FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal restrictions on adolescents’ access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
ACKNOWLEDGEMENT

The SRHR Africa Trust (SAT) wishes to acknowledge the individuals, organisations and law firms that contributed to this report through their expertise, co-operation and hard work.

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SAT wishes to thank Jerome Amir Singh (lead author), Faadiela Jogee and Samantha Chareka (co-authors) from the Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada for working on the ethical, cultural and social review. The ESC research and editorial support was provided by Faadiela Jogee and Samantha Chareka, CAPRISA.

SAT also wishes to thank Civil Society Organisations and partners who attended the Age of Consent Validation Meeting that met to discuss and validate the draft Advocacy Toolkit. The meeting critically reviewed the draft reports, analysing the data collected for its accuracy and merits.

SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social and Cultural (ESC) impacts on sexual reproductive health and rights and HIV.

Last but not least, SAT thanks TrustLaw at the Thomson Reuters Foundation for their continued collaboration with SAT on health and rights and for brokering the partnerships between SAT and the law firms. TrustLaw is the Thomson Reuters Foundation’s global pro bono legal programme, connecting law firms and corporate legal teams around the world with high impact NGOs and social enterprises working to create social and environmental change.
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>EHP</td>
<td>Essential Healthcare Package</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MPR</td>
<td>Multiple-perpetrator Rape</td>
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<td>MSP</td>
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EXECUTIVE SUMMARY

In Indonesia sex between a consenting man and woman may legally take place when both people have reached the age of 15 years. However, for anyone older than 15 years’ sexual intercourse with a person under the age of 15 years is illegal unless the perpetrator did not reasonably know that the woman was underage. Statutory rape is not expressly defined under Indonesian law. The Criminal Code and the Child Protection Law (UU23/2002) effectively prohibit conduct that is generally considered to be statutory rape.

The Child Protection Law contains offences relating to “indecent behaviour” which relate to persons under 18, and it is unclear how these provisions interact. Sex between consenting people of the same gender may legally take place when both people are aged 21 or older.

In practice, contraceptive services and commodities become accessible to young people after marriage through the State funded family planning programs established under the Law on Population Development and Family Development (UU52/2009). Women may also need their husband’s permission to obtain certain contraceptive services. The review noted that there are no known age restrictions to access emergency contraception hence parental consent is not a legal requirement however, anecdotal evidence suggests that emergency contraception is not a popular method of contraception in Indonesia.

Indonesia has a Ministry Regulation concerning HIV treatment and access to antiretroviral therapy. Generally, persons under 18 years of age may require parental consent to access medical treatment.

The country does not have any law prohibiting Post-exposure Prophylaxis (PEP) and Pre-exposure Prophylaxis (PrEP). Subject to the general rule on access to medical treatment in the country. There is however, a Government decree covering use of PEP in workplaces. It does not deal with the Age of Consent. Access to PrEP appears to be permitted under a Health Ministry Regulation. It does not deal with the Age of Consent.

Abortion is prohibited under the Health Law (UU36/2009, article 75). The only exceptions are: If the pregnancy is the result of rape that caused the victim psychological trauma; or in the case of a medical emergency (article 75).

There are no known restrictions on the provision of ANC to unmarried women, or to women of a certain age. The general rule on access to medical treatment applies to young people.

Persons under 18 may require parental consent to access HIV testing. The test results of persons under 18 years of age may be disclosed to his/her parents.
Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have therefore explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15 - 24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘All In To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts at globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility and acceptability. Adherence and quality must inform these services.
The SRHR Africa Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth attitudes survey

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / policies and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

**Methodology**

The Indonesia legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by the legal firm and the ethical, cultural and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations and policies exploring the ages for girls and boys separately where relevant, including where contradictions exist in laws, policies and regulations on these issues.

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives with and without parental consent
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent with and without parental consent
9. Age of Consent to access HIV testing without parental consent.

The ethical cultural and social review highlights some of the social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. Age of Consent for sexual intercourse and sexual debut.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.

This report is primarily a desk review of publically accessible sources, including works published by international agencies such as UNDP, UNFPA, UNESCO, UNICEF, WHO, and the World Bank, Indonesian Government reports, and non-Governmental research outputs.
Country overview

Indonesia is the fourth most populous country in the world with a population of approximately 260,177,336 people. Indonesia’s population equates to roughly 3.5% of the world’s total population. Indonesia’s population is relatively young with a median age of 28.6 years. It is estimated that 49.9% of the country’s population is male and 50.1% is female. Approximately 27.3% of the Indonesian population is under 15 years of age. Indonesia is home to over 300 ethnic and linguistic groups. The largest ethnic group are the Javanese (42%) followed by the Sundanese (15%), Matay (3.5%) the Mudarese and Minankabau (3% and 2.7% respectively), the Betawi (2.5%), Bantenese (2%), Ranjarese (1.7%), Balinese (1.5%), and the Makassereser and Crebonede (1% each respectively). More than 700 languages are spoken in Indonesia. Baha Indonesia, a modified version of Malay, is the country’s official language and English, Dutch and Javanese are the most popular languages spoken in Indonesia beside Baha Indonesia. Approximately 87.2% of Indonesians are Muslim, 7% are Christian, 2.9% are Roman Catholic, 1.7% are Hindu and 0.9% belong to various religious minorities including Buddhism and Confucianism. There are approximately 53.2 million Internet users in Indonesia, which translates to roughly 20.4% of the country’s population and 1.6% of worldwide Internet users. Indonesia has an Internet penetration of 28%, with active Internet user spending an average of 5 hours a day online.

Country context

- Indonesia is classified as a lower middle income country with a GDP of $888.5 billion.
- Indonesia’s population as of May 2016 is estimated to be approximately 260,177,336 persons.
- Indonesia is home to approximately 129.8 million males and 130.6 million females.
- Indonesia is home to approximately 10.6 million adolescents aged between 15-19 years, of which 5.26 million are male and 5.33 million are female.
- There are an estimated 71 million people under the age of 15 years, comprising approximately 36 million males and 35 million females.
- Indonesia’s national adult HIV/AIDS prevalence is estimated to be 0.47% and there are approximately 660,300 people living with HIV/AIDS (PLWHA) in the country.
- An estimated 33,700 HIV/AIDS related deaths have occurred in Indonesia.
Chapter Two: Age of Consent to sexual intercourse

In Indonesia sex between a consenting man and woman may legally take place when both people have reached the age of 15 years (Criminal Code, articles 287 and 290).

However, the Child Protection Law contains offences relating to ‘indecent behaviour’ that relate to persons under 18 years, and it is unclear how these provisions interact (see further below).

The position is different for sex between consenting individuals of the same sex. Certain exceptions apply to prohibit sex between a parent and their child or step-child, or with a child under eighteen years of age who is under the person’s care or custody (Criminal Code, article 294).

Legislation on Age of Consent to sexual intercourse

The Child Protection Law (UU23/2002) provides that it is an offence to knowingly threaten, deceive, persuade or encourage a child to engage in “indecent behaviour” (article 82). A child is defined for the purposes of the Child Protection Law as a person under 18 years of age (article 1(1)).

However, assisting researchers are not aware of any commentary or jurisprudence on what constitutes “indecent behaviour”, or how the Child Protection Law (which provides that it is an offence to force, persuade or encourage a person under 18 years to commit “indecent behaviour”) interacts with the Criminal Code (which provides that the Age of Consent to sex is 15 years).

In Aceh, the Qanun Hukum Jinayat (6/2014) prohibits sexual intercourse outside of marriage at any age (article 3).

Article 287 (Criminal Code)

1. Any person who, outside of marriage, has carnal knowledge of a woman whom he knows or reasonably should presume has not yet reached the age of fifteen years or, if it is not obvious from her age, that she is not yet marriageable, shall be punished by a maximum term of imprisonment of nine years.

2. A prosecution shall be instituted only by complaint, unless the woman has not yet reached the age of twelve years or one of the grounds in articles 291 and 294 applies.

Article 290 (Criminal Code)

The following shall be punished by a maximum term of imprisonment of seven years:

1st, any person who commits obscene acts with someone who they know is unconscious or helpless;

2nd-ly, any person who commits obscene acts with someone who they know or reasonably should presume has not yet reached the age of fifteen years or, if it is not obvious from their age, not yet marriageable;

3rd-ly, any person who seduces someone whom they know or reasonably should presume has not yet reached the age of fifteen years or, if it is not obvious from their age, is not yet marriageable, to commit or tolerate obscene acts or to have carnal knowledge, outside of marriage, of a third party.

An English translation of the Criminal Code is available via hukumonline, http://www.hukumonline.com/pusatdata/download/lt4c7b80e6173ef/node/lt4c7b7fd88a8c3. The above translation is an unofficial interpretation provided by researchers.
Article 294 (Criminal Code)

1. Any person who commits any obscene act with their under-age child, step-child or foster-child, his pupil, a minor entrusted to their care, education or custody or their under-age servant or subordinate, shall be punished by a maximum term of imprisonment of seven years.

2. The following shall be punished by the same punishment:

1st, any official who commits any obscene act with a person who is officially subordinate to them or has been entrusted or recommended to their vigilance;

2nd-ly, any executive, physician, teacher, official, overseer or attendant at a prison, national labour institution of the country, educational institution, orphanage, hospital, lunatic asylum or charity institution, who commits any obscene act with a person admitted thereto.

An English translation of the Criminal Code is available via hukumonline, http://www.hukumonline.com/pusatdata/download/lt4c7b80e6173ef/node/lt4c7b7fd88a8c3. The above translation is an unofficial interpretation provided by researchers.

Indonesia does have specific laws when children are involved, such as the (Child Protection Law (UU23/2002)).

Article 82 (Child Protection Law (UU23/2002)) states that:

Every person who uses violence or the threat of violence to force, or who employs tricks, lies or ruses to persuade, or who encourages, a child to engage in indecent behaviour, or who allows such indecent behaviour to occur, shall be subject to a penalty of fifteen (15) years’ imprisonment and a minimum term of three (3) years’ imprisonment, and a maximum fine of three hundred million rupiah (Rp. 300.000.000) and a minimum fine of sixty million rupiah ( Rp. 60.000.000).

Article 1(1) (Child Protection Law (UU23/2002))

A “Child” shall mean a person under eighteen (18) years of age, including an unborn child.


Article 3 (Qanun Hukum Jinayat)

1. This ‘Quanun’ regulates:
   a. Offenders
   b. Crimes; and
   c. Punishment.

2. For the purposes of paragraph 1, crimes include:
   d. Indecency (‘khalwat’);
   e. Free relations between men and women (‘ikhtilath’);
   f. Sex outside of marriage (‘zina’);
   g. Homosexuality (‘liwath’); and
   h. Lesbianism (‘musahaqah’)

The law firm was unable to obtain an English version of the Qanun Hukum Jinayat. The above translation is an unofficial interpretation provided by researchers.
Definition of statutory rape

Under Indonesian law, statutory rape is not expressly defined. The Criminal Code and the Child Protection Law (UU23/2002) effectively prohibit conduct that is generally considered to be statutory rape. Specifically, the Criminal Code prohibits sex outside of marriage with minors under the age of 15 and, in certain circumstances; the Child Protection Law (UU23/2002) prohibits sex with minors under the age of 18 years.

In Indonesia it is illegal for a man to have sex with a woman who is under 15 years (irrespective of whether she consents). However, there are three exceptions; the activity will not be an offence if: (a) the woman is married to the perpetrator, or (b) the perpetrator did not know and should not have reasonably presumed that the woman is under 15, or (c) if her age is not obvious, the perpetrator did not know and should not have reasonably presumed that the woman is not yet marriageable. The law firm is not aware of any definition of ‘marriageable’ in this context.

The Age of Consent is 15 years for heterosexual couples only - the position for homosexual intercourse is different.

Legislation and policy framework on statutory rape

See section above, specifically; Article 82(Child protection Law (UU23/2002); Article 1(1) Child Protection Law (UU23/2002)) and finally Article 3 (Qanun Hukum Jinayat)

Age of Consent for sex and sexual debut

The legal Age of Consent in Indonesia is 15 years of age. Although, Islam and Christianity place a high premium on preserving virginity until marriage, thus premartial sex is deemed unacceptable. According to the latest version of the Indonesian Demographic Health Survey (IDHS), 7.4% of women aged 20-49 years, sexually debut by age 15 years, 26.8% sexually debut by age 18 years, and 43.7% by age 20 years. Only 1.6% of adolescent girls between 15-19 years of age sexually debut by age 15 years and a surprising 86.2% have never engaged in sexual intercourse. This is not unusual considering that premartial sex is not widely acceptable in Indonesia. According to the Demographic Health Survey (DHS) on Adolescent Reproductive Health (ARH), of adolescent girls 15-19 years of age, only 1% think it is acceptable for women and 1.4% for men to engage in premartial sex. Out of adolescent males in the same age group, 3.3% thought premartial sex was acceptable for women and 6.4% thought it was acceptable for men. The most popular reason for approval amongst adolescent boys was love (86.5%), followed by pleasure (86.3%), and intention to wed (78.9%); adolescent girls were not asked their reasons for approval. Approval of premartial sex was more acceptable amongst rural than urban populations (1.4% and 1.1%, respectively) and it was also more acceptable amongst those who had lower levels of education than those with higher levels of education (2.6% and 1.4%, respectively). The significance of virginity is prevalent amongst never married Indonesian youth (15-24 years), as 77% women and 66% men belief that women should preserve their virginity. Amongst never married adolescent females aged 15-19 years, 76.4% believed that women should maintain their virginity and 75.3% believed that men would value their potential wife’s virginity. In contrast, 63.7% of adolescent boys in the same age group believed that women should maintain their virginity, yet, 89.1% believed that men would value their potential wife’s virginity. Regarding sexual debut, 0.9% of never-married young women (15-24 years of age) have ever had sex and 8.3% of never-married young men have ever had sex. Of these, 0.6% of adolescent girls (15-19 years of age) have had sex compared to 4.5% of their male counterparts. The most popular reason for having first intercourse amongst young women was spontaneity, as 38% said it just happened. Nearly 13% revealed that their first intercourse was forced and 11.3% attributed their actions to curiosity. The latter reason was the most common amongst young men (57.5%) followed by spontaneity (22.3%). Amongst adolescent boys (15-19 years of age) 1.1% debut at age 15 years and younger, 1.3% by age 16 and 1.4% by age 17 years; information on adolescent girls was excluded.
Early marriage

In Indonesia, the legal age of marriage is 16 years of age for women and 19 years of age for men, with parental consent being required if one or both parties are under 21 years of age. The IDHS revealed that 12.6% of adolescent girls 15-19 years of age are currently married, of which 0.2% are living with their spouse and 0.4% are divorced. The median age at first marriage amongst women 20-49 years of age was 17.3 years and 17.5 years respectively. The age increased to 18.4 years in women who completed primary school and early 20 years in women who has some secondary school education. The DHS on ARH found that 3.7% of never married adolescent girls 15-19 years of age married before age 20 years and 1.6% of young women 20-24 years of age wed before turning 20 years old. Marrying before age 20 years was more common in rural (4.8%) than urban (2.1%) areas, and was higher amongst those with lower levels of education than higher levels of education. Surprisingly, 8.9% of never married adolescent boys aged 15-19 years married before turning 20 years and 7.2% of never married young men aged 20-24 years married before age 20 years. The majority of never married adolescent girls and boys revealed their ideal age of first marriage to be between 24-25 years (41% and 49%, respectively) and only 0.7% of adolescent girls and 0.8% of boys thought that the ideal age of marriage was under 20 years of age.

Plan International found that 38% of Indonesian women that are currently married wed before turning 18 years of age, 7.8% married between the ages of 12-14 years and 30.6% married between the ages of 15-17 years. In contrast, only 3.7% of men married between the ages of 15-17 years in Indonesia, none had wed under the age of 15 years. It revealed that 45.5% of respondent agreed that there were benefits to child marriage (under 18 years), 59% agreed that it provides girls with a sense of security and 30.2% agreed that child marriage is a traditional practice entrenched in Indonesian communities. Sixty-two percent of respondents agreed that menstruation indicates that a girl is ready for marriage, thus girls could marry as young as 9 years of age and boys at 15 years of age because in Islam it is believed that puberty occurs around these ages. Girls also felt pressured to marry young in order to release their families of the financial burden of having a girl child. It is preferable for the girl to marry an older man since survival and a better life cannot be guaranteed once she leaves home. Moreover, 58.8% agreed that child marriage prevents girls from sexual violence and 58% agreed that child marriage protects and preserves family honor and reputation. Child marriage is encouraged in Indonesia, especially since it is widely believed females are given fewer life opportunities than males (72.5% of respondents agreed). Moreover, Indonesia is predominantly Islamic and the practice of child marriage could be influenced by the Prophet Muhammad’s marriage to Aisha, who was nine-years-old at the time of marriage. Moreover, Islam and Christianity permit marriage once puberty has been obtained.

Social media and technology

An estimated 33% of the Indonesian population access the Internet via mobile devices, with 77% of Indonesian youth aged between 13-24 years, preferring to always have Internet access, despite location. The country’s WhatsApp penetration rate is currently 52%. Mobile phone is the most commonly used device to access the internet amongst Indonesia adolescent (52%). Approximately 52% of adolescent users have stated that they have been exposed to sexually explicit and graphic content on the Internet; however, only 14% have stated that they have willingly accessed pornographic site on the Internet. Sexually explicit material on mobile phones used by adolescents in pervasive in Asia. Sexually explicit content, particularly pornography, is linked to risky sexual behaviour and early sexual debut amongst adolescents.

Country experiences in addressing the barriers

The National Family Planning Coordinating Board (NFPCB), provides information on sexual reproductive health rights to adolescents and their parents. NFPCB along with UNFPA have developed a number of training modules targeted towards adolescents and their parents as well as relatives that take care of adolescents during their formative years. However, these modules have a limited reach since it is not incorporated in the national school curricula.
The Ministry of Health (MoH) provides counselling and information on SRH to adolescents through a high school program targeted towards primary and high school students. The program also extends the provision of SRH information to teachers and other adults responsible for adolescents. Moreover, the MoH along with WHO developed an ARH pocket book for adolescents aged 14-19 years. However, much like the NFPCB’s effort, the MoH developments only reach a limited audience.

**Homosexuality and transgender expression**

Indonesia, much like the rest of Southeast Asia, is thought to be tolerant of those identifying as lesbian, gay, bisexual, transgender, and intersexual (LGBTI), but this is a myth. Homophobia is systemic in Indonesia, as a global report on homosexuality reveals that a startling 93% of Indonesians believe that society should not be accepting of homosexuality. Therefore, a derisory 3% of Indonesian are accepting of homosexuality, rendering Indonesia the most homophobic country in the Asia/Pacific region. The country is also amongst the top five most homophobic countries globally. Further, Islam is the prevailing religion of Indonesia followed by Christianity. It is trite that both religions condemn homosexuality. Indonesia’s Criminal Code does not proscribe same-sex sexual relations. Hence homosexual relationships are permissible. However, same-sex sexual activity is prohibited if committed with a minor under Article 292 of the Criminal Code. Nevertheless, parliament conferred the Aceh province the right to espouse and implement Sharia law which is only enforceable against Muslims. Punishment includes 100 lashes for engaging in homosexual sex. Further, in South Sumatra LGBTI members may face imprisonment and harsh fines for engaging in same-sex sexual relations. Moreover, a fatwa has been issued by the country’s most influential Muslim clerical group to enact the death penalty for homosexual behavior. Members of the Indonesian LGBTI community are subjected to stigma, discrimination, violence, sexual assault, loss of employment and bullying in and outside of schools, purely on the basis of their sexual orientation. It is erroneously believed that Indonesian LGBTI are not worthy of protection for the following reasons: same-sex relationships are prohibited by God; it is believed that LGBT is merely a lifestyle one chooses out of one’s own volition; the LGBTI lifestyle is synonymous with glamour and excess, poverty, and LGBTI do not mix. Further, since LGBTI members hide their sexual proclivities, the injustices that they often endure are not overt and therefore are not urgent, unlike those faced by religious and ethnic minorities and women. Therefore, state policies concerning their protection is not deemed necessary or urgent.

**Exceptions for gay sex**

Sex between consenting people of the same gender may legally take place when both people are aged 21 years or older. Article 292 of the Criminal Code prohibits an adult from committing an “obscene act” upon another person of the same gender whom he/she knows or ought to know is a minor. The Criminal Code does not define ‘minor’ in this context; however, the Civil Code relevantly defines a minor as a person who is younger than 21 years of age and is not married. Applying a literal interpretation of this provision, sex with a consenting person of the same gender who is younger than 21 years but is married would not fall within Article 292.

**Legislation and policy framework on statutory rape**

Article 292 of the Criminal Code expressly applies to ‘adult’ offenders; hence, this provision prima facie does not prohibit sex between two minors of the same gender. Other than Article 82 of the Child Protection Law (UU23/2002) prohibiting a person from forcing, persuading or encouraging a person under 18 to engage in ‘indecent behaviour,’ and the Qanun Hukum Jinayat (6/2014) in Aceh, the law firm is not aware of any law prohibiting sex between two people of the same gender who are under the age of 21 years.

In Aceh, the Qanun Hukum Jinayat (6/2014) prohibits sexual intercourse between people of the same gender at any age (Articles 63 and 64).

Article 82 (Child protection Law (UU23/2002) ; Article 1(1) Child Protection Law(UU23/2002)) and finally Article 3 (Qanun Hukum Jinayat) as well as
Article 292 (Criminal Code)

Any adult who commits any obscene act with a minor of the same sex, whose minority the adult knows or reasonably should presume, shall be punished by a maximum term of imprisonment of five years.

Article 330 (Civil Code)

Minors are those who have not reached the full age of 21 years and who have not previously entered into matrimony.

See also legislation quoted above
An English translation of the Civil Code is available via Refworld.org, http://www.refworld.org/pdfid/3ffbd0804.pdf. The above translation is an unofficial interpretation provided by researchers.

An English translation of the Criminal Code is available via hukumonline, http://www.hukumonline.com/pusatdata/download/lt4c7b80e6173ef/node/lt4c7b7fd88a8c3. The above translation is an unofficial interpretation provided by researchers.

Ethical implications and recommendations

Indonesia’s Government is a signatory to the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the UN Convention on the Rights of the Child. All these instruments prohibit unfair discrimination against all persons, including LGBTI individuals.

Indonesian authorities should go beyond lip service and the publication of plans and policies, by taking tangible affirmative measures to promote and protect the rights of LGBTI, especially adolescent LGBTI, who are particularly vulnerable given their age and sexual orientation. Education authorities should consider developing education campaigns in schools aimed at discouraging homophobia and discrimination against learners who are LGBTI. In addition, healthcare workers should be given sensitivity-training and reminded that they have an ethical (and legal) duty to provide care to any person in need and that this duty supersedes their personal moral biases regarding sexual orientation and lifestyle choice. Furthermore, health workers and state officials should be reminded that they have a legal and ethical obligation to always act in the best interests of a child, regardless of that child’s sexual orientation.

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Country experiences in addressing the barriers

The Indonesian Constitution affords basic human rights and protections, including the right to be free from discrimination, equality, dignity, freedom and liberty, protection from inhumane and degrading treatment, and although not explicitly stated, such protections should apply to LGBTI.  

Additionally the country's 2004-2009 National Human Rights Action Plan explicitly refers to members of the LGBTI community as ‘a special group whose rights are to be protected’.  

However, the State has been relatively slow to uphold the rights of LGBTI in Indonesia.
Chapter Three: Access to contraception services and commodities

The legal age of majority in Indonesia is 21 years. However, Indonesia’s law on child (under the age of 18 years) protection requires consultations with children who are entitled to have voice their opinions and be listened to in all matters concerning their growth and development. Moreover, every child is entitled to healthcare services. Thus, the law implies that healthcare providers should consult with adolescents under the age of 18 years regarding decisions on medical treatment, including HTC.

There is no law in Indonesia that sets an express legal age at which a young person can access contraceptive services and commodities. In practice, contraceptive services and commodities become accessible to young people upon their marriage under State funded family planning programs.

The Health Law (UU36/2009) provides that every individual has the right to a healthy and safe reproductive life and sexual life; however, this right applies only in relation to a person’s “lawful partner” (see Article 72).

The Law on Population Development and Family Development (UU52/2009) establishes a national family planning program to assist married, or engaged, couples to realise their rights to the State’s ideal marriage age, age for childbirth, reproductive health and access to counselling (Article 21). The Law requires that the Government improve access to information, counselling and contraceptive commodities requested by married couples (Article 23).

The impact of this policy framework largely restricts access to contraceptives to married couples at any age.

Legislation and policy framework

Article 72 (Health Law (UU36/2009))

All people shall be entitled:

a. to have healthy, safe reproductive life and sexual life, free from compulsion and/or violence, with a legal partner.
b. to determine their reproductive life, free from discrimination, force and/or violence, with respect to noble values that do not degrade the dignity of mankind and are consistent with religious norms.
c. to determine when and how often they want to reproduce in a way that is medically healthy and does not contradict religious norms.
d. to obtain information, education, and counselling about reproductive health that is correct and can be accounted for.


Article 21 (Law on Population Development and Family Development (UU52/2009))

1. The family planning policy referred to in article 20 shall be implemented to help candidates or couples in making decisions and realizing their reproductive rights responsibly in relation to:

a. the ideal age of marriage;
b. the ideal age for giving birth;
c. the ideal number of children;
d. the ideal age-gaps between children; and
e. reproductive health education.
2. The family planning policy as referred to in paragraph (1) aims to:
   a. provide for desired pregnancies;
   b. maintain health and reduce maternal, infant and child mortality;
   c. improve access to, and quality of, information, education, counselling and services in family planning and reproductive health;
   d. increase participation in general, and participation of men in particular, in the practice of family planning; and
   e. promote breastfeeding of infants in an attempt to increase spacing between pregnancies.

The law firm was unable to obtain an English version of the Law on Population Development and Family Development (UU52/2009). The above translation is an unofficial interpretation provided by researchers.

Impact of religious laws

Indonesia’s Aceh province enforces Sharia law. Under Sharia law, consensual sexual relations outside of marriage may attract penalties for the offence of zina (fornication). Homosexual conduct attracts penalties for the offences of liwat (sodomy) or musahaqah (sex between women) while a female may be charged with ‘khalwat’ (unlawful premarital or extramarital sexual relations) if she has reached puberty and is found in close proximity with a member of the opposite sex who is not a relative. Under a 2009 law that applies to Aceh, offences such as being alone with an unrelated member of the opposite gender breaking Islamic dress rules can be punished with a public caning. In 2014, the provincial Government of Aceh extended Sharia law to non-Muslims as well. Faced with Sharia law penalties, adolescents in Aceh may be deterred from accessing SRHS.

Contraception

According to the IDHS, 94.7% of Indonesian adolescent girls aged between 15-19 years of age are aware of at least one method of contraception (modern and traditional) and 94.6% of adolescent girls in the same age group are aware of any modern method of contraception. A scant 6.3% of all adolescent girls between 15-19 years of age are using any method of contraception and 6.2% are using any modern method of contraception. The most popular method of contraception amongst adolescent girls 15-19 years of age are injectables (4.9%) followed by the pill (1.2%), and IUD and Implants (0.1%, respectively). Amongst married adolescent girls aged 15-19 years 48.1% used any method of contraception and 47.6% are using any modern method of contraception. Again, injectables was the most prevalent method (37.3%) followed by the pill (8.8%), IUD (0.9%) implants (0.6%) and LAM (0.1%). Remarkably, 100% of all male adolescents 15-19 years of age did not use any methods of contraception. Contraceptive use amongst all women aged 15-49 years was more prevalent in rural (48.3%) than urban (43.3%) areas. Even though the Government does provide contraception free of charge, access is limited and most women utilizing modern forms of contraception purchase it. According to the IDHS, the Government supplied only 3.7% of the pill, 2.7% of condoms, and 2.6% of injectables to the women surveyed. However, more women accessed implants (33.4%) and IUD (23.4%) from the Government free of charge. Approximately 55% of adolescent girls 15-19 years of age had a total demand for family planning and 6.6% had a total unmet need for contraception. The most popular reason for nonuse in women aged 15-29 years was wanting as many children as possible (14.7%). 4% said their husband opposed use, 4% cited religious prohibition, and 4.7% had no knowledge of contraceptive use. Nearly 25% did not use contraceptives because of the side-effects and 6.8% cited health concerns as a reason for nonuse.

According to the DHS on ARH, adolescent girls 15-19 years of age were most familiar with the pill (87.7%), injectables (86.7%), and condoms (76.8%). Only 59.6% of never married adolescent girls aged 15-19 years were aware that condoms prevented pregnancy and 46% knew that condoms could prevent HIV/AIDS. On the other hand, 71.8% of male adolescents in the same age group were aware that condoms could prevent pregnancy and 60.8% knew condoms could prevent HIV/AIDS. Out of unmarried adolescent girls 15-19 years of age, 16% used condoms at first sex and 20% used condoms at last sex compared to 22% and 23.5% of male adolescents who utilized condoms at first and last sex. However, a 2015 international study found that 48% of married adolescents 15-19 years of age used traditional contraceptive methods and 7% had an unmet need for contraception, 12% of married adolescents reported that their husbands made decisions...
concerning contraceptive use. Moreover, according to a 2015 international study, only 5% of adolescents knew where to obtain HCT.

Access to emergency contraceptives

The law firm was not aware of any law in Indonesia that sets an express legal age at which a young person can access emergency contraception in Indonesia.

In practice, contraceptive services and commodities become accessible to young people after marriage through the State funded family planning programs established under the Law on Population Development and Family Development (UU52/2009). It is not clear whether emergency contraception is available through the State’s family planning programs and services. Nonetheless, anecdotal evidence suggests that emergency contraception is not a popular method of contraception in Indonesia.

Although one type of ‘morning after pill’ (Postinor) is commercially available in Indonesia, the legality of providing emergency contraception to any person of any age remains unclear. Article 299 of the Criminal Code prohibits a person from providing treatment that contributes to the termination of a pregnancy. Any health professional providing emergency contraception therefore runs the risk of contravening the Criminal Code and may be barred from practicing in Indonesia (article 299, Criminal Code; see also Amnesty International, Left without a choice - Barriers to reproductive Health in Indonesia, 2010, p.31).

Women may also need their husband’s permission to obtain certain contraceptive services. For example, Article 26 of the Law on Population Development and Family Development (UU52/2009) requires the mutual consent of the husband and wife for use of contraceptives that carry a health risk.

Legislation and policy framework

Article 299 (Criminal Code)

1. Any person who intentionally provides treatment to a woman or causes her to undergo a treatment, giving her to understand or raising the expectation that her pregnancy may be thereby terminated, shall be punished by a maximum term of imprisonment of four years or a maximum fine of three thousand rupiahs.
2. If the offender has acted in pursuit of gain, an occupation or a habit of committing the crime, or is a physician, midwife or pharmacist, the punishment may be increased by one third.
3. If the person found guilty commits the crime in the course of his profession, he may be excluded from the practice of said profession.

An English translation of the Criminal Code is available via hukumonline, http://www.hukumonline.com/pusdatdata/download/l4c7b80e6173ef/node/l4c7b7fd88a8c3. The above translation is an unofficial interpretation provided by assisting researcher.

Lack of adolescent friendly sexual and reproductive health services

According to the most recent IDHS and the Indonesian Population Census, there are approximately 40.4 million Indonesian youth aged between 15-24 years. An estimated 29.4 million youth have never married, of which 16.6 million are male and 12.8 million are female. Indonesia is home to approximately 10.6 million adolescents aged between 15-19 years, of which just over 5.2 million are male and just over 5.3 million are female. Out of the total number of adolescents aged 15-19 years, approximately 9.7 million have never married (approximately 4.93 million males and 4.75 million females). Youth access to adolescent friendly SRHS are thwarted by the country’s prevailing conservative religious and cultural norms. Not only is SRHS dissuaded amongst unmarried youth, it is simply not provided in spite of the country’s commitment to providing SRHS to everyone in Indonesia. Unmarried adolescents find it exceptionally difficult to access SRHS. Even though services may be available to unmarried people, evidence illustrates that approximately 40% of unmarried adolescent girls between 15-19 years of age have much more difficulty in accessing services than their older unmarried counterparts. Unmarried adolescent girls, particularly from rural areas, face a myriad of obstacles to accessing SRHS including stigma and discrimination from families and friends; social taboos
regarding unmarried women accessing such services; gender biases; lack of privacy and financial constraints. The lack of access for unmarried adolescents is compounded by the legislative barriers. Indonesia prohibits unmarried women from accessing Government provided SRHS. Adolescent friendly health services have yet to be established and implemented throughout the country despite the urgent need for such services.

**Ethical implications and recommendations**

The Indonesian Government should do more to expand SRHS access to adolescents. Moreover, the Government should do more to encourage female reproductive rights, female autonomy, and condom use amongst male adolescents. The application of Sharia law to Muslim communities in parts of Indonesia (such as Aceh Province) may serve as a barrier to accessing SRHS if young people are deterred from accessing such services for fear of reprisals for engaging in conduct deemed immoral or because parental or spousal consent is a strict precondition for access to services. The limitation of Indonesia’s Constitutional Court review powers to only statutes passed by the country’s national parliament (People’s Representative Assembly) means that the Court does not have authority to hear challenges to other sources of law, such as Islamic qanun passed by the provincial Government in Aceh and regional regulations (peraturan daerah or “perda”) promulgated by district or municipal Governments that seek to enforce Islamic law or morals. The exclusion of Sharia Law from the jurisdiction of the country’s Constitutional Court effectively means that adolescents (and adults) in Aceh can be deprived of human rights, such as the right to reproductive health decision-making and freedom from discrimination on the basis of sexual orientation, without external recourse.

**Country experiences in addressing the barriers**

In 2007, the Government strengthened its family planning initiatives by improving family planning facilities and services, as well as developing the country’s contraception supply chain. The NFPCB’s KB Kencana program focused on the development of comprehensive and innovative strategies at both the district and national level in order to up-scale family planning activities in the country. Consequently, the KB Kencana program has become a high priority for the Government with respect to advancing family planning in Indonesia. Moreover, the Government welcomed the involvement of the private sector in order to counter the dwindling support of donors, which ultimately led to the private sector backing 73% of the country’s family planning services.

In 2005, the Indonesian Government implemented the Adolescent Reproductive Health (ARH) program, which seeks to provide counselling and information to adolescents on reproductive health matters. The ARH is now incorporated into the national reproductive health policy and strategy, providing services in addition to counselling and communication. The Youth-Friendly healthcare Program focuses on the implementation of adolescent friendly health services; however this program is limited to a certain number of communities. The Ministry of National Education (MoNE) in partnership with the World Bank launched an ARH education project in ten cities across Central and East Java, the project focused on informing adolescents and training teachers on ARH issues. Nevertheless, sex education is seldomly taught in Indonesian schools.

**Child poverty**

Indonesia is home to around 81.3 million children. It is estimated that approximately 13.8 million children are subsisting below the country’s poverty line, as more children than adults are suffering from monetary poverty in Indonesia. Child poverty is particularly pronounced in the provinces of Aceh, Maluku, Papua, West Papua, North Sumatra, and West Sumatra. Children’s vulnerability to poverty is predominantly defined by their position in the context of the population’s general distribution in terms of income and consumption. Unfortunately, children are more likely to be living in the lower section of distribution than adults due to unequal distribution of children across the distribution, as poorer household are more likely to have much larger families. Further, poverty is far more prevalent in the rural parts (approximately 14%) of Indonesia than the urban areas (approximately 8%). Poverty is one of the primary barriers to access to SRHS. Adolescents afflicted by poverty are incapable of purchasing contraceptives and accessing and utilizing SRHS due to their economic constraints. In rural areas, services could be located in places that are not easily accessible, thus requiring indirect cost such as transport, in addition to paying for the actual services. Evidence suggests a correlation between poverty and child labour.
Child labour

According to the most recent Indonesian Child Labour Survey (ICLS) the term ‘working children’ refers to children engaged in child labour; adolescents aged between 12-14 years engaging in light work; and adolescents aged between 15-17 years involved in work that does not include any of the worst forms of child labour.142 ‘Child labour’ includes all children aged 5-17 years who are engaged in the worst forms of child labour (such as human and drug trafficking as well as sex work) and/or working under the minimum age of employment, during a stipulated period of time.143 The ICLS revealed that there are approximately 4 million Indonesian children are considered to be working children.144 Out of this number, an estimated 43.3% (approximately 1.76 million children) are engaged in some form of child labour.145 An estimated 82% (approximately 48 million) of the total number of children aged 5-17 years attended school, of which 41.2% or 24.3 million children were engaged in housekeeping. 146 At minimum, nearly half of all working children worked for 21 hours a week, and 25% worked for at least 12 hours a week. 147 Working children worked for average of 25.7 hours a week, child labourers averaged 35.1 hours a week, and an estimated 21% of child labourers worked under hazardous conditions for more than 40 hours a week.148

Indonesia’s National Labour Force Survey revealed that in 2009 there were roughly 36 million adolescent aged 10-17 years, of which nearly 3.7 million were employed, averaging 27 hours a week and 36% worked up to 20 hours a week. 149 However, many work over 45 hours a week; about 22% of males and 29% of females worked more than 45 hours a week.150 According to the U.S. Department of Labor’s 2014 findings on the worst forms of child labour, approximately 3.6 million adolescents between the ages of 10-17 years are engaged in some form of work in Indonesia.151 Three percent of adolescent aged 10-14 years (around 816,363) are working, 2.1% are working and attending school simultaneously, and child labour is more prevalent amongst adolescents aged 10-17 years in rural areas (12.5%) than urban (5.9%).152 The majority of children worked in agricultural industry (61.1%), including fishing, which requires children to work in dangerous conditions that put their lives at risk for long hours. It is not uncommon to work 10-12 hours a day, living on platforms out at sea for weeks at time.153 After agriculture, most children worked in services (26.5%) and industry (12%).154 According to the International Labour Office’s (ILO), 47% of Indonesian youths (aged between 15-24 years) were part the country’s labour force in 2012.155 Employed children and child labourers endure remarkably protracted working hours.156,157 Therefore, it is unlikely that children engaged in employment and child labour will be able to access SRHR services given their working hours and financial need.

Ethical implications and recommendations

If adolescents are engaged in labour practices, it follows that they will likely be unable to access SRHS, especially if their working hours and the operating hours of SRHS correspond. Indonesia’s prevalence of child labour may accordingly serve as a major barrier to adolescents in that country accessing SRHS. Authorities should consider ways to facilitate access to SRHS for adolescent labourers. This may include the provision of community-based youth friendly SRHS mobile clinics with extended operating hours to cater for adolescent laborers.

Country experiences in addressing the barriers

According to the Manpower Act No 39 of 2003, entrepreneurs are prohibited from employing children (under 18 years).158 However, children aged between 13-15 years may be employed for light work provided it does not encroach upon or encumber “their physical, mental and social developments.”159 The prospective employer is required to obtain written permission from the child’s parents or guardian, and a work agreement must be implemented between the parties. The child is prohibited from working more than three hours a day, employment must not disrupt the child’s schooling, the employee is required to comply with occupational safety and health requirements to ensure the child’s protection, and the child must be given a wage.160 The legislation places the minimum age of employment at 14 years161 and prohibits the employment and involvement of children in the worst forms of child labour,162 including slavery, prostitution, pornography, gambling, drug trafficking and all forms of employment insalubrious to the “health, safety and moral of the child.”163

The Ministry of Labor’s Reducing Child Labor to Support the Family Hope Program (Pengurangan Pekerja Anak- Program Keluarga Harapan) aids child labourers between the ages of 7-15 years by removing them from their places of work, places them in shelters for 4 months, and providing them with counselling, education and financial assistance. 164 In 2014, the program was implemented across all of the country’s provinces,
totaling about 400 districts, the program reached its goal of saving 15,000 child labourers, of which 90% returned to school.⑩⑩

The Ministry of Social Affairs oversees the Family Hope Program (Program Keluarga Harapan). The object of this program is to assist child labourers who have left school by providing them with services.⑩⑤ It provides financial assistance to families on condition that they fulfill educational requirements such as school enrollment and attendance.⑩⑥ Three million households received assistance from the program in 2014. Such programs have proven to be effective in reducing, albeit slightly, child labour in the country.⑩⑦

The Family Hope Program (Program Keluarga Harapan) is a MoSA run program that assists the poorest families in Indonesia.⑩⑧ It endeavors to render financial assistance to these families provided that certain requirements are fulfilled, including educational requirements concerning school enrollment and attendance.⑩⑩ The Social Security Organizing Body for Health (BPJS Kesehatan) and the Regional Health Security (Jamkesda) are Government programs that integrate numerous existing health programs providing access to health services to Indonesians.⑩⑦ It assists millions of poor Indonesians by paying for their health service fees as well as helping millions more via their local Governments.⑩⑧ Unconditional Cash Transfer Program (Bantuan Langsung Semetara Masyarakat) is a Government run program seeking to enhance the livelihood of poor Indonesians by providing them with financial assistance.⑩⑪

**Stigma and discrimination**

The insidious consequences of HIV-related stigma and discrimination of PLWHIV is well-documented.⑩⑩ The implications of HIV-related stigma and discrimination often extends its reach to families and friends of PLWHIV, as well as the communities to which they belong.⑩⑪ HIV-related stigma and discrimination is prevalent in Indonesia and impedes access to HIV preventative care and services.⑩⑤⑩ Research has found that those patients with fairly substantial concerns regarding HIV-related stigma, are less likely to be inclined towards HCT.⑩⑬⑪ A meagre 6% of Indonesians aged 15 years and older are aware of HCT, with the figure dropped to 4% amongst rural men and women.⑩⑬ Fear of stigma and discrimination, along with lack of familial and communal support, breach of confidentiality and service-provider attitude creates barriers to HCT.⑩⑯ Stigma and discrimination also influences the use of PrEP and its accessibility. PrEP use is usually accompanied by stigma associated with risky sexual activity and is often linked to HIV infection, which deters access to the drug notwithstanding its effectiveness.⑩⑩ Additionally HIV-related stigma and discrimination from service-providers thwart access to HIV preventative services in the country.⑩⑱

**Ethical implications and recommendations**

Regular sensitization training and monitoring could enable healthcare workers to address young people’s needs. Health authorities have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values. Authorities should facilitate HCT and SRHS, access in places where adolescents and young persons will feel free and comfortable to access such services. Staff must be trained to provide services in a non-judgmental and child-friendly manner.

**Country experiences in addressing the barriers**

Indonesia’s National AIDS Strategy Plan 2010-2014 primarily endeavored to prevent and reduce the spread of HIV in the country and improve the lives of PLWHIV.⑩⑭ One of the plan’s principal objectives is to reduce HIV/AIDS related stigma and discrimination targeted towards people of key populations (such as sex workers and MSM) and PLWHIV as well as AIDS survivors.⑩⑮ It also seeks to ensure the provision of HIV services without discrimination.⑩⑯
Chapter Four: Age of Consent and HIV testing

In Indonesia the age at which a young person can give informed consent to HIV testing is 18 years old. Informed parental consent is required prior to testing for all children under the age of 18 years.

Legislation and policy framework on HIV testing

Article 3(b) (Health Ministerial Regulation (74/2014) on the guidelines for examinations, counselling and HIV testing) The provision of information when offering HIV testing to children should be done in the presence of the child’s parent or guardian. Special consideration should be given to children and adolescents under the legal age (less than 18 years old). As underage individuals that do not yet have the right to make/give informed consent, they already have the right to be involved in all decisions that concern their lives and to express their views to the best of their developmental status. In this instance, the informed consent of the child’s parents or guardian is required.

The law firm was unable to obtain an English version of the Health Ministerial Regulation (74/2014) on the guidelines for examinations, counselling and HIV testing. The above translation is an unofficial interpretation provided by researchers.

Age of consent to report HIV status directly to adolescents

Indonesian HIV laws and regulations do not specify an age at which HIV status is reported directly to adolescents. The Health Law (UU 36/2009) provides that all people are entitled to information about their own health, and to the confidentiality of any health conditions disclosed to their health practitioner.

However, the Child Protection Law (UU23/2002) stipulates that parents and families have primary responsibility for the health of their children until age 18 years. On this basis, health practitioners may be required to disclose an adolescent’s HIV status to his/her parents up until the age of 18 years.

Legislation and policy framework

Relevant provisions of the Child Protection Law are set out in the answer to Q.6 above.

Article 8 (Health Law (UU36/2009))

All people shall have the right to receive information about their own health, in particular including measures and medication that have been administered to them or are to be administered to them by health personnel.

Article 57(1) (Health Law (UU36/2009))

All people shall be entitled to the confidentiality of their personal health condition as disclosed to the health service provider.


Any information obtained from counselling activities, HIV tests, medical treatment, medical care and other related activities must be kept confidential just like any medical records.

The law firm was unable to obtain an English version of the Decree on HIV/AIDS Prevention and Control in the Workplace, No. KEP.68/MEN/2004. The above translation is an unofficial interpretation provided by researchers.

Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

Access

Health Ministry Regulation 21/2013 on combatting HIV and AIDS enables access to antiretroviral therapy (ART) by stipulating that HIV treatment be undertaken using a combination of Antiretroviral (ARV) medications (Article 32).

Parental consent

Article 45(1) of the Child Protection Law (UU23/2002) provides that a child’s parents and family are responsible for protecting the child’s health. A child is defined under the Child Protection Law (UU23/2002) as a person under the age of 18 years. The implication of Article 45 of the Child Protection Law (UU23/2002) is that treating practitioners may require parental consent prior to providing ART to young people aged under 18 years.

Legislation and policy framework on access to ART

In Article 32 (Health Ministry Regulation 21/2013 on combatting HIV and AIDS)

1. HIV treatment is aimed at reducing the risk of HIV transmission, inhibiting the worsening of opportunistic infections and improving the quality of life of those living with HIV.
2. HIV Treatment as referred to in paragraph (1) shall be provided in conjunction with the screening and treatment of opportunistic infections, provision of condoms and counselling.
3. Treatment of AIDS aims to reduce the amount of virus (viral load) of HIV in the blood to an undetectable level by using a combinations of ARV medications.

Article 1(1) (Child Protection Law (UU23/2002))

A ‘Child’ shall mean a person under eighteen (18) years of age, including an unborn child;

Article 45 (Child Protection Law (UU23/2002))

1. A child’s parents and family shall be responsible for maintaining the health of the child from his time in the womb.
2. Should the child’s parents and family be incapable of fulfilling their responsibilities as referred in Section (1) above, then the Government shall be fully responsible.
3. The responsibility of the Government referred to in Section (2) above shall be subject to the provisions of the laws and regulations in effect.

Article 46 (Child Protection Law (UU23/2002))

The state, the Government, the family and parents shall be responsible for ensuring that a child is born free of life threatening or incapacitating diseases.

Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-exposure Prophylaxis (PrEP)

The research did not identify any law prohibiting both HIV Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) in Indonesia. Access to both PrEP and PEP is outlined in Article 5 of the Health Law (UU36/2009) stipulates that every person has an equal right to access health services. The National HIV and AIDS Strategy and Action Plan for 2010-2014 ('HIV Action Plan') particularly targets HIV positive women and their children for the provision of ARV Prophylaxis. In this way, the Health Law (UU36/2009) and the Action Plan work together to promote equal access to ARV prophylaxis for infants and young people at risk of mother-to-child HIV transmission.

Health Ministry Regulation 21/2013 on combatting HIV and AIDS additionally stipulates that all mothers living with HIV must receive counselling on how to provide their children with ARV prophylaxis and cotrimoxazole prophylaxis treatment. Anecdotal evidence notes that many children have been treated with ARV by grinding up adult medications as paediatric formulas have only recently become available under the State’s HIV programs (Green and Nagar, ‘Care, Support & Treatment for PLHIV in Indonesia’, Yayasan Spiritia http://spiritia.or.id/art/bacaart.php?artno=2018).

However, it is unclear whether PrEP and PEP, as a specific form of ARV prophylaxis, is commonly used in Indonesia. PrEP use is not specified in any of the Government policies, guidelines, law or regulations reviewed by this study. Nonetheless, in the absence of express restrictions on access to PrEP, Article 5 of the Health Law provides equal access to health services. This right prima facie extends to young people exposed to HIV by any route.

In the absence of express restrictions on access to PEP, Article 5 of the Health Law provides equal access to health services. This right prima facie extends to young people exposed to HIV through any route.

Parental consent

On parental consent, article 46 of the Child Protection Law (UU23/2002) establishes the mutual obligation of the State, the Government, the family and parents of children to ensure that infants are protected from illnesses including HIV.

While article 46 establishes a shared responsibility to children in relation to HIV treatment, article 45(1) of the Child Protection Law (UU23/2002) provides that a child’s parents and family are responsible for protecting the child’s health. Only if the child’s parents and family are unable to carry out their responsibilities, will the Government be obliged to ensure the child’s healthcare in accordance with the laws and regulations in force Child Protection Law, article 45 (2)-(3).

The implication of article 45 of the Child Protection Law (UU23/2002) is that treating practitioners may require parental consent prior to providing ARV prophylaxis to young people aged under 18 years.

Legislation and policy framework

Section 3.3.3(4) (National HIV and AIDS Strategy and Action Plan 2010-2014) [Direct quote from official document in English], All HIV positive pregnant women and their children will receive ARV prophylaxis as appropriate.
Annex Two (National HIV and AIDS Strategy and Action Plan 2010-2014) [Direct quote from official document in English] Target: 100% of PLHIV [people living with HIV] access to ARV treatment in line with WHO guidelines, aiming to improve health of PLHIV.

Activity: Provision of ARV to PLHIV in need of treatment, including HIV positive inmates and children (with attention to ensuring optimal supply chain management systems for undisrupted supply of ARVs and related health commodities and equipment).


PrEP and PEP uses is not specified in any of the Government policies, guidelines, law or regulations reviewed by this study.

However, PrEP and PEP uses appears to be permitted under Health Ministry Regulation 21/2013 on combating HIV and AIDS which provides for HIV treatment that is aimed at reducing the risk of transmission by using a combination of ARV (article 32). It is unclear from our research whether PrEP is a commonly used form of ARV in Indonesia.

Article 32 (Health Ministry Regulation 21/2013 on combatting HIV and AIDS)

1. HIV treatment is aimed at reducing the risk of HIV transmission, inhibiting the worsening of opportunistic infections and improving the quality of life of those living with HIV.
2. HIV Treatment as referred to in paragraph (1) shall be provided in conjunction with the screening and treatment of opportunistic infections, provision of condoms and counselling.
3. Treatment of AIDS aims to reduce the amount of virus (viral load) of HIV in the blood to an undetectable level by using a combination of ARV medications.

An English translation of the Criminal Code is available via hukumonline, http://www.hukumonline.com/pusatdata/download/lt4c7b80e6173ef/node/lt4c7b7fd88a8c3. The above translation is an unofficial interpretation provided by researchers.

Legislation and policy framework on access to PEP

There are policies regarding PEP in Indonesia for the workplace. PEP treatment is specifically permitted in Indonesian workplaces by the Decision of General Director of Manpower Management and Monitoring (Decision of the General Director) (Kep. 20/DJPPK/VI/2005) and technical guidance. The technical guidance issued with the Decision of the General Director details the circumstances and manner in which PEP should be used.

PEP use may otherwise be allowed under Health Ministry Regulation 21/2013 on combating HIV and AIDS which provides for HIV treatment using a combination of ARV (article 32).

Article 32 (Health Ministry Regulation 21/2013 on combatting HIV and AIDS)

1. HIV treatment is aimed at reducing the risk of HIV transmission, inhibiting the worsening of opportunistic infections and improving the quality of life of those living with HIV.
2. HIV Treatment as referred to in paragraph (1) shall be provided in conjunction with the screening and treatment of opportunistic infections, provision of condoms and counselling.
3. Treatment of AIDS aims to reduce the amount of virus (viral load) of HIV in the blood to an undetectable level by using a combinations of ARV medications.

The law firm was unable to obtain an English version of the Health Ministry Regulation 21/2013 on combating HIV and AIDS. All extracts from the Health Ministry Regulation 21/2013 on combating HIV and AIDS are unofficial interpretations by the author.
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

In Indonesia abortion is prohibited under the Health Law (UU36/2009, article 75). The only exceptions are:

- If the pregnancy is the result of rape that caused the victim psychological trauma; or
- In the case of a medical emergency (article 75).

Where either of these exceptions are invoked, the Health Law (UU36/2009) enables access to safe abortions and post abortion care by:

- Providing for pre and post abortion counselling by a competent and authorized counsellor;
- Stipulating that all abortions must be carried out by a health practitioner who has expertise and is certified by the Minister; and
- Requiring that abortion clinics satisfy the requirements stipulated by the Minister.

While the law firm is not aware of any specific Age of Consent in relation to lawful abortions, the Health Law (UU36/2009) requires the woman’s husband to give his permission, except if the pregnancy is the result of rape.

Legislation and policy framework on safe abortion and post care

Article 75 (Health Law (UU36/2009))

1. People are prohibited from carrying out abortions.
2. The prohibition contained in paragraph (1) is subject to the following exceptions:
   a. where indication of a medical emergency is detected in the early stages of pregnancy that threatens the life of the mother and/or fetus, is a serious genetic disease and/or inviable deformity, or a condition that cannot be resolved such that it would be difficult for the infant to survive outside the womb; or
   b. the pregnancy resulted from a rape that caused psychological trauma to the victim;
3. The treatment contemplated in paragraph (2) may only be carried out following counselling and with post-treatment counselling by a competent and authorized counsellor.
4. Further regulations concerning diagnosis of a medical emergency and rape, as contemplated in paragraph (2) and paragraph (3) shall be provided for in a Government Regulation.

The above translation is an unofficial interpretation provided by researchers.

Article 76 (Health Law (UU36/2009))
Abortion as contemplated in Article 75 may only be carried out:

a. before the pregnancy reaches 6 (six) weeks from the first day of the last period, except in a medical emergency situation;
b. by health personnel who has expertise and authority and holds the certificate stipulated by the minister;
c. with the consent of the pregnant mother concerned;
d. with the consent of the husband, except in the case of a rape victim; and
e. in health service provider which satisfies the requirements stipulated by the Minister.

The above translation is an unofficial interpretation provided by researchers.
Chapter Eight: Age of Consent on access to antenatal care (ANC)

Access to Antenatal Care in Indonesia is provided under the National Health Insurance Program. Indonesia’s Antenatal Care Guidelines recommend pregnant women receive at least four antenatal consultations: one during both the first and second trimesters and two during the final trimester. According to the Guidelines, antenatal services should assess height and weight measurements, assess blood pressure, measure foetal height, take blood and urine tests, administer immunisations and iron tablets, and provide the mother with advice.

The law firm is not aware of any restrictions on the provision of ANC to unmarried women, or to women of a certain age.

Legislation and policy framework

Article 13 (Health Ministerial Regulation (71/2013) regarding health services under the National Health Insurance Program)

1. Each Participant is entitled to health services which include positive, preventive, curative, and rehabilitative services, including medicines and medical consumables in accordance with his/her medical needs.
2. Health services for participants guaranteed by social security consist of:
   a. First Level healthcare;

Article 16 (Health Ministerial Regulation (71/2013) regarding health services under the National Health Insurance Program)

First Level healthcare is a non-specialist health service that includes:

a. administrative services;
b. positive and preventive services;
c. examination, treatment, and medical consultation;
d. non-specialist medical action, both operative and non-operative;
e. drug services and medical consumables;
f. blood transfusions according to medical need;
g. level one diagnostic laboratory investigations; and
h. hospitalization of first instance in accordance with the medical indications.

The law firm was unable to obtain an English version of the Health Ministerial Regulation (71/2013) regarding health services under the National Health Insurance Program. The above translation is an unofficial interpretation provided by researchers.

Article 17 (Health Ministerial Regulation (71/2013) regarding health services under the National Health Insurance Program)

1. Healthcare of First Instance referred to in article 16 for medical services includes:
   ... 
   e. examination of pregnant women, women who have recently given birth, nursing mothers, infants and young children by a midwife or doctor; and

2. The health service referred to in subsection (1) shall be conducted in accordance with clinical guidelines.

3. The clinical guidelines for the health service referred to in paragraph (2) shall be determined by the Minister.
Antenatal Examinations
In accordance with the policy of the Department of Health, antenatal service visits should be paid at least 4 (four) times during pregnancy at the following times:

• a minimum of once during the first trimester
• a minimum of once during the second trimester
• a minimum of twice during the third trimester

The law firm was unable to obtain an English version of the Antenatal Service Guidelines 2007. The above translation is an unofficial interpretation provided by researchers.

The law firm was unable to obtain an English version of the Health Ministerial Regulation (71/2013) regarding health services under the National Health Insurance Program. The above translation is an unofficial interpretation provided by researchers.
Chapter Nine: Access to HPV vaccine and cervical cancer screening and treatment

Indonesia does not appear to have a national policy framework or legislative scheme enabling access to Human Papillomavirus (HPV) vaccines, cervical cancer screening or treatment. However, people may be able to access these services independently from their healthcare providers.

Consent

The Child Protection Law (UU23/2002) stipulates that parents and families have primary responsibility for the health of their children until age 18. Treating practitioners may therefore require parental consent prior to providing HPV vaccinations or screening services to young people aged under 18 years.

Legislation and policy framework

Article 1(1) (Child Protection Law (UU23/2002))

A “Child” shall mean a person under eighteen (18) years of age, including an unborn child;

Article 45 (Child Protection Law (UU23/2002))

1. A child’s parents and family shall be responsible for maintaining the health of the child from his time in the womb.
2. Should the child’s parents and family be incapable of fulfilling their responsibilities as referred in Section (1) above, then the Government shall be fully responsible.
3. The responsibility of the Government referred to in Section (2) above shall be subject to the provisions of the laws and regulations in effect;

Article 46 (Child Protection Law (UU23/2002))

The state, the Government, the family and parents shall be responsible for ensuring that a child is born free of life threatening or incapacitating diseases.
Chapter Ten: Contradictions and inconsistencies

On the Age of Consent for sexual intercourse, the Criminal Code sets contradictory age requirements that distinguish between heterosexual and homosexual couples.

While the Health Law (UU36/2009) and decrees guarantee confidentiality for HIV/AIDS testing in general, there is a potential conflict with the Child Protection Law (UU23/2002), which places the responsibility for maintaining the health of the child (person under 18) to the child’s parents. Thus, healthcare professionals may be obliged to report a child’s HIV status to his/her parents.
Chapter Eleven: Conclusion

Indonesian authorities should facilitate autonomous adolescent access to SRHS, regardless of marriage status. Moreover, authorities should undertake tangible affirmative measures to promote and protect the rights of adolescent LGBTI, who are particularly vulnerable given their age and sexual orientation. Given the impact of poverty on adolescent health, Indonesian authorities must sustain their poverty-alleviation schemes and their efforts to eradicate or reduce child labour in the country. The practice of Sharia law in Aceh Province and its exemption from the country’s Constitutional Court jurisdiction poses a threat to the SRHR of adolescents in that region. Notwithstanding Sharia law, Indonesian authorities have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values.

A limitation of this work is that data sources were limited to publically-accessible documents in English, and not based on original qualitative or quantitative research. Relevant studies may have been missed if they were not included in the databases reviewed for this report.
## Chapter Twelve: Recommended intervention on legal and policy framework

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Annex 1

KEY QUESTIONS IN ESC REVIEW

i. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents (males and females).

ii. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

ii. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

iv. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

v. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

vi. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?
2. Is there a definition of statutory rape? Please define.
3. Are there exceptions to question (1)? For example gay sex?
4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.
5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’) At what age? Please specify if there are different ages with and without parental consent.
6. Policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART), including Age of Consent with and without parental consent.
7. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent with and without parental consent.
8. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
9. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.
10. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent with and without parental consent.
11. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
12. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.
13. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent with and without parental consent.
14. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent with and without parental consent.
15. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent with and without parental consent.
16. What is the Age of Consent to access HIV testing without parental consent?
17. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/policy requirements to report this status to her/his parents?
18. Please explain any inconsistencies between the answers above.