lampung region.

2) Rizkia Meutia Putri, SP

Rizkia Meutia Putri, was born in Bandar Lampung. She completed her undergraduate degree at the Department of Agrotechnology, Faculty of Agriculture, University of Lampung (2013-2017). In 2015, she was elected as the faculty ambassador and carried out activities that were directly involved with the community. Her busy life during college did not dampen her high interest in social activities. She also joined many on-campus and off-campus organizations and communities. The Path of Social Innovation (Janis) is one of the organization she was involved in that fulfilled her passion for children and society's issues. She was invited as a young speaker at the "Voices and Actions of Young People" (2017) organized by Save the Children about the Sustainable Development Goals. In addition, she was a facilitator of the Empowomen social project (2017-2018) which has the full support of the Alumni Grant Scheme (Australian Embassy) which focuses on increasing the capacity of women in Lampung. Previously, she was facilitator for North Lampung district (2018) for

"Integration Strategy for the Sustainable Development Goals Program (TPB) to the Region" by the United Nation Development Program (UNDP). She is currently a young researcher for the Explore 4 Action (E4A) program since June 2018 for Bandar Lampung region.

Enumerator:

- 1) M. Eriyansa Perdana Putra
- 2) Maria Finka Rena Avrelia
- 3) Fakhmi Umar
- 4) Ika Khodijah
- 5) Debby Agsari
- 6) Shinta Wahyuningtias

b. Denpasar

Field Coordinator: I Gusti Agung Agus Mahendra, SKM., MPH

I Gusti Agung Agus Mahendra was born in Bali. Since 2009, he has been actively volunteering at KISARA (Kita Sayang Remaja) which is a youth center managed by the Indonesian Family Planning Association (PKBI) Bali. In 2010, he was selected as a youth staff to be in charge of research and empowerment, then in 2011 was selected as the KISARA coordinator. In addition, in the same year he was selected as the "I am young with Choices" Project Manager, a project that implements comprehensive sexual education in schools, aims to increase visit to youth-friendly health service, and increase the awareness of program and policy makers on reproductive health issues and teen sexuality. I Gusti Agung Agus Mahendra completed his undergraduate degree in public health at Udayana University in 2012, then obtained his master degree in public health at Gadjah Mada University in 2017, majoring in Maternal and Child Health - Reproductive Health. Upon graduation, he joined the Center of Public Health Innovation (CPHI) at the Faculty of Medicine, Udayana University as a research staff. In 2018 he joined the Explore4Action project

research team, as the coordinator of the Denpasar area researchers. In addition, I Gusti Agung Agus Mahendra is also a lecturer in the Public Health, Technology and Science Study Program at Dhyana Pura University, Bali. His recent organizational activities include: member of the Association of the Public Health Educators, chair of the research division of PKBI Bali.

Young Researcher:

1) Iwan Abdi Suandana, SKM

Iwan Abdi Suandana graduated from Public Health undergraduate degree program, Faculty of Medicine, Udayana University and currently is a young researcher in the Explore 4 Action program for Denpasar region. Before joining the Explore 4 Action program, he was a research assistant in a research project organized by the Department of Community Medicine and Disease Prevention (IKK-IKP) Faculty of Medicine, Udayana University and Center for Public Health Innovation (CPHI) Faculty of Medicine, Udayana University in 2018. In addition, he was also a volunteer in KISARA PKBI Bali on reproductive health, sexuality and HIV / AIDS.

2) Putri Septyaning Rahayu Ariesta
S.Sosio., M.Sosio

Putri Septyaning Rahayu Ariesta was born in Surabaya. Septy obtained her undergraduate degree at the Sociology study program (2010-2015) and master degree at Airlangga University. Sociology is the opening door for Septy to dig deeper into people's lives through conducting research or doing community services. She also has special interest on gender issues. She has been involved in a number of social research, including a research project conducted in collaboration between the provincial government and several agencies in East Java Province (2012-2017); a research for Ministry of Research, Technology and Higher

Education (2015-2018) and the Ministry of Women's Empowerment and Child Protection (2016). She is currently research assistant at the Center for Gender and Child-LPI Studies at Airlangga University (2015-present), member of the PUSPA Forum for research and women of the East Java Provincial Office of Women's Empowerment and Child Protection, and young researcher for the Explore 4Action (E4A) program since June 2018 for the Denpasar City area.

Enumerator:

- 1) Ni Kadek Wiwik Dwipayanti
- 2) Ni Putu Yunika Gamayanti
- 3) I Putu Agus Purnama Wirawan
- 4) Made Adhyatma Prawira Natha Kusuma
- 5) Ni Putu Sri Widhi Andayani
- 6) Ni Made Padma Batiari

c. Semarang

Field Coordinator: Solia Mince Muzir, S.Sos

Solia Mince Muzir is a Minangnese woman migrated to Yogyakarta to do her undergraduate study in the Department of Sociology of Religion, Yogyakarta State Islamic University in 2004. Since college, she has actively participated in training, seminars and workshops related to gender and reproductive health issues. Since her introduction to PKBI DIY in 2009, she has begun to focus on the research and services/assistance on reproductive health for young people. She joined the Explore for Action program as research coordinator for the Semarang Region in Central Java. Previously, she was a facilitator for reproductive health education program for female domestic workers in the Tjoet Njak Dien Grass Institute. She was also involved in humanitarian work in conducting studies on the fulfillment of reproductive health rights of victims of disasters by joining the Gender Working Group of Yogyakarta.

Being a R&D staff at the Center for Advocacy for Women, Children and Disabilities, she focuses on conducting research on reproductive health for persons with disabilities. Her work on reproductive health and sexuality that has been published is "Lost Weed; Teenage Short Story in Different and Colored", "Adolescent Sexual and Reproductive Health Education with disabilities; Parental Guidance and Child Assistance with Disabilities.

Young Researcher:

1. Lina Agnesia, S.Sos

Lina Agnesia, is a graduate of the Anthropology Study Program (2012-2016), Faculty of Cultural Sciences, Brawijaya University, Malang, Indonesia in 2016. Lina has an interest in the social field, especially on religious and gender issues. Through anthropology, Lina explores qualitative research using ethnographic approaches and life history. Anthropology has led Lina to devote herself to research, especially social research. Since 2013-2016, Lina has been involved as a surveyor and observer in political activities with the MNC Group. In 2016, Lina was involved as a researcher from the Indonesian Human Service Foundation (IIM). In 2017, Lina was involved in several studies in Faculty of Cultural Sciences and Institute for Research and Community Service (LPPM) Universitas Brawijaya, Airlangga University and Bogor Agricultural Institute, and UNICEF CRBP. Lina also served as an administrative apprentice staff in the Anthropology Study Program from 2016-2017. At present, Lina is part of the Explore 4 Action program as a young researcher in the Semarang area. By raising the issue of reproductive health and sexuality in adolescents and youth, the

Explore 4 Action program makes Lina increasingly interested in exploring the issue, and sees the phenomenon from a social, religious and gender perspective. She is currently a young researcher for the Explore 4 Action (E4A) program since June 2018 for the Semarang City area.

2. Putri Indah Novitasari, SKM

Putri Indah Novitasari, a young person who has been concerned in the world of reproductive health and teen sexuality for the past 5 years. She graduated from the undergraduate Public Health program at Muhammadiyah University Semarang (UNIMUS) in 2017. Between February 2014-October 2017 she volunteered at PKBI Central Java for the PILAR teenage program (Youth Information and Service Center). She was a research assistant in several research projects on Comprehensive Sexual Education (CSE), Comprehensive Sexual Services (CSS), Child Marriage and Maternal and Child Health (MCH) in several institutions such as the UI Gender and Sexuality Study Center, the Women Research Institute, Rutgers WPF Indonesia and ASEAN Regional UNFPA. She is currently a young researcher for the Explore 4 Action (E4A) program since June 2018 for the Semarang City area. The existence of young researchers is an important value in this study in voicing the voices of young children.

Enumerator:

- 1) Siti Muflikhatur Rosyada
- 2) Ikha Solikha
- 3) Fiky Nurmawati Sutikno Putri
- 4) Nesya Saricha
- 5) Izza Kumalasari
- 6) Dwi Ernawati

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