SRHR alliance

Opportunities and Barriers for Increasing the Uptake of SRH Services among Under-Served Young People in Indonesia

Final Report

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SRHR alliance

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The Access, Services and Knowledge (ASK) programme is a three-year programme (from 2013 to 2015) funded by the Dutch Ministry of Foreign Affairs with the aim of improving the SRHR of young people (10 – 24 yrs.), including underserved groups. The programme which is a joint effort of eight organizations comprising of Rutgers (lead), Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI) is implemented in 7 countries, namely Ethiopia, Ghana, Indonesia, Kenya, Pakistan, Senegal, and Uganda. Operations research (OR) was identified as an integral part of activities in the ASK programme. The aim was to enhance the performance of the program, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme Theory of Change.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASK	Access, Services and Knowledge
Askes	Asuransi Kesehatan or Health Insurance
ART	Antiretroviral Therapy
ARVs	Anti-retrovirals
BBM	Black Berry Messages
BPJS	Badan Penyelenggara Jaminan Sosial or Social Security Organizing Agency
BPS/CBS	Biro Pusat Statistik or Central Bureau of Statistics
CD Bethesda	Community Development Bethesda
CHI	Child Helpline International
CHPM UGM	Centre for Health Policy Management Faculty of Medicine, Gadjah Mada University
DIY	Daerah Istimewa Yogyakarta or Special Region of Yogyakarta
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ID	Identification in Bahasa Indonesia is known as KTP or Kartu Tanda Penduduk
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
Jamkesmas	Jaminan Kesehatan Masyarakat is Indonesia's government-financed health coverage program for the poor and near-poor
JPY	Jaringan perempuan Jogyakarta or the Women's Network of Yogyakarta
KAP	Key Affected Populations
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSM	Men-having-sex-with-Men
NGO	Non-Governmental Organisations
OR	Operational Research
PE	Peer Educators
PI	Principal Investigator
PIK-KRR	Pusat Informasi dan Konseling Kesehatan Reproduksi Remaja
PITC	Provider-Initiated Testing and Counselling
PKBI	Perkumpulan Keluarga Berencana Indonesia or Indonesian Plant Parenthood Association
PKRR/PIKER	Pendidikan Kesehatan Reproduksi Remaja/Pusat Informasi Kesehatan Reproduksi Remaja or Youth Friendly Health Services at Puskemas
PLWHA	People Living with HIV/AIDS
PRECEDE-PROCEED	Predisposing, Reinforcing, and Enabling Construct in Education/Ecological, Diagnosis and Evaluation- Policy Regulatory and Organizational Construct in Educational and Environmental Development
Puskesmas	Pusat Kesehatan Masyarakat or Community Health Centres
Renstra Kemenkes	Rencana Strategis Kementrian Kesehatan or Strategic Plans of the Ministry of Health
RIH	ResultsinHealth
RWPF	Rutgers World Population Foundation
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSI	Semi-Structured Interview
STDs	Sexually Transmitted Disease
STIs	Sexually Transmissible Infection
UNFPA	United Nations Population Fund
USG	Ultrasonography
VCT	Voluntary Counselling and Testing
YEA Alliance	Young Entrepreneurs' Alliance
YPLWH	Young People Living with HIV

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Introduction

This study was conducted as part of Operational Research (OR) implemented in the Access Services and Knowledge (ASK) Programme. The ASK programme is a three-year programme funded by the Dutch Ministry of Foreign Affairs with the aim of enhancing uptake of SRH services among young people aged 10-24 years, including underserved groups. The programme, which is a joint effort of eight organizations including: Rutgers WPF, Simavi, Amref Flying Doctors, CHOICE for Youth and Sexuality, dance4life, Stop AIDS Now!, the International Planned Parenthood Federation (IPPF), and Child Helpline International (CHI). ASK has been implemented in seven countries: Kenya, Uganda, Ethiopia, Ghana, Senegal, Pakistan and Indonesia, and runs from 2013 to 2015.

The ASK programme focuses on young people who are highly vulnerable for SRHR problems and have specific needs (LGBTIQ, YPLWH, young adolescents (10-16), young people in remote areas and disabled youth). In particular, the programme aims to increase youth access to quality youth-friendly services and SRH commodities including ARV and contraceptives. Within the YEA Alliance and ASK programme, the assumption is that improving access to direct information on SRHR and increased outreach to inform youth on where and how to access youth-friendly services, will lead to service uptake by 'hard to reach' youth.

The OR has been identified as an integral part of activities in the ASK programme. It aims to enhance the performance of the programme, improve outcomes, assess feasibility of new strategies and/or assess or improve the programme's Theory of Change. The OR is intended to provide insights into current SRH needs, knowledge, practices, rights-violations and the target-group's specific 'culture' to effectively adjust the programme. 'Underserved' groups are particularly relevant to be targeted by the research in order to contribute to the improvement of the accessibility of services offered to these groups by the ASK programme. A first OR (OR1) was conducted earlier in order to identify SRHR related information needed by young people and the channels in which the information is disseminated.

In May 2015 ResultsinHealth (RiH) was assigned by RWPF Indonesia to conduct a Literature Review on opportunities and barriers for increasing the uptake of SRH Services among underserved young people in Indonesia. This literature review aimed to inform the OR and provide information to adapt a pre-developed proposal, focusing on aspects such as: confirmed target groups, data collection sites, milestones, activity planning and budget. The objectives of the review were to collect and analyse available (published and grey) literature on: (a) young people's access to SRH information and services in Indonesia and (b) young people's access to the private and informal sector for SRH services in Indonesia and attitudes of private sector health workers towards young people in Indonesia.

Following this literature review assignment, RiH was asked to conduct a second OR (OR2) from June-October 2015, focusing on opportunities to increase the SRH service uptake of (underserved) young people in the Yogyakarta province of Indonesia. This study aimed to obtain 'positive examples' from real-life experiences of young people accessing SRH services in the study area. In addition the research was expected to provide insights into the existing referral systems that have been established for young people and the different roles and possible ways of collaboration between the not-for-profit and for-profit health sectors. In order to maintain a continuation and linkage to OR1, the design and analysis of OR2 took the findings of OR1 into account in order to avoid duplication.

This report is the result of OR2. It provides an overview of the background of the study (Chapter 1), and presents the methodology used in conducting the study (Chapter 2). Chapter 3 presents the findings, focusing on three separate sub models that were developed in order to identify positive examples and strategies used when it comes to young people's SRH service uptake. In Chapter 4

these findings are discussed further, providing an overview of the different pathways that can be taken towards SRH service uptake. In the conclusion (chapter 5), the main research questions – that focuses on the most effective strategies to increase young people's SRH service uptake – will be answered, after which general and specific recommendations (for the ASK programme) are made.

1. Background

1.1. Findings of Literature Review

According to the new National Midterm Development Plan 2015-2019, Indonesia is about to benefit from a demographic bonus marked by a decrease in the dependency ratio that has the potential to boost economic growth. However, to realise this bonus, the quality of life for the next generation will need to be carefully guided by policies and practices, including those related to sexual and reproductive health and rights (SRHR). 'The next generation' - Indonesia's youth - are a large group with specific sexual and reproductive health (SRH) needs. The latest population census conducted by the Central Bureau of Statistics (BPS, 2014) noted that Indonesia has a population of 237.6 million of whom 27.6% are adolescents and young people between the ages of 15-24 years.

Political commitment to improve young people's SRHR is evidenced by the 2009 Health Law no. 36 and further supported by a specific regulation issued by the Ministry of Health no. 61 in 2014. Both articulate the importance of improving adolescents and young people's access to quality SRH information and services. In addition, the current National Health and Development Plan (Renstra Kemenkes) outlines a minimum SRH service package that should be available in all public health facilities to prevent unintended pregnancies and the transmission of STIs (including HIV) among young people.

While some progress has been made, the status of young people's SRHR in Indonesia remains fragile. The general discourse in the country does not encourage nor accommodate a free and healthy SRH environment. To illustrate this, Holzner & Oetomo (2004:40) argue, "the dominant prohibitive discourse in Java denies and denounces youth sexuality as abnormal, unhealthy, illegal or criminal, reinforced through intimidation about the dangers of sex". This existing discourse influences the approach of SRH programs – governmental, non-governmental organisations (NGOs), and other – since by adhering to legal and social norms in Indonesian society, they promote a culture of 'responsible abstinence' (Holzner & Oetomo, 2004). In particular, when it comes to accessing SRH services, (unmarried) youth face both legal and social restrictions. Both the absence of contraceptives for unmarried young people and laws that prohibit girls and women from having an abortion increase the difficulties and risks in their SRH. One third of the 2.4 million abortions performed in Indonesia in 2012 were for young people and access to safe abortion for this group is severely restricted. Unsafe abortion accounts for 15-30% of the maternal mortality in Indonesia. In addition, the highest prevalence of HIV and AIDS is found among Indonesian youth (15-29), with unsafe sex being the main mode of HIV transmission.

Available literature describing Indonesian adolescents' reproductive health needs, barriers and enabling factors for SRH service uptake, and whether or not the current system meets their needs is quite scarce. To our knowledge, no comprehensive study on these topics has been conducted to match young people's SRH service needs and demands with the existing services in the country. In addition, there is no information available on specific key affected populations (KAP).

Following the results of the literature review, it is clear that effective, comprehensive, and multi-faceted strategies are needed when targeting young people's SRH needs and service uptake in Indonesia. *Puskesmas*, NGOs and the private sector need to address the realities of young people's SRH needs and service uptake. In doing this, (perceived) barriers and supporting factors in accessing SRH information and services need to be explored in order to develop programs that increase service uptake. Internationally, there are ample available examples of SRH programs for young populations although these programs have had mixed results. Only a few reviews have shown successful implementation, showing that integrated and multi-faceted interventions are the most effective and

sustainable. The literature review has demonstrated that recognition of the need to incorporate all layers of society – and particularly relevant actors in young people's lives – in SRH programs plays an important role in strategies to improve adolescent SRH. Identifying 'gatekeepers' (e.g. parents, teachers, peer educators etc.), and increasing their awareness and skills in regard to SRH issues is essential for successful SRH programming and an increase in SRH service uptake.

Furthermore, the studies reviewed show that, despite the fact that young people often have knowledge of SRH services, there exists a significant gap between this knowledge and the actual *use* of services. Even though SRH services are available in Indonesia, this does not mean that young people will automatically access them. Lack in service uptake often has to do with multi-level barriers that are experienced by young people; such as individual/psychological factors, service-related factors and/or socio-cultural, legal and economic factors. In addition, the prohibitive discourse in Indonesia when it comes to SRH issues (which is influenced by restrictive laws and regulations on safe abortion and contraceptives for unmarried young people), significantly impacts the availability of and stigma surrounding SRH information and services as well as limited availability of (youth friendly) SRH services for young people in Indonesia. Differences in characteristics of public and private SRH services have also influenced the pattern of SRH services uptake among young people.

One of the objectives of the ASK programme is to assess whether or not implemented measures are increasing SRH service uptake and eliminating possible barriers. Following the review findings, it is recommended that ASK's Operational Research target youth in general to explore the factors that facilitate young people's access to SRH services delivered by the government's health centres and private clinics. The review has shown that the provision of SRH information and services for young Indonesians in general are inadequate. Therefore, it can be argued that all 'young people' fall under the term 'underserved', rather than specific key affected young populations. For Indonesia, we propose a working definition of underserved that includes all youth (age group 10-24).

1.2. Sexual and Reproductive Health in DIY

Daerah Istimewa Yogyakarta (DIY, or the Special Region of Yogyakarta) is in the middle of Java, Indonesia. The latest data in 2013 showed that total population of DIY was 3,560,080, including 1,758,098 males and 1,801,982 females (Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia - Ministry of Health's Data and Information Centre, 2013). The Indonesian population, including Yogyakarta, is considered to be a young population. Although the number of births has decreased compared to five years ago, the number of young people (10-24 years) and the number of people in the reproductive age population (especially 25-29 years) for both men and women has increased (Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia - Ministry of Health's Data and Information Centre, 2013).

The latest baseline study on youth's sexual and reproductive health in Yogyakarta was initiated and funded by UNFPA and conducted by the Centre for Health Policy Management Faculty of Medicine, Gadjah Mada University in 2013 (UNFPA – CHPM UGM, 2013) showing that level of knowledge of young people on SRH covers puberty, menstruation, contraceptive method, and STI (including HIV). Most of them said these topics were taught during high school. Ninety-five per cent of the respondent sensed the need for reproductive health service providers for youth and information on reproductive issues was the most desired type of service to be provided (85%). Furthermore 41% of the respondents felt the need for contraceptive information and services provided by reproductive health providers. About 5% of unmarried female and 19% of unmarried male respondents had ever had sexual intercourse. Males were more likely to have more than one sexual partner compared to females. Nearly 65% of those who had ever had sexual intercourse had used contraception during their first sexual intercourse. In terms of ways of obtaining information about contraceptive use, most of the respondents discussed it with friends or partners. The majority of the youth population

in Yogyakarta (73%) felt that having contraceptive service providers for youth is important. According to the majority of the respondents, the perceived ideal age to marry (for both men and women) was 20-24. For having a child, more respondents thought that the ideal age for men was older than 25, while for women it was 20-24. More than 80% of the respondents thought that unwanted pregnancies should be kept and taken care of. The findings from this baseline study show that the level of SRH knowledge among young people in Yogyakarta is still limited when it comes to basic knowledge of reproductive health. Young people perceived to be in need of SRH services and contraceptives, since some of them had been sexually active. In regard to the appropriate age to get married, they preferred a more mature age than the minimum age of 16 (female) and 19 (male) stated in the Indonesian law[1].

Focusing on the existing or currently available reproductive health service providers, only 33% of the young respondents had ever seen/heard of such providers. Whilst, since the Ministry of Health released a health regulation, UU nomor 36 tahun 2009[2], some initiatives on reproductive health services have started. Among those, Pelayanan Kesehatan Peduli Remaja (PKPR) – Youth Friendly Services are available in *Puskesmas*, as part of the essential reproductive health services ("Pelayanan Kesehatan Reproduksi Esensial"). These essential reproductive health services consist of the implementation of regulations with regard to reproductive health. By having these regulations, the government is officially justifying the establishment of and opening opportunities to expand SRH services for young people in primary health centres (e.g., *Puskesmas*). This also means that, in principle, SRH services for young people should be available at public health facilities. However, the reality is that not all *Puskesmas* currently implement this policy.

[1] http://luk.staff.ugm.ac.id/atur/UU1-1974Perkawinan.pdf

[2] https://www.k4health.org/toolkits/indonesia/kebijakan-dan-peraturan-perundang-undangan

2. Methodology

2.1. Theoretical Background

The theoretical background used for this research was the PRECEDE-PROCEED Health Promotion Planning Model[3] developed by Lawrence Green and colleagues (1980)[4]. The PRECEDE model was originally designed as "a framework for the process of systematic development and evaluation of health education programs". The model is multidimensional and, as such, "recognizes that health and health behaviours have multiple causations which must be evaluated" (National Cancer Institute, 2005). The PROCEED component was added to the framework to address health promotion interventions beyond traditional educational approaches to changing unhealthy behaviour. The main purpose of the model is to focus initial attention on outcomes rather than inputs. This means that the desired outcome is the starting point, after which one works backwards to determine what factors caused that outcome. In other words, the model is used to determine what *preceded* the desired outcome (same sources as above).

For the purpose of this research, we focused on the PRECEDE aspects of the model and examined the factors that preceded the desired health behaviour. In the context of this study, the desired behaviour was an increased utilization of SRH services by young people in Indonesia. We used the model's phase of *educational diagnosis* and the causes identified in this phase (causing a particular desired outcome). This phase includes three sets of factors that (can) precede the occurrence of a desirable outcome (in our case, SRH service uptake): predisposing, enabling and reinforcing factors. These factors are considered to be crucial components and most likely to result in a behavioural change. In the PRECEDE/PROCEED model, **Predisposing factors** are defined as any characteristic of a person or population that motivates behaviour prior to the occurrence of that behaviour. Predisposing factors include knowledge, beliefs, values, and attitudes. **Enablers/Enabling factors** are defined as environmental characteristics that facilitate action and any skill or resource required to attain a specific behaviour. Enabling factors include accessibility, availability, skills, and laws (local, state). **Reinforcing factors** are defined as rewards or punishments following or anticipated as a consequence of behaviour. These factors particularly serve to strengthen the motivation for behaviour. These factors include family, peers, and teachers, but can also be external factors such as the media or (referral) systems in place.

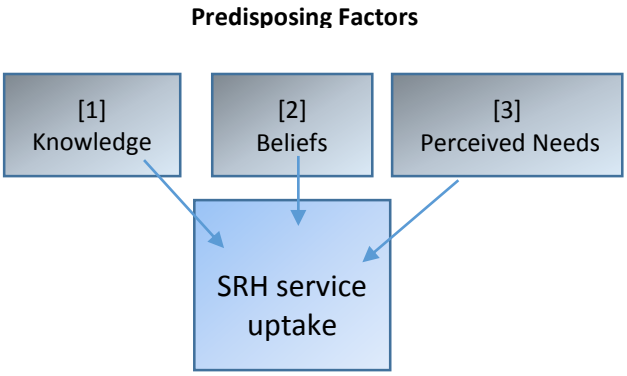
The PRECEDE-PROCEED model was chosen because using this approach (positive and negative) the components of predisposing, enabling and reinforcing factors can be identified and sorted. This strategy informs program implementers about the factors that need to be prioritized and addressed to change and maintain the desired outcome (in this case, an increased SRH service uptake by youth) (National Cancer Institute, 2005).

Following the design of the educational diagnosis phase of the PRECEDE model, predisposing, enabling and reinforcing factors were used to categorise the study findings. Thus, the original model was modified to suit the context and content of this research.

Predisposing Factors (referred to as Sub-Model 1, see figure 1) defined in this study include: knowledge of reproductive health, services and sources of information, and reasons for accessing services including: perception, motivation, perceived needs, norms and values of young people, stigma and stereotyping. This sub-model serves to provide an understanding of the internal characteristics of the young respondents that influenced their SRH service uptake.

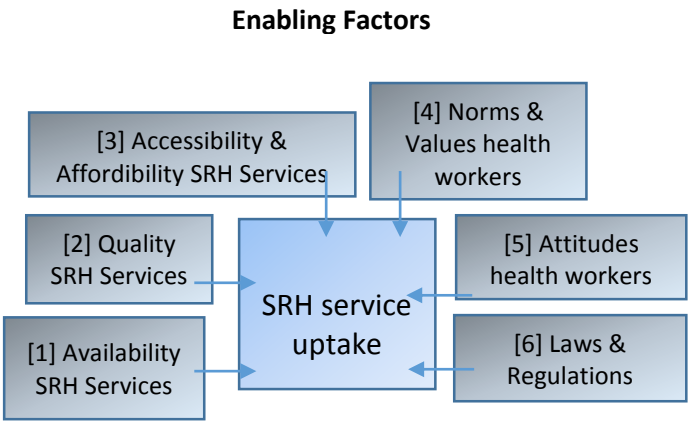
[3] PRECEDE is an acronym for Predisposing, Reinforcing, Enabling, Causes in, Educational Diagnosis and Evaluation. PROCEED is an acronym for Policy, Regulatory, Organizational Constructs in Educational and Environmental Development.
[4] See Annex 1 for an illustrative presentation of the PRECEDE-PROCEED model

Figure 1. **Sub-Model 1 – Predisposing Factors**



The **Enabling Factors** (referred to as Sub-Model 2, see figure 2) include characteristics of SRH health providers that may or may not facilitate young people's utilization of services in the study area. Characteristics include the availability of SRH services and commodities, quality of services provided; accessibility and affordability of SRH services; health worker norms, values and attitudes; and laws and regulations related to SRH issues. Sub-Model 2 serves to provide examples of (the quality of) services provided by SRH service providers.

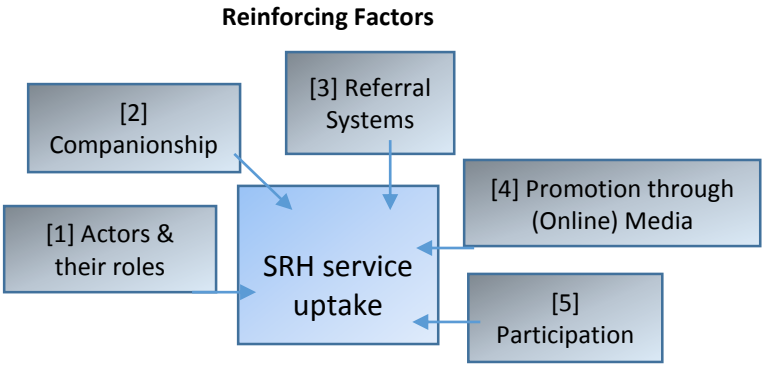
Figure 2. **Sub-Model 2 – Enabling Factors**



The **Reinforcing Factors** (referred to as Sub-Model 3, see figure 3) include the actors in young people's lives and the roles they (can) play in the provision of SRH information. They also include companionship, referral systems that have been established by various service providers (governmental and non-governmental), youth participation in SRH initiatives (e.g. the ASK and other SRH-related programs), and the promotion of SRH information and services (e.g. through [social] media).

According to the PRECEDE/PROCEED model, the presence of these three groups of factors is needed for the desired outcome to occur (represented in our Main Model – see figure 4). In order to be able to utilize the services, all three factors have to be present. Based on the PRECEDE model, the combi-

Figure 3. Sub-Model 3 – Reinforcing Factors

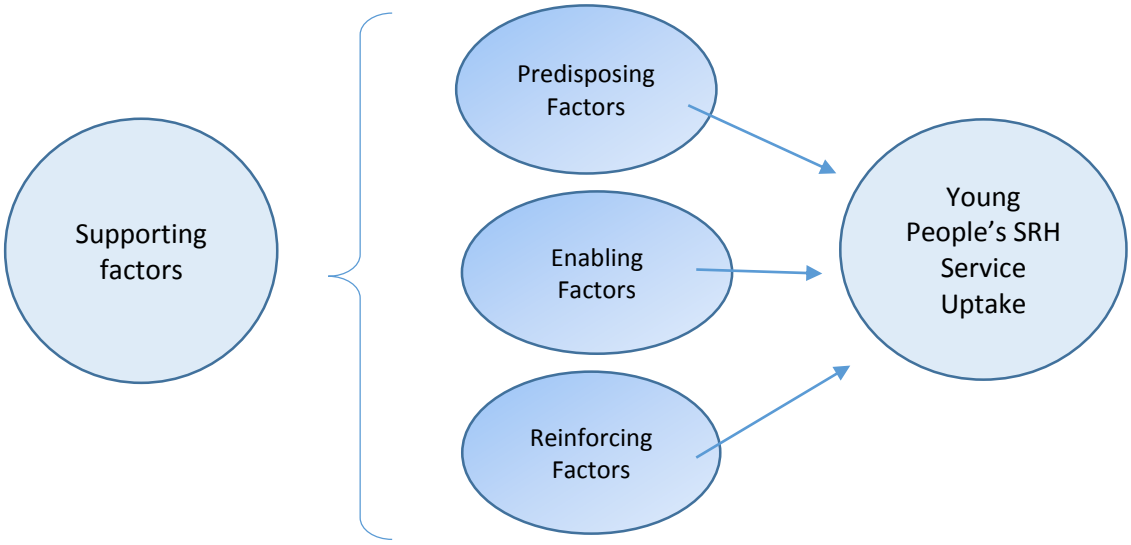


nation of the predisposing factors, enabling factors and reinforcing factors strongly influences/ contributes to behavioural change. In this study, the presence of these three factors were expected to support SRH service uptake of young people. Therefore, the adjusted precede model developed presents predisposing, enabling and reinforcing factors as supporting factors for young people's SRH service uptake (see figure 4). Data analysis was conducted within and across the sub-models to describe the dynamics of the various factors. The results of this analysis were used to identify factors that could be used to answer the main study question:

What are the most effective strategies to increase the uptake of sexual and reproductive health services among young people in Indonesia including key targeted populations (e.g. young disabled persons, young LGBTIQ)?

The most effective strategies were formulated after deducing and analysing the factors that contributed to the young people's decision-making process when utilizing SRH services. Following the sub-models, the factors we identified in this research consisted of internal (within individual) and external factors (outside the individual, e.g. health services and/or programmatic factors, such as ASK or other SRH programmes). All components defined in this research were explored, with a particular focus on those that were dominant and often existed among young study respondents thus contributing to their decision to make use of available SRH services.

Figure 4. Main Model – Supporting Factors for Young People's SRH Service Uptake



2.2. Research Questions

In this study, one main question and several detailed sub-questions were developed. The purpose of the central question we proposed for this study was to obtain 'positive examples' from the real-life experiences of young people accessing SRH services in the study area. We expected to retrospectively identify the youths' pathways in health-seeking behaviour for SRH issues. The main central question was:

> *What are the most effective strategies to increase the uptake of sexual and reproductive health services among young people in Indonesia including key targeted populations (e.g. young disabled, young LGBTIQ)?*

This question was then divided into sub-questions on the following topics: (1) perception of and demand for SRH services among young people and (2) the actual SRH services provided for young people.

A. Perceptions of and demand for SRH services among young people

I. *How do young people currently seek and obtain SRH services?*

II. *What factors prevent young people from accessing SRH services and commodities, including those who are sufficiently informed about SRH issues? (Probe on social stigma, and bringing shame to families)*

III. *What are the perceived needs of young people regarding SRH services in DIY?*[5]

IV. *Who are the most important educators in improving young people's knowledge of SRH and disseminating information on SRH services? Is the information well accepted? Is their work effective in influencing young people's behaviour?*

V. *How do young people perceive SRH services (quality, accessibility, availability, relevance, etc.)?*

B. Service provision for young people

I. *Which SRH services do health providers (including public and private health providers) consider to be appropriate for young people at different stages of their reproductive life-course?*
II. *When necessary (for young people who are sexually active), which contraceptive methods do private providers*[6] *consider to be appropriate for young people at different stages of their reproductive life-course?*
III. *What barriers do public and private providers (clinicians and distributors) and the informal sector feel exist in providing SRH services and commodities to young people? How do private providers deal with financial barriers for young people?*
IV. *What factors determine the success of certain providers in offering services to young people?*
V. *Do the norms and values of health providers in SRH provision differ? In what way? Are there any specific issues that need to be addressed?*

[5] In regard to these topics, the results of OR1 were taken into account when developing the data collection instruments to avoid redundancy.
[6] Only private providers were asked this question since they were the only ones providing contraceptives to (unmarried) young people in Indonesia.

VI. *What types of referral systems have been established by these service providers? How do provider attitudes affect young people's movement within referral systems? How do provider attitudes affect referrals made?*

VII. *What are effective ways to involve young people in quality improvement initiatives for SRH services?*

VIII. *In a case of abortion, there are various terms used (menstrual regulation,* induksi haid*). Are health providers aware and understand the meaning and differences between the terms?*[7]

2.3. Objectives of study

By answering all research questions in this study, the objective we proposed for this study can be achieved: to identify the supporting factors that facilitate young people's access SRH services provided by government's health centres and private clinics.This study will provide positive examples of SRH service uptake of young people in Yogyakarta province, Indonesia.

2.4. Research team

ResultsinHealth and *Siklus* conducted the research on opportunities for increasing the uptake of SRH services among underserved young people in Indonesia. The core team consisted of three people. Ms. Hidayati as the Team Leader was responsible for overall coordination and involved in the monitoring (quality assurance), data analysis and report writing. Ms. Ciptasari, the Principle Investigator, was responsible for the ethical clearance submission, daily management of research activities, coordination and quality assurance. Ms. Veenstra supported both the Team Leader and Principle Investigator and was involved in the project administration, data analysis and report writing.

The research team consisted of three senior Indonesian researchers (who spoke Javanese[8]) and three young local researchers. The young researchers' involvement in this research was important to improve individual and group empowerment, partnerships and cooperation with adults, and ensure a learning process within the research activity[9].

All team members were well equipped with extensive knowledge and experience in SRHR and conducting qualitative research including working experience in the study area. A list of the researchers can be found in Annex 2.

2.5. Research Time frame

This research project was conducted from June through October 2015 (five months). The research activities included ethical clearance submission, two workshops (kick-off and a preliminary analysis workshop), data collection process, and a monitoring/quality assurance visit, data entry and analysis, report writing and factsheet development. The overview of the research timeframe can be found in Annex 3

The research was conducted in DIY Province (Yogyakarta Province) specifically in the Sleman, Kulon Progo and Bantul districts and the Yogyakarta municipality (four districts in total)[10].

[7] The purpose of this question was to understand the 'appropriate and accepted' terminology for safe abortion based on the current law in Indonesia in order to provide safe abortion for young people in a 'safer way'.
[8] In order to accommodate the possible use of local languages, smoothen rapport with local authorities, and improve understanding of the local context as well as the quality of data.
[9] Explore Toolkit for involving young people as researchers in sexual and reproductive health programs (IPPF and Rutgers WPF, 2013)
[10] The justification for the selection of these three provinces is presented in the section sampling and research collection

2.6. Preparation to Data Collection

Ethical Clearance

Prior to the implementation of the study, the RiH team sought ethical clearance from the Ministry of Health (MoH) of Indonesia as per request of RWPF Indonesia. Several ethical clearance applications were submitted adhering to the MoH regulations. In addition to the ethical clearance, research permission was sought and granted by the Province and District Ofifice in DI Yogyakarta Province. The ethical clearance approval and research permission letters can be found in Annex 4.

Kick-Off Workshop

A two-day kick-off workshop familiarised the researchers with the data collection tools (focus group discussion [FGD] and semi-structured interview [SSI] guidelines) and prepared the data collection logistics in the four selected districts in Yogyakarta Province. This kick-off workshop was organised in Yogyakarta. The workshop participants included the Team Leader, Principal Investigator, three senior researchers, two young researchers, and the administrative staff of Siklus Indonesia (a total of six workshop participants).

2.7. Research Design

Prior to this study, a literature review was conducted to identify published and grey literature on young people's access to SRH information and services in Indonesia with a focus on marginalised and underserved groups. The findings of this review defined the study topic.

Using a qualitative approach, the operational research built on the review findings and further explored and identified young Indonesians' access to SRH information and uptake of services and commodities. Young people living in four selected districts in the Yogyakarta Province were targeted. The motivations and barriers to providing services and information to young people amongst private-sector providers as well as potential solutions to overcome barriers and support/create enabling factors that assist young people to access SRH services and commodities were also investigated. The qualitative study aimed to elicit young people's perceptions of SRH services, SRH service uptake, enabling and reinforcing factors in their strategies to access SRH services/information, and suggestions for new service delivery models to overcome existing barriers.

Data Collection Methods

To answer all study research questions we employed two data collection methods: FGD and SSI. FGDs were used to obtain group (collective) perspectives, opinions and cases among young people, whereas SSI provided deeper individual perspectives, opinions and cases of topics mentioned in FGDs. SSIs were predominantly used to solicit information from health providers regarding service provision for young people.

Guidelines for key FGDs and SSIs were developed and pre-tested prior to the data collection process in the field. All focus groups and interviews were recorded with the participants' informed consent. SSIs and FGDs were conducted in Indonesian, transcribed verbatim and summarised in two languages (Indonesian and English).

In this study, the FGDs were done in groups of 4-8 young people facilitated by one researcher while a second researcher observed and took notes. Groups were assigned based on gender homogeneity as well as specific population (for example, there was a group of men-having-sex-with-men [MSM]). Although originally the study was designed to have FGD and SSIs with participants and researchers of the same gender due to sensitivity of the topic, in practice, this was not possible. Fortunately, an opposite gender was not a barrier for either FGDs or SSIs. Researchers conducted SSIs and facilitated

FGD sessions in pairs (a male and female researcher or two female researchers)[11]. The research tools used for the interviews can be found in Annex 5.

The total time needed to interview each respondent was about 60-90 minutes. All SSI respondents received compensation of souvenirs (in kind), whilst FGD participants received transport cost reimbursement.

Scope of Data

Based on the research objectives and questions described above, the scope of data covered in this research was developed and outlined as presented in Annex 6.

2.8. Sampling of Respondents

In this research, we used a purposive sampling method and snowball sampling approach to identify the SSI and FGD participants with the following inclusion criteria for young people:

1. Young people aged 10-24 (in accordance with the result of the literature review). LGBTIQ, particularly MSM, were included as participants, as well as respondents with a (mental) disability.
2. Male/Female, married and unmarried

As mentioned in the objectives, this study positive aimed to provide examples of young people's SRH services uptake in the study area. Therefore in recruiting the young respondents for this study, a third criteria was used: young respondents must have accessed SRH services in the study area (as an example of positive action taken by young people).

When it comes the health provider respondents recruited for this study (health workers in *Puskesmas*, private clinics and health commodities suppliers), we only used one specific inclusion criteria: the respondent has provided SRH services and/or commodities in the selected areas.

2.9. Data Collection Process

A total of 40 SSIs and 4 FGDs were planned for this study: 10 SSIs and one FGD in each district. At the end of the data collection process, there had been 36 SSIs and three FGDs in four districts (in total 53 respondents, 11 males and 42 females). In general, the data collection process was quite challenging. Due to the fact that there was limited time available for data collection and there were some difficulties with recruiting the respondents, most of the interviews happened in the last minute. However, in collaboration with the ASK partners, we managed to achieve the targeted number of respondents.

2.10. Research Location

The research was conducted in one selected ASK Programme project site, Yogyakarta Province, based on the research objectives. We used ASK clinics as our base for data collection.

2.11. Data Management

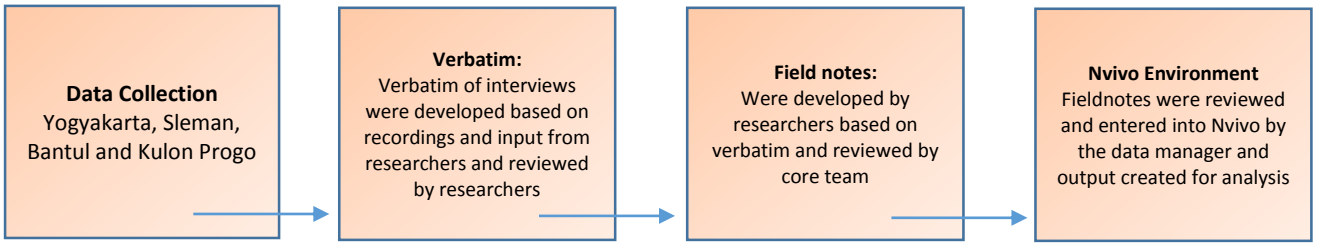
Data Management

The processes of data collection, analysis and feedback are represented by Figure 5. To ensure the quality of data collected, a quality assurance mechanism to monitor and evaluate both the data collection process and the quality of data was developed. This process involved senior researchers,

[11] We had more female researchers than male, therefore, it was not always possible to maintain the same gender respondent-researcher rule.

the PI and Team Leader who had a set role in the data flow to evaluate the quality of the field notes/verbatim translations.

Figure 5. Data collection and processing



There were several stages in the quality control process. Each senior researcher performed the first stage of evaluation and monitoring. He/she was responsible for reviewing the transcripts, highlighting and summarising important findings and organizing all the transcripts from his/her area. The PI conducted the second stage of evaluation and monitoring. The PI collected and reviewed all transcripts to identify important findings from all SSIs and FGDs, compared similarities and variations in the findings, identified problems in the process of transcripts writing and identified issues in the topics/coding of the transcripts. Once the final SSI and FGD transcripts were approved, the senior researchers summarised each one using an agreed-upon matrix covering attributed values, informant criteria, research area and additional information from interviewers. The matrix served as a data analysis framework using a coding system to draw out key themes and findings.

In the next stage of quality control, the PI was responsible for proofreading all summaries made by the senior researchers to identify problems and send feedback to the senior researchers. Once the PI approved the final Indonesian summaries, they were translated into English. Finally, in the last stage of quality control, the translated summaries (in English) were reviewed and compared with the Indonesian summaries and proofread by the team's English speakers. This last stage was performed by the Team Leader, PI and data analyst together.

2.12. Limitations and Challenges of the Study

In designing the study, several limitations were acknowledged:

- The participants of the study did not represent all age groups; age group included was 17-24 (planned age group was 10-24)
- The NVivo analysis is based on field notes (e.g. summaries of the interviews conducted), instead of the original verbatim due to the fact that the research was performed in a limited time frame and analysis was performed on English summaries of the interviews.
- The topic of the study is quite sensitive and not all young people with experiences in accessing SRH services might have been willing to participate in this study, particularly those who experienced an unwanted pregnancy. Therefore, the study might not have been able to recruit all potential participants and gather all information needed. However, with the wide networks of the ASK partners, as well as those of the research team, we managed to find the respondents needed for this study.

During the implementation of the study, we encountered several challenges such as:

- Slow progress on the ethical clearance approval which resulted in the delay of the preparation of the data collection and its implementation process in the field.
- The preparation and arrangement of the fieldwork was not as smooth as planned due to the workload of the ASK partners during the period of the data collection. This situation then led to an uneven distribution of workload in collecting the data in the first and second week of the data collection, where the second week was busier than the first one.
- Slow communication progress between all parties involved in the data collection process which also resulted in delays.
- Since we used interview as the main method in gathering information from respondents, the value of the results very much depended on the skills of the interviewer. However, we did anticipate this challenge by recruiting senior researchers as interviewers, developing interview guides for each type of respondents and conducting a kick off workshop to bring all interviewers to the same level of understanding. In order to minimize the distance between the researchers and respondents, we also recruited and involved local young co-researchers.
- In general, the time allocated for this study was very limited. As a consequence for data collection, we only had very short time for searching, approaching and convincing potential respondents to participate in this study.
- There was another study running in the same period and in the same areas. Therefore the ASK program partners were challenged in managing and coordinating between the two studies.

3. Findings from Operational Research

This operational research's study population consisted of 53 respondents with whom semi-structured interviews and focus group discussions were held. The group of respondents for the semi-structured interviews consisted of 25 young respondents (21 female and 4 male) and 11 health provider respondents (health workers and pharmacists; all female) – 36 SSI respondents in total. A summary of the profile of the young SSI respondents can be found in Table 1. An overview of all SSI respondents can be found in Annex 7.

Table 1. Characteristics SSI Respondents

Characteristics		No. of Respondents (n=25 in each characteristic)
Marital status	Unmarried	15
	Married	10
Location	Urban area	8
	Sub Urban area	11
	Rural area	6
Age group	≥ 20 years old	16
	< 20 years old	9
SRH related cases	MSM	4
	Unwanted pregnancy	12
	HIV positive	7
	Living with disability and experienced sexual violence	2

Three FGDs were conducted, one in the Yogyakarta municipality, one in Kulon Progo and one in Bantul District, with a total of 17 participants (7 male and 10 female). The average age of the FGD participants from Yogyakarta was 22 (range of age 20-24 years old); the educational background of most of the participants was high school, with one respondent studying at university and one participant already employed. All participants are MSM. Four out of six participants are HIV positive and were undergoing ART. In addition, all of them had experienced STI symptoms. The characteristics of participants involved in the FGD in Bantul: all female, still studying either at high school or university, aged 18-22 years old. The participants involved in the FGD in Kulon Progo were all female, including 2 students, and 3 unemployed women, and ages between 17-24 years old.

3.1. Findings Sub Model 1

Sub-Model 1 focuses on the influence of predisposing factors on young people's uptake of SRH services. The findings presented below address the various predisposing factors included in Sub-Model 1: (1) knowledge (including knowledge of SRH, SRH services and sources for SRH information and services) (2) beliefs (including cultural values, attitudes towards SRH issues and stigma and stereotyping) (3) perceived needs (including motivation for accessing services). These findings were obtained from the answers of the young respondents in this study to sub questions A-I, A-II, A-III (see chapter 2).

[1] Knowledge

Knowledge of SRH

The findings show that there are some young respondents who -to some extent – have knowledge of SRH related topics. Most of the SRH knowledge they have is on reproductive health instead of sexual health though and the respondents found it difficult to explain about sexual health. The reproductive health knowledge they have covers (1) reproductive health organs (anatomy); (2) health issues with

their reproductive organs (e.g. STI, vaginal discharge, itchiness around genital organs, HIV infection); (3) how to prevent (taking care of hygiene of their genitals) as well as how to cure STI symptoms; (4) puberty (e.g. menstruation and problems related to menstruation, wet dreams); and (5) (unprotected/ unsafe) sexual intercourse and its consequences (e.g. unwanted pregnancy). Young respondents also knew about contraceptives, particularly condoms, their function and how to use them correctly. Some of them also knew about cysts and cancer related to reproductive health organs and the importance of leading a healthy life style. Those who are HIV positive knew about nutritious meals for people living with HIV, how to access HIV services (e.g. VCT and CD4 test) as well as access to ART funding. Most of the young respondents who had knowledge of reproductive health problems usually obtained this knowledge due to the fact that they personally experienced such problems.

Some of the young respondents that were exposed to and active in SRH related programmes/ activities in NGOs such as PKBI, mentioned that SRH is also about sexual and reproductive rights, focusing on issues such as sexual orientation, options for safe abortion when young people experience unwanted pregnancies, as well as issues with family planning (such as pregnancy spacing and number of children). In addition, these young people said SRH includes physical, psychological and mental health related issues, which are caused by SRH problems -e.g. unwanted pregnancy or HIV status - (including acceptance towards their sexual orientation), sexual violence, and problems in regard to attitudes and behaviour. Only one young people respondent suggested gender (male and female roles) to be part of SRH knowledge.

On the other hand, this study also found that some young people lack and/or have incomplete knowledge and awareness of sexual and reproductive health related issues. Young people in Indonesia generally learn about SRH as part of their biology class, which starts in junior high school and continues through high school. However, biology class only covers limited information about SRH. Accordingly, young people do not have comprehensive knowledge of SRH, which may prevent them from utilizing SRH services that are available to them.

In addition to a lack of service uptake, limited knowledge can also cause young people to believe in myths, such as demonstrated in the case below:

"My boyfriend once suggested that I drink Sprite soda drink or Kratindaeng *energy drink… Every month he would ask the same thing whether I had had my period or not. I told him I had missed my periods for two months. I did not want to take his advice because I had ulcer and I did not want my ulcer to recur again..." (ID 20)*

Knowledge of SRH services

Young respondents showed varied knowledge of SRH services available to them, yet generally limited. Most of them mentioned *Puskesmas*, midwives, and services run by NGOs (including partners of the ASK *programme*: CD Bethesda and PKBI). One respondent mentioned that she knew PKBI offers safe abortion services and shelter for those who experience an unwanted pregnancy. A lack of information and knowledge of where services are located and the procedures involved prevent young people from accessing services.

Several respondents also provided information that was related to the ASK *programme*, although most of them never heard about the *programme* itself. However, according to their answers, the following services are provided by the ASK *programme*: condoms/condom outlets, Peer Educator Groups, awareness raising activities, youth gatherings, counsellors for young people, free access to reproductive health services for young people (at CD Bethesda and Philia clinic - VCT clinic), referral to other services, and regional youth meetings.

"ASK is like a campaign approach, but it uses various online media which encourages young people to share. ASK Friends provides information on how to access services. Besides, it educates young people by using hashtag" (FGD participant, ID 03)

Some young respondents also knew about Rifka Annisa services provided for survivors of violence.

Sources of information regarding SRH knowledge and services

This study has shown that there is still a limited availability and exposure of sources of appropriate and accurate information on SRH and SRH services. As a result, many young people only start looking for SRH information after being in an urgent situation, e.g. they did not have their period for several weeks, became infected with an STI, or suffered from an opportunistic infection because of their HIV status.

The sources of information to increase their knowledge of SRH and how and where to access SRH services that were mentioned by the young respondents varied. Some received information from parents and/or family members, people in their neighbourhood, friends, and health workers. Other sources named were the Internet (including social media), books, television, awareness-raising events in and out of school, street advertisements, and the activities conducted under the ASK programme. However, the young respondents mentioned that they felt uneasy about obtaining information about SRH services. Generally, young people who really need SRH services start by seeking information silently through sources close to them: their friends or others who already experienced accessing such services.

[2] Beliefs

Knowledge of young people on SRH and SRH services is associated and influenced by their personal beliefs. Beliefs, often based on certain norms and (cultural) values, they adopt and act on. For example, below are two definitions of SRH according to two respondents that show their underlying beliefs when it comes to SRH:

"SRH is all issues and illness caused by reproductive health and sexual problems, including any activity that young people not yet of age are forbidden to do according to the religious and social norms in Indonesia, for instance free sex practices that may lead to psychological and physical problems." (ID 15)

"Sexual and reproductive health is an ownership of our bodies to be able to develop ourselves more, a way to reproduce and channel the desires to reproduce. People have different ways of channelling the desire. Sometimes they channel them the way they should be but sometimes the ways they channel them are against the commonly accepted ways." (ID 03)

Young respondents in this study mentioned some specific beliefs regarding SRH. For example, sex was thought to be taboo and should not be talked about with others. In addition, the use of contraceptive methods as well as the termination of pregnancies was perceived to be sinful behaviour. In addition, several young respondents said they believe people/the community associate a young person who accesses SRH services with a 'bad girl or boy', who is sexually active or a drug addict. They are also afraid that they might lose face; being blamed by health workers and ignored or even bullied by their peers. One respondent believed that friends would think negatively of them when they would access SRH services.

The findings also show the existence of self-stigmatization; young people believe they will be stigmatized by others if and when they access SRH services. Several young respondents mentioned that, in case they experienced symptoms, they decided to go for check-ups. However, since SRH

services for young people are located in the same place as general medical services, they often feel ill at ease. They are worried that the health workers and other patients will discriminate against them. According to them, it is uncommon for young people to access SRH services. This is why they are embarrassed and reluctant to go there since they fear (and anticipate) embarrassment of meeting people who think negatively of them. One young person said that she felt that all eyes were on her, especially when she walked out from the OB/GYN's consultation room to check on her menstrual pain. In describing this experience, she stated:

"When I entered the consultation room, it was okay. I didn't really notice my surroundings. I was in pain and all I was thinking was to get treated quickly. But when we went outside, I felt people stared at me as if there was something wrong with me. They may think something bad about me. It made me uncomfortable". (ID 14)

Some young respondents decided to seek alternative medication such as using herbal medicines to overcome their SRH problems (vaginal discharge, unwanted pregnancy) as a result of their beliefs. When this effort failed they then decided to go to formal SRH services such as *Puskesmas* or PKBI.

In addition, another example of stigmatization experienced by a female young people respondent is about spreading the HIV status to the extended family, and as a consequence this respondent has to bear stigma and discrimination from the neighbourhood on top of her own feeling of ashamed and embarrassed by being HIV positive.

Based on another young person's experience, the feeling of shame when going to a clinic for SRH services for the first time is also associated with the stigma that people place on them. In one of public hospital, one young person who accessed the services assumed that health providers intentionally put three red dots on the card of patients with HIV. In his opinion there was no need to put that sign on the card because he knew that other patients do not bear these marks. The marks only reveal the patient's identity as a person living with HIV/Aids (PLWHA). Therefore young people are reluctant to access services that stigmatize them.

[3] Perceived Needs

This study has found that, among the young respondents, there exist two types of perceived needs. First of all, most of them will only utilize SRH services if they experience a perceived need for help (in other words, if they are suffering from SRH problems). Secondly, the young respondents talked about their perceived needs for particular SRH services/activities.

The findings show that for almost all young respondents the decision to utilize SRH services was based on their perceived need for such services. This perceived need had to do with the urgency or seriousness of the SRH problem they were experiencing. Therefore, for the young respondents in this study, experiencing a (severe) SRH problem and having a perceived need for expert help thus created the reason for SRH service uptake. Examples of such problems mentioned by the young respondents are an unwanted pregnancy, or symptoms in their reproductive organs (e.g. STI infection, penile or vaginal discharge, pain around the genitals, or menstrual pain). An additional reason for one of the respondents to access SRH services was due to the perceived risk she had: with her ex-boyfriend being HIV positive and her having experienced an unplanned pregnancy.

This study showed that there exists a perceived need among young people for access to SRH information in order to increase their knowledge and awareness of SRH problems. This knowledge will help them in figuring out their initial problems and where to go to receive help. Those young people who have sufficient SRH knowledge and are aware of the risks involved realise that this

knowledge is important for youth and that they should be examined before they actually start experiencing symptoms. As stated by one young respondent:

"Besides treatment, we all actually need to be educated first. There are increasingly young people suffering from SRH problems now, especially those who are younger than me. I really do not want to see other young people infected. Just let me be the only one." (ID 04)

In the absence of SRH problems, young people may feel they do not need SRH services. Young people rarely seek SRH services when they have no symptoms. The respondent mentioned above (ID 04) explained that he believes that there exists a lack of self-awareness among youth; they are ignorant as long as they do not experience any problems. However, some young respondents did mention some perceived SRH needs for youth, regardless if they are experiencing any symptoms. Such needs include: (1) counselling, (2) contraceptives (particularly condoms) for sexually active young people, (3) financial and companionship support (from NGOs) to access SRH services, (4) nutrition for PLHIV, and (5) safe abortion services and safe shelter for those with unwanted pregnancy.

An overview of the findings of Sub Model 1 is presented in Table 2.

3.2. Findings Sub Model 2

The factors/components in Sub-Model 2 include the availability of health services and commodities, quality of (expected/needed) services, accessibility and affordability of health services and commodities, norms and values of health workers, attitudes of health workers, and the laws and regulations for SRH provision. For the factors involved in the Sub-Model 2, we present both the young people and health providers' perspectives, using their answers to sub questions A-II, A-V, B-I, B-II, B-III, B-IV, B-V (see chapter 2).

[1] Availability of SRH Services and Commodities

Availability of SRH services

Based on the study findings, young people believe that there is still a limited availability of SRH services both at public (*Puskesmas* and government hospital) as well as private health services (clinics run by NGOs). SRH services (particularly for unwanted pregnancy and men having sex with men [MSM]) for young people are much needed and yet they are scarce. SRH services available in *Puskesmas* include STI treatment, VCT, counselling on acceptance of HIV status and psychological support for people living with HIV. In private health facilities there are more comprehensive SRH services for young people in DIY Province.

'Special' services for unwanted pregnancy and safe abortion

For some girls, the reproductive health cycle becomes more complicated when they have an unwanted pregnancy. One health provider respondent who provides counselling services for unwanted pregnancies for young people said that her experience shows that young people need informative, non-judgemental, non-intimidating, and free-from-personal-views service from health staff. Young people need a complete explanation of the problems they face and the risks associated with their choices of sexual activities and pregnancy. Based on the findings, there are two private health providers providing safe abortion services: PKBI and Samsara. Samsara provides three options for services for young people with an unwanted pregnancy: (1) continue the pregnancy, (2) place baby up for adoption, or (3) safe abortion. There are two types of safe abortion offered by these two service facilities: abortion completed with medication and abortion through curettage/medical procedures. The medication used for abortion is Misoprostol. The health providers from Samsara as well as PKBI mentioned that Gastrul Cycotec and Misotab are among the brand names for

Table 2. Findings Sub Model 1 - Predisposing Factors

Factors	*Current Situation (based on research findings)*	*Ideal situation/Suggestions for Improvement*
	According to Young People	
[1] *Knowledge of SRH*	- In general limited knowledge of SRH related topics. Knowledge they do have is mostly on reproductive health; - Important difference in level of knowledge between those who have experience with SRH problems and those who do not; - Knowledge of condoms, their function and how to use them; - Lack of knowledge does not only influence their SRH service uptake, but also increases their belief in myths.	Improve young people's knowledge on sexual health
[1] *Knowledge of SRH services*	- Limited knowledge of available SRH services; - Had no prior knowledge of available services before they needed them; - Young people are aware of services provided by *Puskesmas,* PKBI, and CD Bethesda.	Improve young people's knowledge on sexual health and SRH services (both public and private)
[1] Knowledge of *Sources of SRH Information*	- Limited availability and exposure of sources of appropriate and accurate information on SRH and SRH services; - Sources mention vary: either people (e.g. parents/family members, friends, health workers), or other sources such as the Internet, books, television and awareness-raising activities.	N/A
[2] Beliefs	- Knowledge is associated and influenced by their personal beliefs; - Beliefs mentioned: sex is taboo and not to be talked about, contraceptives and termination of pregnancy are a sin; - Self-stigmatization; belief that they will be stigmatized by others if and when accessing SRH services; including the influence of other young people's negative experiences with SRH services - Some seek alternative methods to deal with SRH problems due to beliefs.	N/A
[3] *Perceived Needs*	- Two types of perceived needs: (1) perceived need for SRH services if experiencing SRH-related symptoms, and (2) perceived need for specific SRH services for young people; - Young people only utilize SRH services if they are experiencing SRH related symptoms (unwanted pregnancy, STI symptoms, menstrual pain)	- Perceived need among young people for access to SRH information in order to increase knowledge and awareness - Perceived need for counselling, contraceptives, financial and companionship support, nutrition for PLHIV, and safe abortion services and shelter

Misoprostol in Indonesia. PKBI also provides shelter for those who want to continue their pregnancies after receiving counselling services.

Availability of SRH commodities: Condoms and other contraceptives

Based on the answers given by most health provider and young respondents in this study, there is agreement that condoms are the most appropriate contraceptive method for (sexually active) young people because they prevent pregnancy and STIs. Both groups mentioned several reasons why condoms are the most appropriate contraceptive for young people, such as: condoms do not have side effects and they are easier to access. A hormonal contraceptive is not recommended for young girls since it can disturb menstruation process

"… Condom is easier to access and to use. Many young people don't know how to take birth control pills (for example when to take the white pill or the yellow pill); they need adult supervision to do it and discussing with adults is a challenge for them …" (ID 10)

However, according to some young respondents, obtaining condoms is not so easy due to the stigma attached to young people who (try to) access them in health services, pharmacies and/or mini markets. One respondent even mentioned that she did not know where to access condoms if she needed them.

The provision of contraception commodities for young people is problematic. Most health providers from *Puskesmas* mentioned that in *Puskesmas*, condoms are not provided for unmarried young people. This situation is different from the private health providers. UNALA, in the Bantul District, is an example of one private health provider's effort to focus on prevention rather than cure. UNALA provides contraceptives under UNFPA funding, which can be accessed by young people for free by using vouchers for an examination, counselling and condom services. These efforts facilitate young people's easy access to SRH services and commodities. UNALA health providers agree on the provision of condoms for (sexually active) young people to prevent unwanted pregnancies and STIs. However, they also believe that counselling should still be given to young people (male and female) to provide comprehensive information on the various options and associated risks of sexual behaviour and how to protect themselves from STIs and unwanted pregnancies including how to improve their SRH.

"Through the counselling process, they [young people, girls and boys] will also be provided with an explanation about condoms, a type of contraception that, in my opinion, is not risky but at the same time can prevent sexually transmitted disease. However, we have to make sure that both partners go to the counselling." (ID 13)

One health provider respondent from PKBI also mentioned that PKBI has no problem in providing condoms for (unmarried) young people; they can obtain condoms at a PKBI office or from volunteers/staff. This provision of condoms/condom outlets is also supported by the ASK program through its partners.

"Since PKBI already agrees that condom is the most appropriate device for young people, condoms are provided for free and young people can easily get as many free condoms as they need at PKBI. We don't have a problem with that. But it's a different case if they need other contraceptive methods such as birth control injection". (ID 11)

Even though health providers usually refrain from providing young people with contraceptives other than condoms, exceptions are made, particularly when a young person has had an abortion. This young person may choose to use other types of contraception (non-condom) such as an intrauterine device (IUD). However, this decision should also be made after the counselling process to the girl and her partner. Another exception that was made for the use of a non-condom contraceptive was the

case of a young person with an intellectual disability who was treated in UNALA and received an injectable contraceptive because she frequently had sex with men.

"We made an exception in the case of a young woman with mental retardation. Her family has abandoned her and with the limited intellectuality, she often looks disassociated from the surrounding. Different men seduce her to have sex and we try to protect her by giving injection for birth control every 3 months. Of course will be different when she's married. We're just trying to protect her from getting pregnant with a stranger". (ID 13)

[2] Quality of Expected/Needed SRH Services

This section discusses various aspects categorized under expected and needed SRH services (according to both health providers and young respondents) with a strong emphasis on the *quality* of these services for young people. In addition, this section addresses (the quality of) youth-friendly services that are provided by private health providers as perceived by the young respondents.

Privacy and Confidentiality

Privacy and confidentiality was the most frequently mentioned aspects of quality SRH services provided by health provider respondents. Due to the sensitivity of SRH issues for unmarried young people, these two aspects were considered very important by young people and also identified by health providers. Young people do not want to be recognised by people they know, even if they have to go to a distant health provider to access the services they need. Young people do not want to be recognized by health providers when showing their ID during registration either. Hence, they really take privacy protection into account when choosing SRH services.

"I avoided the health centre because I have to show my ID. I am worried that people around the health centre will recognise me and my status" (ID 04)

"The further the place, the more I feel my confidentiality will be kept. And I like it this way" (ID 03)

In Indonesia, *Puskesmas* are usually visited by married women or young mothers. Therefore, young people do not feel comfortable going to *Puskesmas* since they are not yet married. Young respondents also mentioned that a separate examination room, which is not available in public health services, has become an important aspect for young people to protect their privacy and confidentiality. Young respondents said that even better would be a separate and special policlinic dedicated for young people, since they feel embarrassed when they have to undress in front of health workers and other clients/patients.

Waiting Time

Another important consideration for young people to choose certain health services is the duration of their waiting times. According to most young respondents, *Puskesmas* have long waiting times and queues for both registration and examination, which is a hassle for young people and makes them feel reluctant and embarrassed to go there to share their problems. This long waiting time makes young people avoid accessing *Puskesmas*, even though the facility is close by and provides free services.

"The queue make me bad mood and the patients are mostly young mothers, there are no young people" (ID FGD 02)

Unavailability of Medical Supplies and a Lack of Resources and Capacities of Medical Staff

There are negative examples of the quality of service at public hospitals perceived by one young person based on his experience when he accessed SRH services at Sardjito Hospital (a public hospital in DIY Province). He identified the unavailability of reagents for CD4 cell count test, free services

continuously running out of reagents, unprofessional staff behaviour (such as coming late), a lack of human resources and the low competence/capacities of the doctors. From the study findings, some young respondents said that having a youth-friendly staff with an understanding of young people who patiently listen their issues are important skills to encourage young people to overcome their shyness, nervousness and fear when they access SRH services.

From the *Puskesmas* health providers' perspectives, having extra work to be responsible for youth-friendly services at SRH and STI clinics might cause a not-so-optimal performance in delivering the services. This is because the staff has to serve up to 150 patients every day (with limited health staff) and there is only one health staff (midwife) assigned to providing SRH services. The midwife (staff of *Puskesmas*) is already responsible for other wards, in addition to attending meetings and other activities that have to be attended to. In this situation, dedicating the ideal time to each patient (particularly young people who need more attention, including raising their awareness of SRH issues) is sometimes not possible. This situation causes long queues in *Puskesmas*, which hinders young people from accessing SRH services.

Health Provider-client Relationship: Youth-friendliness

According to young respondents, they will seek friendly services that can address their problems and maintain their privacy and confidentiality. Many young respondents compared the services provided by *Puskesmas* and NGOs (in this case PKBI). They said that even though some of the *Puskesmas* have been established as 'youth-friendly *Puskesmas*', they are not yet friendly enough. PKBI is considered by young respondents as providing youth-friendly services[12]. Several respondents mentioned aspects that could improve young people's access to SRH services both in public and private facilities in regard to youth-friendliness: comfortable consultation and examination rooms, punctual doctors, immediate diagnosis and referral to a medical specialist, detailed information on the patients' diseases and any medication they will have to take. In addition they would like prioritised and specific services for the young people to avoid feeling embarrassed or being stigmatised by people they know or meet in services, efficient referrals to ensure that young people really access referral services, and the availability of companions and friends with whom they can share and who will understand their problems.

In regard to the SRH services provided at *Puskesmas*, the quality of the service is not the same in each *Puskesmas*. Based on his knowledge, one respondent identified five youth-friendly *Puskesmas*: Wirobrajan, Gedongtengen, Umbulharjo, Mantrijeron and Tegalrejo (out of 18 in DIY Province), and *Puskesmas* Temon Kulon Progo. He stated that these *Puskesmas* provided good and relatively friendly services to certain groups of young people such as MSM and also have transvestite clients. Another respondent also said that she was satisfied with these *Puskesmas* and would recommend them to her friends. The respondent's satisfaction was based on the friendliness of the Puskemas' staff, simple procedures, short waiting times, and free-of-charge services and most importantly, the client's privacy being well maintained. However, the results of this study also show that private health provider SRH services usually are much easier to access for young people; therefore, they are more satisfied accessing these SRH services.

[12] In this finding, youth-friendly services are defined as providing health services based on a comprehensive understanding of what young people in any given society or community want and need. It is also based on an understanding of and respect for the realities of young people's diversity and sexual rights (IPPF, 2013) Source: http://www.ippf.org/our-work/what-we-do/adolescents/services. According to UNFPA, youth-friendly services should cover universal access to accurate sexual and reproductive health information, A range of safe and affordable contraceptive methods; sensitive counseling, quality obstetric and antenatal care for all pregnant women and girls; and the prevention and management of sexually transmitted infections, including HIV (Source: http://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health#sthash.eVzEY46I.dpuf)

Young people also mentioned several private providers when discussing the topic of youth-friendliness; PKBI, CD Bethesda and Vesta, were all considered as providing good examples of SRH services.

PKBI's health attendants were friendly and understood young people's problems and could be trusted. PKBI services were open during the hours that suited young people's schedules. The facility was comfortable enough for young people, (e.g. a closed space for counselling to make young people comfortable and secure) and had a less complicated procedure for administration.

"The clinic is usually preferable because it has longer opening hours and its procedures are not as complicated as the ones at the hospital, where we have to fill in personal data form and go through many stages. Clinic has a simpler procedure." (ID 19)

However, the respondent thought that it was not enough to provide services only for two days in a week. Regarding paid services, she said it was fine to pay as long as she received good quality services. However, payment has to be affordable for young people. Nevertheless, there is one issue that was raised in regard to PKBI services—privacy. Privacy starts when young people have to fill in PKBI forms on which information is required about marital status. Since in most cases, young people who access SRH services are not married, this may prevent them from receiving SRH services.

"This is an important point. Let's say you want to register to see an obstetrician. At the registration you might expect the registration attendant to say: Well look here, we have a child with child, and of course you will cancel the appointment". (ID 19)

One female respondent mentioned that she has benefited from ASK Program services through the services provided by CD Bethesda. She has experienced accessing information and services regarding her SRH needs such as condoms, ART, and follow-up counselling. She found the services from CD Bethesda were good and beneficial for her. She considered that CD Bethesda was the only consistent and easy-to-access provider of information, services, solution and support.

Another respondent who accessed services provided by Vesta expressed her satisfaction regarding the service. She said that the services provided were more open for young people and free of charge; however, she has not seen promotion of the services. She explained that when she came to Vesta for the first time, they allowed her to use an alias name instead of her real identity for confidentiality purposes. In addition, she was given a referral card for the next three months to have VCT at Vesta.

[3] Accessibility of SRH Services and Commodities

Accessibility of SRH services

Based on the study findings, accessibility as seen as an important factor for young people to access SRH services. In this study, the term accessibility includes service hours, location, and whether the administration and procedures to access the services is easy or not for both government health and private health services.

In regard to the hours for SRH services, most of respondents mentioned that *Puskesmas*' hours are not suitable for young people because they are open at the same time when young people are in school. If young people want to access SRH services, they have to get permission from their teachers and this makes them feeling uncomfortable (embarrassed). However, some young respondents (who were not at school) said that *Puskesmas* were seen as the first alternative to go to when they had SRH issues.

Young respondents who lived in suburban and rural areas mentioned that midwives were also considered to be easier to access because they were in the young people's neighbourhood. Young

people feel more comfortable talking to a midwife and feel secure and satisfied with the services. Midwives also can refer either to *Puskesmas* or hospitals if needed. According to young people, by attending midwives services they do not have to deal with the long waiting times and complicated procedures of administration/registration such as in the *Puskesmas*.

"It is better to go directly to the midwife than going to the Community Health Centre, because at the Centre you will later be referred to a hospital anyway... It is discouraging just to think that you have to be in a long queue." (ID 36)

In addition, young respondents also said that the location of the services, whether they were easy to access using public transport and within short or long distance from where young people lived, was another inhibiting factor to access SRH services. Usually, *Puskesmas* are more accessible and affordable (due to transportation costs) than hospitals for those living in semi-urban and rural areas since *Puskesmas* exist in every sub-district in Indonesia. However, when distance is compared to open hours, although *Puskesmas* are closer, their services are not accessible due to young people's time constraints (school) as mentioned earlier.

Young people mentioned the ease and simplicity of administration and procedures to access SRH services as preferred factors when accessing services. They stated that they preferred to go to private health providers that have a 'hassle-free' registration process, rather than *Puskesmas* or a hospital due to their complicated administrative requirements.

Accessibility of Commodities: Contraceptives

In terms of accessibility to contraceptives for young people, both young people and health provider respondents mentioned that it is not easy to access condoms. It is even harder for unmarried young people to access other types of contraceptives. There are many factors inhibiting the accessibility of contraceptives for young people, such as young people's perception that wearing condoms is seen as 'traditional', health workers norms and values about young people and contraception, stigma and discrimination, laws and regulations (see section of laws and regulations), etc. In most health facilities, including (most) pharmacies, to receive or buy condoms one has to show an ID which also notes marital status. When buying condoms in a mini market, a young person might receive a 'strange' look from the cashier/shop keeper. This attitude makes them embarrassed to buy condoms.

[4] Norms & Values of Health Workers

There is a conflicting value between (and among) health staff and health providers on the provision of SRH services and commodities (particularly about providing safe abortions and condoms) for (unmarried) young people. The norms and values held by *Puskesmas* staff on condom provision for unmarried young people and safe abortion are generally in line with the *Puskesmas*' policies and regulations, which is not to provide these services for unmarried people. Therefore, public health providers are usually more conservative compared to private health providers, although some public health staff will provide condoms to unmarried young people.

"Well, actually, although it is not in the Puskesmas' policy, sometimes we still provide contraception's to unmarried young people; we think that it is better not to have premarital sexual intercourse. However, fact says differently. We believe in the paradigm of prevention to keep us healthy." (ID 13)

In regard to abortion for young people who have had an unwanted pregnancy, some health providers who are not against abortion will provide the necessary information to these young people to make them well informed on all options/choices and associated risks. This includes information on the availability of shelters to stay and wait until the baby is born and safe abortion services, which are generally possible until 8-10 weeks at certain appointed health providers.

Samsara, one private provider offering safe abortion counselling, also mentioned that the sensitivity of the abortion issue in Indonesia has to be taken into account when the organization decides to provide safe abortion services. In Samsara's neighbourhood, Samsara is known as an association of an art community rather than as an SRH service provider.

"We provide information on unwanted pregnancy and safe abortion. In the context of Indonesia, abortion is illegal so I think this is one of the major constraints. In certain conditions, the safety of the staff members is the main concern and everyone works from home to ensure their safety". (ID 25)

[5] Attitudes of Health Workers

Similar to the health workers' norms and values, young respondents in the study said that the health workers' attitudes when treating young people with SRH issues became a youth-friendliness indicator of the services. Judgemental and discriminatory attitudes of health providers towards (unmarried) young people may prevent this group from accessing needed SRH services since they feel the manifestations of health providers' norms and values when they access the services delivered by these health providers.

"I was treated a bit differently as indicated by the voice and intonation of the health workers ... Sometimes they gave strange responses in intonation that makes you uncomfortable. I received the expression and intonation of disgust shown by the health workers in two occasions." (ID 03)

One MSM respondent mentioned that the services provided by private health providers was non-judgmental. In the respondent's experience, this was contrary to the services at *Puskesmas.* A similar comment was made by another respondent about the services provided for young people with an unwanted pregnancy in private health facilities:

"They understood what the young people with unwanted pregnancy were going through and they did not scare them away." (ID 20)

However, according to young respondents, the findings show that not all public health providers are judgemental and discriminatory. In some *Puskesmas* and public hospitals, the health workers never attach labels nor judgements and they are friendly as well.

[6] Laws & Regulations on SRH Provision

Based on a regulation of the Indonesian government, contraceptives are only available for married couples. *Puskesmas* share and respect the values and norms of the majority of the society by not providing abortion services or contraceptives for unmarried young people.

"We are not ready for the pros and contras on this. We once made introduction on contraceptives but I'm afraid we can't make them available for young people." (ID 12)

However, some private SRH services such as PKBI and UNALA have their own regulations including providing contraceptives to unmarried young people, but not long-term contraceptives. In PKBI, condoms are provided to unmarried young people who have accessed STI and VCT services. More types of (long-term) contraceptives are provided for married young people depending on their conditions and suitability after an examination with information on contraceptive benefits and how to use them.

The findings show that various *Puskesmas* may have specific SRH policies and regulations based on their Head of *Puskesmas*, which might hinder or support the provision of SRH services. For example, the Head of one *Puskesmas* issued an official letter on SRH service provision that made everyone understand, confident, and committed about their role and responsibility despite conflicting personal

norms.

An overview of the findings of Sub Model 2 is presented in Table 3.

3.3. Findings Sub Model 3 – Reinforcing Factors

Sub Model 3 focuses on the influence of reinforcing factors on young people's health seeking behaviour and their utilization of SRH service in particular. The various factors of sub model 3 include: (1) Actors and their roles, (2) companionship, (3) referral systems, (4) participation (in SRH programming/initiatives), and (5) promotion of SRH services through (online) media. The findings presented below address the answers of young respondents and health provider respondents to sub questions A-IV, B-V and B-VI.

[1] Actors & their Roles

When asking the respondents about the most important actors in young people's lives, and their roles when it comes to the provision of information and young people's use of SRH services, several important actors are mentioned such as: perceived experts, peer educators, and (health) institutions/organisations.

Perceived Experts – Health Care Providers & Teachers
Most of the youth mentioned people who – in their opinion – are experts in SRH issues and possess comprehensive, accurate knowledge of SRH. Acknowledging the importance of ensuring that the provision of information is done by a reliable source, youth particularly mention medical doctors and health staff. One respondent stated that important educators are those who have the competency (doctors, community health centre staff). Provided with information from these sources, the respondents believed that the information will be well accepted by young people. In relation to this, several young respondents specifically mentioned the importance of midwives when it comes to SRH education: they are considered knowledgeable and come directly into the villages to help and raise awareness. In addition to health workers, the young respondents mentioned subject and counselling teachers when it comes to providing young people with information on SRH issues. They are considered to have expert knowledge of SRH issues and services and have a direct relationship with young people. They are thought to be well suited to disseminate SRH information among school-going youth.

Peer Educators
The young people and health providers interviewed in this study agree that peer educators (PE's) function as messengers in the provision of information about SRH to their (school) friends and encourage them to access SRH services. In addition, PE's can accompany youth to the services and/or invite them to join SRH-focused activities such as discussion evenings. Peer Educators can come from the community, or can be representatives of schools. One of the respondents mentioned a need for actors that have personal experience with SRH issues and are willing to share those experiences with young people. Peer educators who have utilized SRH services themselves can have an important role here.

Additional Actors
When discussing actors, the young respondents also mention institutions, such as *Puskesmas*, hospitals, NGOs, as important sources when it comes to the provision of SRH information. Such sources can raise awareness and influence young people's use of SRH services through activities in school and/or communities. Furthermore, youth and community organisations, and their leaders in particular, are mentioned as actors who can inform youth on SRH issues and increase their knowledge and awareness.

Table 3. Findings Sub Model 2 - Enabling Factors

Factors	*Current situation (from Research)*		*Ideal situation/Suggestions for improvement*
	According to Health Providers	**According to Young People**	
[1] Availability	- Limited availability of service points; - Limited availability of types of services provided (only for unwanted pregnancy)	- Limited availability of services at both public and private facilities, though more comprehensive services available in private facilities; - Limited availability of types of services provided (for unwanted pregnancy and for MSM); - Limited availability of condoms; - Availability of medical supplies not guaranteed in public facilities	- Types of services provided should be more varied - Comprehensive SRH services and specialized services for young MSM are needed; - More service points should be available; - Availability of non-judgmental information on SRH is needed; - Need to increase availability of condoms, including reducing the negative beliefs connected to condoms; - Improve availability of medical supplies in all facilities dedicated to young people;
[2] Quality	- Normal workload is already high at public facilities and the youth service is adding to it; influences the quality of services provided	- Privacy and confidentiality not always guaranteed; - Long waiting time; - Providers not on time; - Not all are youth friendly enough; - PKBI is more youth friendly than public facilities.	- Privacy and confidentiality should be guaranteed; - Availability of separate examination room in an integrated clinics; - Allocation of time for young people who access the service: opportunity for SRH education as well; - Quality of care and information provided should be youth friendly – appoint dedicated people for youth clinic. - Opening time should suit the realities of young people lives (e.g. school times); - Ease and simplicity of procedures, registration and administration should be improved (and time efficient);
[3] Accessibility		- *Puskesmas* is very accessible - In the urban area accessibility is a non-issue	- Should be accessible with public transport; - SRH services should be affordable for young people - PKBI, CD Bethesda and Vesta are considered to be accessible
[4] Norms/Values Health Workers	- Government clinics hold normative values; - Private providers more progressive - Internal conflict within health providers on issues related to abortion		- Provision of appropriate and youth friendly information and services on SRH by health providers -can be improved;
[5] Attitudes Health Workers		- Health workers do not always have a youth friendly attitude (understanding, patience) - Private providers are less judgemental; - In some *Puskesmas*, they are also not judgemental	- Competency of health providers to have a youth friendly attitude should be improved; - Health providers should not be judgmental and/or discriminative towards young people
[6] Laws & Regulations	- Contraceptives are only legally available for married couples – incl. condoms; - Abortion is illegal, unless medically indicated; - Private providers provided contraceptives according to needs of clients; - Policy depends very much on the head of *Puskesmas*		- Clear policy on provision of (different types of) contraceptives for public and private health facilities; - Presence of appropriate information on availability of contraception in public and private health facilities; - Operationalisation of laws regarding safe abortion and provision of SRH education for young people

Acceptance and Effectiveness of Information Provided by Actors

When it comes to the question whether SRH information is well accepted by youth, most of the young respondents in this study said that the information they received has been well accepted, has been helpful and solved problems. As mentioned above, several respondents mentioned the value and credibility of health workers, which improved the level of acceptance of the information. In addition, respondents stated that information from peers is well heard an accepted due to the fact that peers are usually trusted and youth feel familiar with them.

When it comes to the roles of the different actors, the answers of the young people show a (perceived) need for them to take on a role that is based on trust and empathy, focusing on the provision of information to and accompaniment (see below) of youth when it comes to SRH services. For example, youth base the *effectiveness* of the role and work of peer educators - and their influence on youth's behaviour and use of SRH services - on the fact that most young people will trust their peers, and look to them for information and advice. However, such a relationship does not automatically exists: some of the respondents mention that 'matching' a peer educator with a young person does not guarantee a successful relationship.

[2] Companionship

In addition to health workers and teachers, the youth respondents considered PE to be important in the dissemination of SRH information and the promotion of services. Most importantly, however, they mentioned the role of PE in accompanying them to SRH services, explaining procedures and helping them through the various steps of treatment. The PE help young people to clarify how they can access services, and what they can expect. One of the respondents discussed his experiences with PE and stated that one can benefit a great deal from the PE ability to provide information on things such as the prevention of STD transmission, how to effectively wear a condom, what nutritious meals should be provided to people with HIV, and how to access services and funding. In relation to this, other respondents stated:

"They [PE] assisted me all the way through. Starting from the time I tried to access the complicated services for the first time, to getting financial support and dealing with the administration" (ID 06).

"It is important. They are in the same age group, but they are more resourceful. They can be our friends and we can talk about our problems more openly. […] This is the first time ever I heard about peer educators. They sound fun. I think it would be nice to have a peer educator to share our problems with, especially if they become our close friends. The peer educator can give us the right suggestions" (ID 14).

Other Companions

Partners, family members and close friends are mentioned by young respondents as important actors when it comes to support (logistical, mental) and particularly accompaniment to SRH services. The health provider respondents particularly mentioned parents, who can be great, effective reminders and referrals for young people that face SRH problems, encouraging and accompanying them in accessing SRH services. Both the health providers and young respondents also mentioned the companions from health care providers and/or NGOs as people who provide them with information and help and accompany them in accessing SRH services.

[3] Referral Systems

The findings presented below address the governmental and non-governmental referral systems that have been established by various health care providers to ensure/improve SRH service access and

delivery to young people.

Referrals by Governmental Facilities

One of the respondents, who is an employee at a *Puskesmas* facility, stated that internal and external referral systems have been established there, but there is a lack of cases for referral. Some referrals were made by *Puskesmas* for STD and HIV treatment. In addition, some girls with an unwanted pregnancy in *Puskesmas* Moyudan have been referred to PKBI for counselling services or assistance with their unwanted pregnancy (whether to continue the pregnancy or to undergo abortion):

"We did have such cases. In one case, we had discussed with the family, who insisted on termination of pregnancy. We referred them to PKBI, which is at least a safer option then going to a healer or self-abortion by consuming un-prescribed medicine. But the decision was only made after many counselling sessions and we explained that termination can only be done once" (ID 13).

For referrals to *Puskesmas,* a respondent (a midwife) stated that there was a referral system in place from the midwives' private practice to the *Puskesmas*, and from the *Puskesmas* to the hospital. The respondent also made referrals for treatment at the *Puskesmas* in cases of teenage unwanted pregnancy and young people who needed further examination such as those with chronic or severe STIs.

Bethesda Hospital has a referral system in place, specifically when it comes to HIV treatment. A medical doctor working at Bethesda hospital stated that the referral system is part of the hospital's standard operating procedures (SOP) and aims to ensure patients are provided with necessary services. In regard to referral for unwanted pregnancies and/or abortions, she stated that Bethesda hospital would not receive a referral nor provide services for abortion and would not promote or issue a referral for a safe abortion to be conducted in other health facilities in Yogyakarta. They would let patients find their own information for these services.

Other Referral Systems: PKBI

PKBI has two clinics for young people. The Youth Centre Clinic only provides counselling services and reproductive health check-ups. For medical action, young people are referred to the PKBI clinic in Badran with more staff members and better facilities. Most cases of unwanted pregnancies are referred to the PKBI facilities at the provincial level. For urgent cases, referral is issued immediately. Describing part of the referral system established at PKBI, and its aim to avoid complicated administrative procedure, a PKBI employee stated:

"We often refer clients to PKBI Yogyakarta. Sometimes, we also refer the clients to the local Puskesmas or the local hospital. […] For clients that are referred to the Puskesmas, we discuss and communicate both with the Puskesmas on what the expectations are and with the clients and their family to get their consent". (ID 10)

Puskesmas sometimes refer patients to PKBI although, according to one of PKBI's employees, this is a quite complicated process due to the fact that officially a referral can only be issued to a higher institution (e.g. a hospital at the district or province level).

In addition, PKBI collaborates with the private sector. Referrals to PKBI services are usually issued by midwives or medical doctors who work in the private sector. The organisation also has a referral system in place in collaboration with several NGOs, including those that focus on women, street children, and people with disabilities. These NGOs issue a referral for the people they work with so they can access PKBI services. The referral system is simple with no complicated requirements. The clients don't need to bring a reference letter from the original institution:

"*Actually, we are flexible. Our referral system is simple. No reference letter is needed. Sometimes we receive clients from other NGOs. Many organisations refer their clients to us. […] It is easier to build a referral system with NGOs rather than with the public clinics because the bureaucracy is too complicated (due to the regulations that are given by the Health Department)" (ID 11).*

The respondent added that PKBI is also part of a network of organisations (e.g. JPY, the Women's Network of Yogyakarta). These networks hold regular meetings, exchange information and build rapport so they can refer patients to each other's services.

Young People & Referral
When it comes to health providers' referral systems, several of the young people interviewed had never experienced a referral to another health care provider. The ones that had been referred needed additional and/or more specialized care for their SRH problems. The health providers they went to see initially – midwives, *Puskesmas* – were unable to treat them and thus decided to refer them to other providers.

One of the respondents was referred to Sardjito Hospital when she had her prenatal check-up at the *Puskesmas*. The reason was that the hospital could provide her with more specialized care, since she was a pregnant woman with HIV. Another respondent was referred to Wates Regional Hospital when she was about to give birth. This hospital provides natal services and pre-natal Ultrasonography (USG). The respondent said that the referral helped her receive better services in a place with better facilities and medical specialists. Several of the female respondents had similar experiences of being referred to a hospital by their midwives and/or the *Puskesmas* in order to receive specialised care during their pregnancies. One respondent went for a routine pregnancy check-up with the midwife and *Puskesmas*.

In one of the FGDs, the (male) participants discussed the need for the referral system to be improved. Patients should be given sufficient information about the procedures and the cost of the services at the referred facilities. In relation to this, one of the health providers interviewed argued that to ensure referred patients really go to the referred services, efforts should be made to find out which services are close to the patient's home and to make sure that the patients feel comfortable with these services. Only after that referral can be issued. In this way, referral takes into account the patient's need and willingness. In her opinion, it would be useless to refer patients to a facility that they are not planning to access. This corresponds with the answers provided by the young respondents, who mention comfort, distance and trustworthiness as important factors that play a role in their decision to access the referred services.

[4] Participation

The factor of participation focuses on the idea that young people's active participation in SRH initiatives can reinforce their knowledge of SRH and their uptake of SRH services. In this study, respondents were asked to share their ideas about and experiences with the most effective ways to involve youth in SRH initiatives in a participatory manner.

Participation According to Health Providers
When health providers were asked about effective ways to involve young people in SRH initiatives, several ideas were put forth:

Create and Engage Young Communities
One of the most effective ways of involving young people in SRH initiatives discussed by several of the health providers, was to ask young people to actively participate in youth community organisations in their villages and schools and to engage these communities in SRH initiatives. One of

the respondents argued that communities of young people who are concerned with SRH issues should be established and regular visits to these communities should be made and regular activities must be held there.

Organisation of Activities

In addition to engaging youth communities, activities focused on youth should be organised. Activities mentioned included discussions, forums, seminars, and awareness-raising activities in the community. One of the respondents working for PKBI believed that it would be effective to involve youth in discussions on sexuality at the PKBI office. In these discussions, young people's questions could be answered while counselling services and PE programs were provided at the same time. She said:

"We can start to involve them in discussions and make them curious about sexual and reproductive health issues. During the discussions we can answer their curiosity by providing the right answers that they may not get through the internet. Therefore, young people will be more encouraged to ask PEs or come directly to the clinic for information on SRH issues" (ID 10)

Involvement of Young People in Current/New SRH Programmes.

- *PE Programmes & Training Youth Representatives*

One of the methods to effectively involve young people in SRH initiatives mentioned by many respondents was through the involvement of PE/counsellors. An example of this initiative was to train representatives (or leaders) of youth communities, for instance on counselling or peer education, and enable them to actively participate in service provision. The trained leaders could collaborate with health and admission staff and inform and accompany youth to SRH services. A health provider from Samsara mentioned that they engage young people as counsellors, and ask youth for their feedback after a counselling session at Samsara. She stated:

"Anyone can be involved here actually but we choose to involve the young people because they are more dynamic and we become familiar with their way of thinking. Involving the young people is our strategy to cover many more young people" (ID 25).

Health providers also mentioned the effectiveness of establishing networks of peer counsellors. This could be done in the school environment as well as at the community level. PKBI Bantul already has a PE programme in place in several schools, and regularly trains 25 PE each year. Another respondent (an ASK program manager at *Puskesmas*) described the peer counselling services that she established and stated that this was the most effective way of involving youth in (quality improvement) initiatives for SRH by asking young people to actively participate.

- *Accompaniment Initiatives*

Involving youth by having them accompany others to SRH services so they get to know the possibilities and risks that come with SRH was mentioned as one strategy by the health providers. One of the respondents described a plan she had for *Puskesmas* to involve youth in an antenatal care programme. There are cases when pregnant women fail to show up for their health checks and antenatal care appointments since there is no one who can accompany them or remind them of the need for check-ups. "Killing two birds with one stone", this programme would target both pregnant women and youth. Asking young people to accompany pregnant women would make them "understand that being pregnant is not an easy job". Their direct involvement would make them aware of the issues that come with pregnancy including the risks pregnant women face (and the immediate responses to such risks).

Participation According to Youth

In discussing effective and participatory ways to involve youth in SRH initiatives (regarding quality improvement of services, improvement of knowledge and use of SRH services and the identification of SRH needs), our young respondents put forth several topics. Most of their ideas and perceived needs had to do with the dissemination of SRH information and awareness-raising activities.

According to the youth included in this study, it was important to increase youth involvement in the provision of SRH information and their active participation in youth communities and their activities to promote reproductive health services. For example, involving them in assistance and accompaniment programs in youth communities both as counsellors and community organisers (reaching out to youth communities) was considered as a potential strategy by the young respondents.

Awareness Raising Activities

Several respondents mentioned the importance of awareness-raising activities. These included activities that gather many young people and provide them with lectures, information on SRH and the opportunity for discussion. For example, seminars for unmarried adolescents and young people should be held. Activities could also be held for youth at the village level, and young people who are companions for other youth who are at risk could be involved.

Another respondent spoke about the importance of seminars and discussions that could be carried out during large events and fun activities to involve youth in SRH issues and increase awareness and understanding. He also mentioned the importance of informing youth of such initiatives, which could be published through social media:

"*The young people should be informed of any discussions, seminars or events held. The events should be fun and artistic and use games and performances to attract the young people. Through such events, people with HIV/AIDS will no longer be underestimated or stigmatized" (ID 27).*

The effectiveness of SRH-focused events and activities was described by one of the respondents talking about his experiences in attending a SRH education camp (*Jambore*). The camp had helped him to understand where to seek help when suffering from SRH complaints and increased his awareness of initial STI symptoms.

"Now I know for example where married couples can get family planning services, how to get condoms, and how to get immediate treatment for illness" (ID 04).

Youth Community Organisations

In order for youth to become more involved in an effective manner, several respondents mentioned the role and importance of youth community organisations in involving, informing and rallying young people. It was suggested that more young people's communities should become involved in HIV and other SRH-related issues:

"We need more communities for us to be able to play more direct roles and become more capable to provide information for each other. We need to be useful for ourselves and others". (ID 14)

Another respondent argued that young people would access SRH services if they were included in the activities of the youth community organisations that they are members of. Several other respondents also acknowledged the important role of youth organisations in functioning as a forum for youth to be involved in SRH initiatives. One of them spoke about attending activities held by certain communities (such as the LGBTIQ community) and participating in awareness-raising picnics,

outings and other events focusing on SRH and HIV/AIDS that were organised by NGOs (where educational materials were distributed).

[5] Promotion of Health Services and (Online) Media

In regard to the use of (online) media, the results of this study confirmed the findings of OR1. Young people look for SRH information on the internet, including the use of social media sources such as Facebook, BBM, and twitter. They tend to share the information they find with their peers (face to face or via social media) by discussing and sharing their experiences. Facebook is one of the most important social media channels they use; many young people in Indonesia are Facebook users. Respondents acknowledged young people's attachment to technology and social media and their use of these sources to find SRH information. One respondent stated:

"We share a lot of information via social media, for example Facebook, also Twitter or BBM. If someone asks about VCT for example, we will share what VCT is, what reproductive organs are, etc. We don't use newspaper and TV for providing such information." (ID 06)

"Since now I have a mobile phone, it is now much easier to access the internet …" (ID 36)

However, the respondents interviewed in this study still acknowledged the importance of awareness-raising activities and programmes. They believed that these initiatives should be directly connected to online activities. For example, after a campaign, online services could be provided to motivate young people to access online services first, providing a safe environment and hopefully creating the preconditions for youth to physically access SRH services as well. The findings show that young people nowadays do not like to visit services immediately. They rely on the internet to become informed.

This study also found that although young people initially seek SRH information online, they also tend to continue their search and ask people they consider to be experts for additional advice. Therefore, the roles of midwives, counsellors, and field workers are still important, since young people consider them to be trusted sources of SRH information. According to one of the respondents young people tend to initially search for information on the internet but then continue to ask people who have experience with SRH issues.

An overview of the findings of Sub Model 3 is presented in Table 4.

Table 4. Findings Sub Model 3 – Reinforcing Factors

Factors	*Current situation (based on Research Findings)*		*Ideal situation/Suggestions for Improvement*
	According to Health Providers	**According to Young People**	
[1] Actors & their roles	1. Peer educators 2. Health providers & facilities **Role:** provide information on SRH and SRH services. Information provided is perceived to be well accepted	1. Experts (medical doctors, health staff/ professionals, teachers); 2. Health care facilities; 3. NGOs **Role:** provide information on SRH and SRH services. 4. Peer Educators (PE's) **Role:** provision of SRH information and accompaniment of young - The quality of available information is good and generally well accepted by young people	- Perceived need for actors to take on a role that is based on trust and empathy; - Source of information should be "reliable" (competent) and credible; - Midwives are particularly mentioned as one of the most appropriate actors in the provision of SRH information;
[2] Companionship	- Companions from health facilities/NGOs to accompany young people to services	- Companions from health facilities/NGOs; - PE is the best "buddy" for young people when accessing SRH services; - Parents, family members and close friends are also considered as good companions, for logistical issues and emotional support, in the absence of PE	- PE can be from the community, the school; but most importantly, have personal experience with SRH issues; - Involvement of parents, family members and close friends are important as well; can positively or negatively impact service uptake
[3] Referral System	- Referral system is established at *Puskesmas* and public hospitals; - Collaboration established between PKBI and governmental and private providers; - PKBI has simple procedures for referral, no complicated administrative regulations	- The experience with referral is good and the reason for referral is appropriate; - Need to have better provision of information when being referred; - Referral not closely monitored; - Some health facilities have their own policy regarding termination of pregnancy	- SRH health facilities have their own policy regarding referral on pregnancy termination; - Clear, simple and appropriate referral procedure is needed, addressing young people's needs (e.g. accessibility);
[4] Participation	- Need to involve young people	- Need to involve young people - as companions when visiting the clinics;	- Involvement of young people in SRH issues is needed and should be improved; - Involvement of young people should be improved through formation of group, PE or in attending events/seminar; - Young people can be involved as an accompaniment for client;
[5] Promotion & Online Media	N/A	- (Social) Media is one of the sources of information for SRH and also for sharing information;	- The role of social media in provision of information on SRH should be improved i.e. tailor-made to the local context and need of target group; - Awareness raising activities (not online) is still needed; - Mapping of source information for young people is needed

4. Discussion

4.1. Submodel 1 – Predisposing Factors

[1] Knowledge

In general, the findings of this study have shown that young people have limited knowledge of SRH and SRH services. In addition, the answers of the respondents show that the type of knowledge that does exist is related to basic reproductive health and not sexual health. An exception to this are those young people who have been exposed to SRH programmes such as the ASK programme or similar and/or have had experiences with SRH related problems. Looking at the answers of this study's respondents, they indicated that young people will start looking for information on SRH only when they are faced with SRH issues. With regard to knowledge of SRH services in young people is even more limited. Of the services young people are familiar with, SRH services provided by *Puskesmas* are best known, followed by services provided by NGOs, such as PKBI, CD Bethesda and Rifka Annisa.

Knowledge of SRH and SRH services can have a positive or negative influence on youth's decision whether to use or not to use SRH services, since they used their knowledge to rationalise and justify the step to use SRH services. Incorrect knowledge (such as thinking that HIV can be transmitted through kissing, or the idea that young people are not welcome in *Puskemas*) may lead to the avoidance of SRH services. On the other hand, correct knowledge often positively supports the decision to use care, provided that earlier experience with SRH services was also positive (e.g. youth friendly staff and atmosphere).

These findings are supported by findings from the literature review[13] which showed that, despite the fact that young people often have knowledge of SRH services, there exists a significant gap between this knowledge and the actual *use* of services. Thus, even though knowledge exists, and SRH services are available in Indonesia, this does not mean that young people will access them.

Sources of information for SRH knowledge and services for young people vary from the people closest to them (e.g. family and friends) to more distant relationships (acquaintances, experts, health workers). In addition to these sources, most young people use the Internet (including social media) when searching for information on SRH. Similar with knowledge of SRH and SRH service, the type of sources may also influence the decision to use or not to use the available SRH service. Sources who provide correct knowledge and have positive experience or opinion on the available SRH services will positively influence the decision for using SRH service. Taking a closer look into the SRH care trajectories the young respondents in this study have engaged in, SRH sources were often consulted prior and during this process. Therefore, the availability of sources who are able to provide appropriate information and support youth in accessing SRH services may be crucial in the decision making process for young people whether or not to use SRH services.

[2] Beliefs

Findings of this study have shown that beliefs in regard to issues surrounding SRH influence the decision of young people to use SRH services. SRH related beliefs (for example, the belief that 'free sex practices' may lead to psychological problems) may lead to self-stigmatization (being afraid of

[13] All references to the literature review refer to the Literature Review Report on Opportunities and Barriers for Increasing the Uptake of SRH Services among Under-Served Young People in Indonesia, developed by ResultsinHealth (2015).

stigmatized by others) when accessing SRH services or prevent the utilization of services altogether. On the other hand, correct beliefs - such as the belief that an STI can be cured with the right medication - can increase the use of SRH services by young people. SRH beliefs were also mentioned as a reason to opt for alternative or informal care/services, especially when the beliefs are not fully correct (e.g. the idea that pregnancy can be terminated using a certain herbal mixture); or that health facilities will not help young MSM, as homosexuality is considered a taboo. Within the SRH trajectories, the role of belief in selecting the type of SRH services highly depends on prior experience young people with SRH service. For instance, a bad experience with informal SRH services may cause young people to switch to the formal SRH services, and the other way around. This is particularly the case with the young respondents who experienced unwanted pregnancies.

The findings on the influencing role of beliefs on SRH service uptake are in line with findings from the literature review. Feeling afraid, shy, or embarrassed related to SRH issues is the most important barrier to SRH service uptake (formal or informal) identified by young people. This barrier is said to be rooted in the social context surrounding young people's sexuality, can lead to risky sexual behaviour and a delay in health seeking services as they often resort to self-treatment.

[3] Perceived Needs

Findings of this study have shown that perceived need was the main reason for young people to use SRH services. This need is represented by the urgency/severity of SRH symptoms (e.g. unwanted pregnancy, symptoms related to reproductive organs) and perceived risk (e.g. the boyfriend is tested HIV positive). In the absence of those needs, most young people will not use SRH services. The urgency or severity of SRH needs almost always positively influenced young people's decision to use SRH service. However, it may either positively or negatively influence the decision to select the *type* of SRH service, often in combination with a young person's knowledge and beliefs. For instance, when the need is high, and the knowledge and beliefs provide a positive image of a private SRH provider, they tend to opt for the SRH services of those private providers. Similarly, when the need is high and the knowledge and beliefs guide them towards alternative methods, the decision will be to use this informal type of care. When the need is not high, despite the presence of correct knowledge and belief, young people tended not to utilize the SRH services available to them. Interestingly, in the case of unwanted pregnancies, the informal SRH services are almost always selected as the first option. Formal SRH services are only selected in the case of unsuccessful outcomes of earlier efforts. This indicates that the norms and values around unwanted pregnancy that exist in Indonesia are translated into the image and expectations of young people when it comes to formal SRH service.

Findings of this study suggested that the presence of correct knowledge and beliefs regarding SRH and SRH services do not necessarily increase the uptake of SRH services of young people. This situation deviates from the common assumption that the presence of correct knowledge and beliefs may be considered to be the foundation for action. It is the presence of need (in terms of severity or urgency of SRH symptoms/problems), which serves as the starting point for young people when it comes to using and selecting type of SRH. Perceived need thus presents a stronger influence on SRH service uptake by young people than knowledge and/or beliefs on SRH and SRH service.

4.2. Sub model 2 – Enabling Factors

Sub model 2 addresses the role of availability, accessibility, affordability of SRH services and commodities; quality of SRH services; values, norms, and attitudes of health workers; and laws and regulations related to SRH as enabling factors for young people to use SRH services. In the context of utilization of SRH service, these factors have shown to influence and complement each other. However, findings also showed a certain hierarchy among these factors. For example, young respondents mentioned that flexible opening hours and accessibility are important to them,

however, quality of services in terms of privacy and confidentiality and youth friendliness were considered to be more important and have stronger influence in their decision to use SRH service. This finding is supported by findings of the literature review, where fearing a breach of confidentiality and privacy, health workers being judgmental and rude, as well as feeling ignored and neglected by health providers were put forth as barriers to accessing SRH services. In addition, attitudes of health workers is also mentioned to be important by young people, particularly due to the sensitivity of the SRH issue in Indonesia.

For the health providers interviewed in this study, norms and values as well as laws and regulations on SRH are considered to be the most important enabling factors. Laws and regulation on SRH is used to legitimate the delivery of SRH services at public facilities (e.g. *Puskesmas* and public hospital) and to a certain extent for private facilities. Health providers mentioned that they need "assurance" in terms of law, regulations and policies that protect them in providing SRH services (particularly for the provision of safe abortion services and contraceptives for unmarried young people). This is understandable since the indication and condition for provision of safe abortion practices and contraceptives are limited to married couples only. These findings are in line with findings of the literature reviews which mentioned that current Indonesian policy prohibits sexually active young and/or unmarried people to obtain certain SRH services (e.g. contraceptives, STI treatment, abortion (only in particular cases), etc.), and therefore the availability and accessibility of such services for Indonesian youth is very limited.

Looking at the different components within the enabling factors, differences are observed between public and private SRH facilities. Public facilities tend to be more affordable and accessible in terms of distance, but have low quality of services and are less youth friendly. The private facilities are often more expensive and thus may be less available, but provide higher quality and more youth friendly SRH services. Therefore, private SRH service is preferred by Indonesian youth. This is in accordance with findings of the literature review, which showed that access to private clinics is perceived to be better than access to public clinics. Providers at private clinics further emphasized that, at public clinics, young people will be denied access to services (due to legal restrictions), and that they would receive lectures and verbal abuse, or their information would not be kept confidential.

When it comes to affordability, SRH services are not always fully covered by the current social insurance scheme in Indonesia. However, this does not seem to be a barrier in accessing SRH services. Young people's willingness to pay is much more influenced by the urgency and/or severity of their SRH issues.

4.3. Sub model 3 – Reinforcing Factors

[1] Actors & their Roles

The findings of this study have shown that experts, and in particular health care providers, are considered to play an important role in the provision of SRH information to young people. Whereas the health provider respondents see a role for these experts in the facilitation of young people's access to information and services by creating a lower threshold and/or hosting informative activities, the young respondents look at it from a different angle: they consider providers to be reliable and knowledgeable when it comes to SRH information; they are trusted to be experts in the field and the information they provide and thus be accepted by young people. In addition, respondents in this study described the value of peer educators (PE's) when it comes to the provision of SRH information, and guiding them through the realities of SRH services – on both the practical and emotional level. Based on the findings of this research PE's have a significant ability to reinforce young people's SRH service uptake, with youth being able to identify with them and susceptible to

and accepting of what they have to say. Finally, both from the study and literature review findings confirmed that it is important to take the role of family and friends into account: seeing that these people are often very close to the young people, they can have a significant role and impact when it comes to their decision to use SRH service (Low, 2009). Either positively, providing them with information and encouraging them to access services. Or negatively, due to negative attitudes, judgement and/or a lack of knowledge.

Acceptance of information provided by these actors can reinforce young people's SRH service uptake; knowledge of SRH issues and information about available services can provide young people with the understanding, confidence and even sense of urgency to go and access SRH services. However, experts are often not as 'readily available and accessible' as (for example) young people's peers: these experts often work in health care facilities, which means youth will already have had to make the decision to access these facilities. Therefore, when aiming to successfully increase young people's SRH service uptake, one might want to focus on those actors that are close (or can get close) to young people, such as peer educators, family and friends.

[2] Companionship

The reinforcing potential of actors and their roles in the SRH service uptake of young people is directly linked to sub model 3's second component: *companionship*. For the people in this study, companionship entails helping young people in their search for SRH information (either by providing it themselves, or by knowing where to find the rights sources), but especially accompanying them in accessing SRH services. Companions can reinforce young people's decision to utilize SRH services by explaining the procedures and helping them through various steps of treatment. In addition, their mere presence forms an important emotional support for young people, which has a positive impact on their confidence to access SRH services. This study especially shows that companions who have personal experience with SRH issues are believed to be able to understand and support young people better. Having to deal with unknown, complicated issues alone, may keep youth from accessing SRH services. This study has shown that when there is a companion there to inform, guide and support them, making them aware of the realities of SRH issues, this has a positive influence on young people's SRH service uptake.

These findings are similar to the ones found in the literature review which has shown that there exists an important need to recognise the role of the community and the important people that may influence young people's behaviour in the design and implementation of SRH programs. Especially the identification of 'gatekeepers' (e.g. teachers, parents) and increasing their awareness and skills regarding SRH issues has been identified as a key feature for successful SRH programming.

[3] Referral Systems

This study has shown that the referral systems currently in place enable and reinforce *additional* SRH service uptake young people. Governmental health providers such as *Puskesmas* have to adhere to strict referral procedures - following the official guidelines of the Health Department - only referring patients to 'higher level' institutions (i.e. hospitals at the district and provincial level). However, this study shows that, in practice, they sometimes refer young people to the private sector (e.g. PKBI, CD Bethesda or other NGOs). This is particularly the case when it comes to unwanted pregnancies and other SRH related issues when public health facilities cannot handle cases due to the (limited) services available (in accordance with existing laws and regulations). When it comes to other types of referral systems that are established in order to support young people's SRH service uptake, private providers such as PKBI are of particular importance. PKBI does not work with complicated administrative procedures that can obstruct and slow down referral processes. This flexibility in the referral procedures can have a positive and reinforcing influence on young people's SRH service

uptake: the least complicated it is for youth to be referred to and access additional services, and the better the communication between different providers, the more chance there is that young people will adhere to the referral and make use of these services. In addition to this, this study has shown that there is a need for referral systems to take into account the needs of young people (in regard to quality and accessibility of services) in order for referral systems to be effective and reinforcing in terms of SRH service uptake by young people. For example, there exists a strong relationship between companionship and the effectiveness of referral systems. Having a companion can thus significantly influence the decision of young people to make use of the referred services.

[4] Youth Participation & [5] Promotion through Online Media

The finding of this study support the idea that involvement of young people in SRH initiatives (e.g. the ASK and other SRH programmes) has the potential to reinforce their SRH service uptake. In particular, the study has shown that there exists a (possible) pathway to SRH uptake by involving young people in SRH initiatives through online activities. Even though the respondents in this study suggested the organisation of activities by health care providers and (youth) community organisations to be an effective strategy to involve young people, the sensitivity of SRH topics can also prohibit youth in attending such activities. Online sources tend to feel safer (no face to face contact) and are accessible to young people.

Based on the findings of this study and the results from OR1, young people often turn to online sources for SRH information, sharing this information with their friends (either face to face or through social media). Online promotion of SRH information and services, and efforts to involve young people in online SRH-focused activities thus provide valuable strategies when it comes to improving young people's SRH knowledge and service uptake. There are many sources of information out there for youth to find. Many of these sources are very sophisticated and complete in terms of design and content. Therefore, the added value of websites or social media initiatives created by SRH programmes (implemented by governmental organisations, health providers and/or NGOs) potentially lies in providing and promoting online content that suits the local context, and actively tries to involve youth (e.g. key target groups).

In terms of additional ways to effectively involve young people in SRH initiatives, the findings again show an important role for peer educators. Involving young people in peer educator programmes and training other youth representatives can significantly improve the information and network available for young people to help them in their SRH service uptake. Training peer educators can lead to a network of peers that young people can call upon.

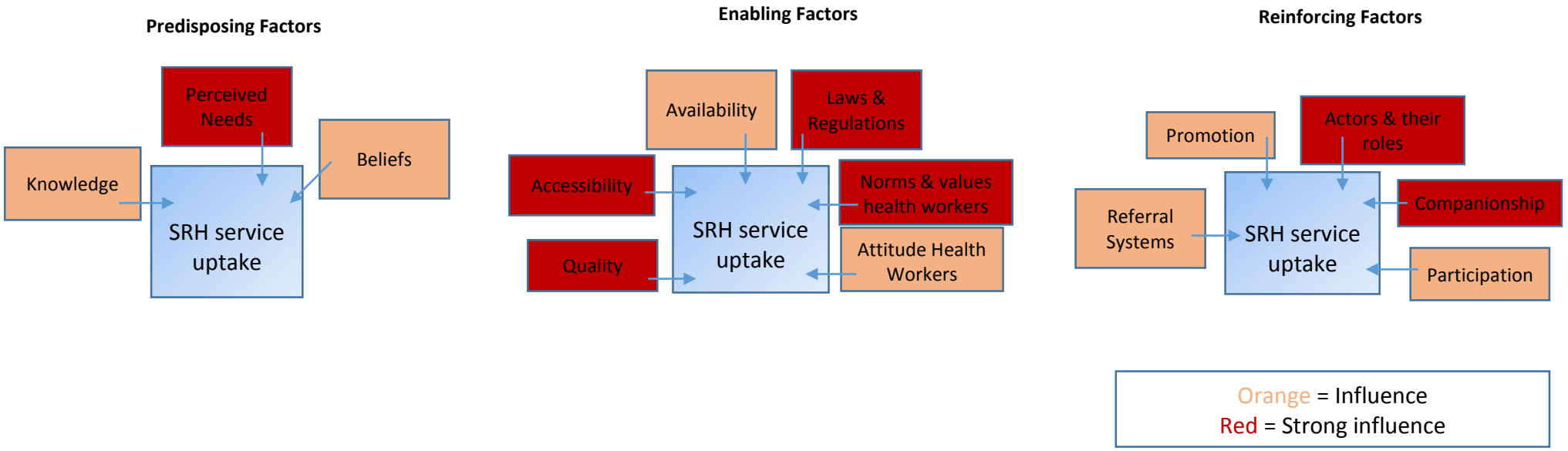
4.4. Concluding Remarks on Findings Sub Models

Based on the analysis of the dynamic of the components within each sub model, it can be concluded that: within the predisposing factors, perceived needs have the strongest influence on young people's SRH service uptake compared to other components. Within the enabling factors, young people consider quality and accessibility to strongly influence their utilization of SRH services, whereas health providers believe norms and values of health workers and laws and regulations to be the most influential when it comes to youth's SRH service uptake. Looking at the reinforcing factors, actors and their roles as well as companionship have the strongest influence on SRH uptake by young people. Figure 6 illustrates the different level of strength of the components within each sub model.

4.5. Main Model Discussion

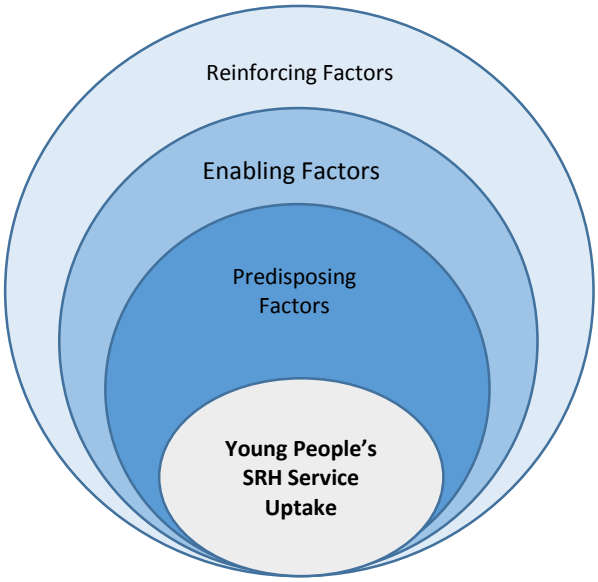
As described in chapter 2, this study used parts of the PRECEDE model to develop a main model to identify factors that influence young people's SRH service uptake in DI Yogyakarta. In this model,

Figure 6. Factors and their level of influence on young people's SRH Uptake



predisposing, enabling and reinforcing factors were assumed to equally influence the utilization of SRH services (see Figure 4, chapter 2). However, the findings of this study have shown different dynamics. Predisposing factors (e.g. perceived needs) seems to have a direct influence on youth's decision to use SRH services, while enabling factors and predisposing factors had an in-direct influence on their service uptake. For example, the availability of youth friendly health providers and peer educators supported the decision to use SRH service; but did not *directly* influence the decision to actually seek care. This decision was actually influenced directly by the presence of a perceived SRH need. This implies that the 3 groups of factors do not have the same level of influence – and importance – when it comes to SRH uptake, as previously assumed in the original main model developed for this study. Rather, the different sub models represent different 'layers' of direct and in-direct influence on young people's SRH service uptake: with predisposing factors being the direct influence, and enabling and reinforcing factors having an in-direct influence (see Figure 7).

Figure 7. Main Model according to Findings Operational Research



Despite this nature of influence, the fact that only predisposing factors have a direct influence on the uptake of SRH services does not imply that interventions should only be directed towards these factors. Instead, the adjusted main model is also meant to show the inter-connection between the different factors. This model strongly suggest that if components within the predisposing factors need to be strengthened, interventions should also be directed towards developing and supporting the enabling and reinforcing factors. In addition, because of the interconnectedness of the different factors, impact of interventions will be more optimal if the interventions on the 3 factors are conducted simultaneously (parallel intervention), instead of separately.

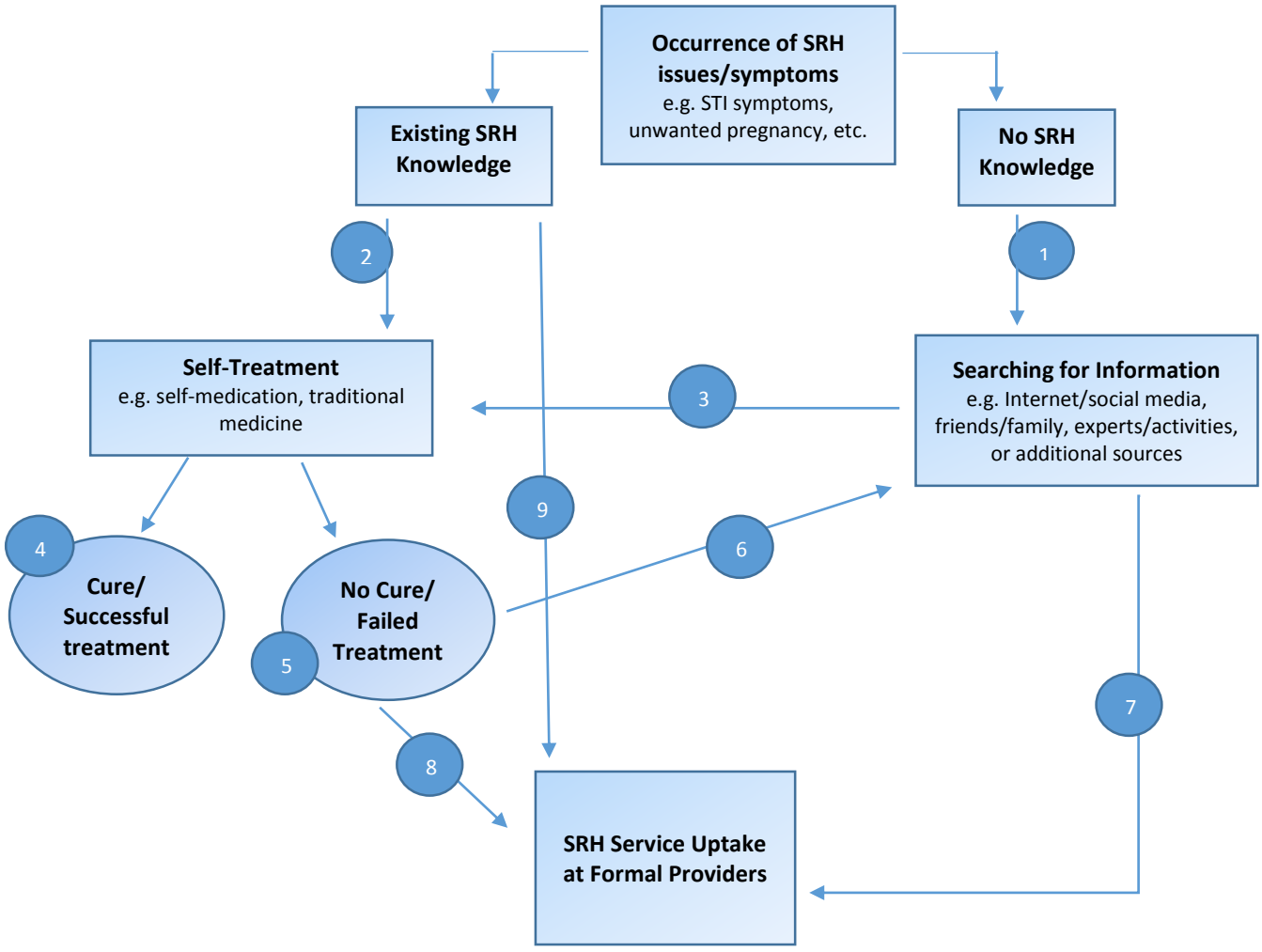
4.6. Pathways to SRH Service Uptake

Analysis of the factors that influence utilization of SRH service among young people in DI Yogyakarta has further shown patterns in regards to their SRH trajectories. To show these different trajectories, pathways to SRH services for young people are presented below. These pathways describe the steps taken by young people in their "journey" towards uptake of available SRH services. For most young people their pathway starts with the presence of SRH needs/issues. For female youth the most common need is the presence of an unwanted pregnancy, for others it may be having signs of an STI.

Depending on the level of correct knowledge on SRH and SRH service, 2 steps may be taken: for those with limited knowledge on SRH and SRH service, the step to search for knowledge from readily available sources is taken. Those with some existing knowledge of SRH and SRH services may make the decision to immediately access formal services or to self-treat by using western or traditional medicines. However, the decision to self-medicate or self-treat can also be the result of the obtainment of knowledge, if the knowledge obtained guides them to do so. Another possible result of the obtainment of knowledge is the decision to use informal SRH services. An additional route to the utilization of informal SRH services is through the outcomes of self-medication/self-treatment. If the outcome is positive (cure or problem solved), the trajectory stops; if the outcome is negative (no cure or failed treatment), young people may also take the step to use formal SRH services. The complete trajectories is shown in the below figure using the following categories:

Step 1 = obtainment of knowledge
Step 2 = self-treatment as results of existing knowledge
Step 3 = self-treatment as result of obtainment of knowledge
Step 4 = cure/problem solved
Step 5 = no cure/treatment failed
Step 6 = decision to obtain knowledge after informal treatment failed
Step 7 = decision to use formal SRH services after obtainment of knowledge
Step 8 = decision to use formal SRH services after informal services failed
Step 9 = decision to use formal SRH services based on existing knowledge

Figure 8. Pathways of SRH Uptake



Based on the figure above, short and a longer pathways can be identified. The short pathway starts with the presence of symptoms and ends with utilization of service, with or without the step to obtain information on SRH and or SRH service. This pathways happened frequently in the case of unwanted pregnancy, as the sense of urgency (in terms of time) determined the decision to access SRH service. In most cases the type of SRH service utilized was the one that was known to be able to provide an immediate "solution" to an unwanted pregnancy (e.g. safe abortion). Another group that followed this pathway were young MSM faced with STI symptoms. The symptoms of an STI were usually clear to young males and they often directly resorted to formal SRH services, instead of finding alternative solutions.

The long pathway also started with the presence of an SRH problem and ended with the utilization of formal SRH services. However, in some cases this pathway was influenced by (perceived) stigma and stereotyping related to the SRH problems encountered and the limited knowledge on SRH and SRH services. In cases where the SRH problem experienced was stigmatized (e.g. considered as taboo or bad), some young people decided to self-medicate or self-treat, either on their own, with friends/ family or by engaging with informal/traditional SRH providers. Where there existed a lack of correct or appropriate knowledge, information was sought from various sources, which may have supported the decision to self-medicate/self-treat or use informal SRH services. In case the outcome of self-medication/self-treatment was not satisfying, some young people decided to obtain (more) information or directly access formal SRH services.

An example of a long pathway is the situation where young people missed their period, which may be due to pregnancy or other causes, and solutions were sought through different sources. In the case of unwanted pregnancy, the care form formal SRH service is often sought only when severe health problems (i.e. bleeding) occur as a consequence of efforts performed to terminate the pregnancy. Another example of a long pathway can be seen among young people with HIV. Early signs/symptoms of HIV were not always clear and were sometimes associated with self-stigmatization and stereotyping. In those cases, utilization of informal care is generally very common, in order to avoid embarrassment or stigma. Only when the disease progressed and the signs and symptoms became more clear and severe, care from formal SRH services was sought.

Some of the shorter pathways save young people from the unnecessary and often risky treatment that may put their life at risk (e.g. people with existing knowledge immediately accessing formal SRH services). However, the lack of preventive action on the part of young people and thus the risk of repeated occurrence of SRH issues, even if treated immediately and effectively, still bear health risks in the long run (i.e. infertility). The longer pathways almost always put young people's life at risk and resulted in late presentation of a disease (i.e. STI or HIV), increased severity of symptoms or a near full term of pregnancy, which may limit the options for treatment or a workable solution. These situations pose a greater burden on young people, the family and the health system.

The fact that the presence of SRH problem was the starting point in both short and long pathways indicates that the current health seeking behaviour of young people is illustrative of the phenomena of a secondary type of prevention (prevention after the occurrence of health problems in order to limit health consequences). While, ideally, in order to address SRH issues among young people, a primary type of prevention (before occurrence of health problems) is preferred, as this is assumed to be more effective and efficient. When linking this to the adjusted main model presented above, primary prevention on SRH for young people can only be achieved if efforts are directed to supporting components within all three groups of factors.

5. Conclusion

This section will reflect on the findings in order to answer the main question of this study: what are the most effective strategies to increase the uptake of SRH services among young people in Indonesia including key targeted populations (e.g. young disabled. Young LGBTIQ. The answer to the main question of this study is expected to bring this study closer to accomplishing its main objective, namely: identifying the supporting factors that facilitate young people's access to public and private SRH services.

Following the theoretical model used for this study, uptake of SRH service is influenced by predisposing, enabling and reinforcing factors. Predisposing factors represents the characteristics and situation of young people; enabling factors refer to the available SRH services; and reinforcing factors serve to strengthen the motivation for particular behaviour. The assumption at the start of this study was that those 3 factors are equally strong when it comes to influencing young people's decisions to use SRH service.

To verify the above assumptions, this study sought to answer the 12 sub-questions (which were developed and classified based on the 3 sub models), using data from field findings and the literature review. It turned out that young people in DI Yogyakarta use SRH service *only* when experiencing SRH problem (having a [perceived] need). The (perceived) need for types of services varied, depending mainly on young people's sexual orientation and sexual behaviour. Furthermore, SRH seeking behaviour has been shown to be influenced by the knowledge and beliefs regarding the problem experienced and the knowledge and perception of available SRH facilities. Findings from the field have shown that young people's knowledge on SRH is generally limited to reproductive health (with a significant lack of knowledge regarding sexual health) and information obtained from prior experiences with SRH problems (if any). Therefore, sources of information on SRH and SRH services have an important role in shaping the decision of young people to seek care.

The type of SRH service accessed may be public or private; formal or informal, depending on the availability and knowledge of the young person in need. Barriers to access services were often related to issues such as guilt (including shame and rejection), stigma (self-stigmatization or stigmatization by others) and fear of rejection (either by family, friends or health providers). Young people perceived the availability of youth friendly SRH services to be limited, especially when it comes to the provision of services that ensure full privacy and confidentiality. In relation to this, private SRH facilities were preferred, although there were some public facilities mentioned to provide youth friendly services. Young people particularly mentioned the role of midwives in the provision of SRH service at public facilities and findings of this study emphasized the potential role of midwives in addressing issues of SRH of young people.

In addition, this study has documented the importance of a supportive environment for health providers in delivering SRH services to young people. Health providers mentioned the need to enjoy the protection and assurance of laws and regulations when performing practices such as the termination of pregnancy and the provision of contraceptive for unmarried youth. This was particularly the case for those working in public facilities. For health providers in private facilities, the issue was equally important, however people working at private SRH facilities tended to have more flexibility than their colleagues in public facilities. The findings have shown that affordability of SRH services in private SRH facilities and the current referral systems established do not seem to be considered as barriers for accessing SRH service by young people.

Field findings also showed the importance of the role of particular actors involved in the provision of information on SRH. Peer educators were the preferred sources of information and accompaniment

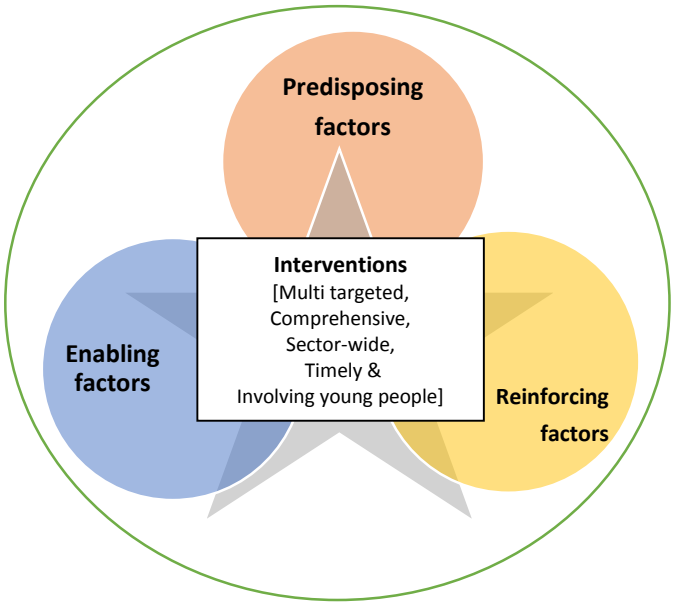
for young people when entering the SRH care trajectory, especially those who had similar experiences. In the absence of peer educators, family and friends were mentioned. In terms of involving young people in SRH initiatives, the role of peer educator was mentioned again as an effective strategy, especially when combined with the formation of peer networks that young people can rely on.

Once the decision to access SHR service is made, pathways to reach formal SRH services are determined by the obtainment of correct knowledge on SRH issues and SRH service. Based on the steps taken, young people may take a short or long pathway towards formal SRH service uptake. The pathways to SRH care illustrate the possible risk faced by young people and the consequences for them, their surroundings and the health systems: the current SRH pathways of young people show a secondary type of prevention, instead of the desired primary type of prevention.

Contrary to the main theoretical model developed for this study, field findings have shown that the 3 factors actually do not influence the decision for SRH service uptake in equal measure. Predisposing factors were found to have a direct influence, whereas enabling and reinforcing factors were having an indirect influence on the utilization of services. In addition, findings have shown the inter-connectivity between the groups of factors - in terms of components and timing – which suggests that efforts to increase young people's uptake of SRH services should be focused on all factors and conducted simultaneously.

To summarise, strategies to increase uptake of SRH service for young people should include the 3 groups of influencing factors. This implies that strategies should be multi-targeted (addressing multiple issues related to SRH service provision), sector-wide (include all stakeholders within and outside health sectors), comprehensive (covering primary and secondary prevention) and timely (implemented simultaneously). In addition, strategies should be developed with the participatory involvement of young people and employ methods that foster participation of young people in addressing SRH issues even further (see figure 9). The next chapter presents concrete recommendations that can be considered in the design and implementation of SRH programming.

Figure 9. Recommended Effective Strategies to Increase SRH Service Uptake



6. Recommendations

This study set out to identify the most effective strategies to increase the uptake of SRH services by young people. This chapter presents several recommendations for different stakeholders that can be used to maximize the impact of such strategies.

General Recommendations

(1) Recommendations for Young People

- Young people should adopt a critical attitude towards information on SRH and SRH services and its sources.
- Young people should adopt a proactive attitude and willingness to participate in SRH related activities
- Young people should take an active role in improving their SRH situation; when possible and feasible become agents of change (e.g. through accompaniment, being sparring partners or peer educators)

(2) Recommendations for Health providers

- Public and private health providers should continuously conduct (internal) discussions on issues related to beliefs, norms and values of SRH for young people as well as finding acceptable solutions for complicated SRH cases or situations experienced by young people.

(3) Recommendations for SRH Programs

- SRH programmes should improve the content of (online and offline) SRH information to accommodate the local context, taking into account the real needs of young people when it comes to SRH information and services.
- SRH programmes for young people should consider the most appropriate channel for delivering its messages. When using social media, the purpose, the type, and the way of operation should be clearly defined in order to optimise its impact.
- SRH programmes should build and strengthen networks of institutions and/or organisations with a similar focus, and include stakeholders from outside the traditional SRH sectors to facilitate multi-targeted interventions.
- Peer educators and companions were proven to be of essential importance for young people. Therefore, SRH programmes must include and foster meaningful and participatory involvement of young people through the expansion of their role, increasing numbers of young people involved and building their capacity.

(4) Policy makers/designer of health systems/donor

- SRH program players tend to underestimate the role of *Puskesmas* and midwives whereas the findings of this study have shown that they are in fact important players. Their role can be optimised in order to expand SRH services for young people, especially in sub-urban and rural areas.
- In relation to this, it is very important for the government to endorse the implementation of the new regulations on the provision of youth friendly services through the PKPR Program in *Puskesmas*. This will help to expand the SRH services in collaboration with private practices of midwives and expand *Puskesmas*' services in the SRH area. In addition, the operationalization of such regulations can help to reduce the stigma surrounding SRH issues and its services as well as the stigma and discrimination towards young people who are accessing SRH service.
- Facilitate public SRH services (such as *Puskesmas*) in the delivery of quality and youth friendly SRH services, particularly in terms of privacy and confidentiality. This can be achieved by –

for example – increasing the number of professionals that deliver the services (particularly in public services), strengthening the role of midwives, offering flexible opening hours to fit the needs of young people, simplifying the flow of services, and assigning specialised professionals to deliver youth friendly services.

- Development and provision of supportive and youth friendly SRH policy through intensive advocacy efforts focusing on the Ministry of Health and Ministry of Education.
- Strengthening the capacity of *Puskesmas* staff and midwives through series of capacity building efforts (e.g. training, supervision and mentoring) including successful examples of (public and private) SRH services as role models.

(5) Other stakeholders

- Key actors such as parents, teachers and health experts should be involved in the implementation of SRH programs. These actors can be part of a network focusing on the provision of comprehensive SRH information for young people

Specific recommendation

For the ASK programme:

- ASK together with their partners and alliances can be the lead advocator for the integration of *Puskesmas* in the delivery of SRH services for young people in the study area in the current existing system (as a pilot project) as well as establishing stronger partnerships with *Puskesmas* and alternative SRH services such as (private practices of) midwives (in sub urban and rural areas) as the first gatekeepers to 'catch' young people with SRH issues. Finally, efforts should be made towards an improved and integrated referral system focusing on youth friendly SRH services for young people in the study area.
- ASK can also review their programmatic approach particularly those aspects that are relevant to strengthening reinforcing factors (as defined in this study) such as the promotion of SRH services using more 'friendly channels' in order to be more accessible for young people in the study area and by optimising the use of other components included (actors, various channels of media).

We would also like to propose several ideas for potential future research as a follow up to this study:

- Conduct a comprehensive PKPR Program Review/Evaluation to be used as a reference point for improving the role of *Puskesmas* as a key SRH service provider for young people
- How to improve *Puskesmas* role in being a key SRH service provider for unmarried young people
- How to integrate public and private SRH services effectively

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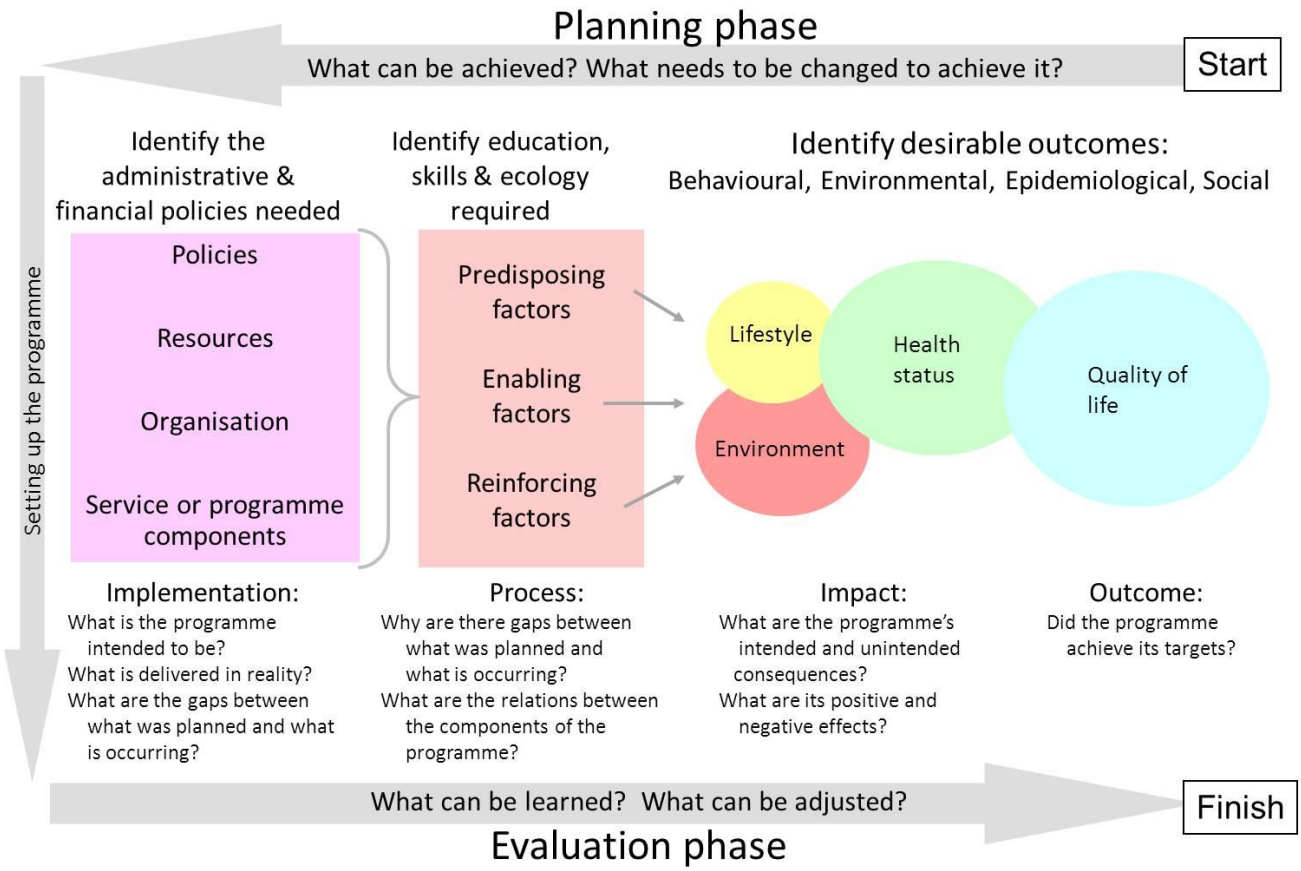
Annex 1. PRECEDE-PROCEED Model



Adapted from: Green L. http://www.lgreen.net/precede.htm (Accessed May, 2009)

Annex 2. List of Researchers

No	Name	Sex	Role
1	Ciptasari Prabawanti	Female	Principal Investigator
2	Erlian Rista Aditya/	Male	Senior Researcher
3	Henri Puteranto	Male	Senior Researcher
4	Indana Laazulfa	Female	Senior Researcher
5	Kharisa Irfani	Female	Junior Researcher
5	Paramita Dian Andini	Female	Junior Researcher
6	Ragil Prasedewo	Male	Junior Researcher

Annex 3. Timeframe Operational Research

Description	May				June					July				August					September				October				November
	4	11	18	25	1	8	15	22	29	6	13	20	27	3	10	17	24	31	7	14	21	28	5	12	19	26	
Preparation and validation of detailed research plan, data collection tools and consent forms.								■	■																		
Ethical clearance and research permission approval										■	■	■	■	■													
Pre-testing the data collection tools															■												
Develop data analysis plan, creation and validation qualitative data analysis framework and coding parameters											■	■	■	■													
Data collection in Yogyakarta Province (4 districts)																■	■	■									
Transcription of verbatim data																■	■	■	■	■							
Translation of verbatim																■	■	■	■	■	■						
Manage qualitative data																	■	■	■	■	■						
Preliminary analysis workshop																		■									
Further analysis based on the preliminary analysis workshop																			■	■	■						
Drafting of preliminary research report																					■	■	■				
Presentation of preliminary report with key stakeholders																								■			
Revision to the report, development of Factsheet																									■		
Translation of final report/factsheet																										■	
Dissemination Activities																											■

Annex 4. Ethical Clearance and Research permission

Research Permission

PEMERINTAH KOTA YOGYAKARTA

DINAS KESEHATAN

Jalan Kenari 56, Yogyakarta 55165 Telepon (0274) 515866, 515869 Faksimile (0274) 515869
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WEB SITE : www.jogjakota.go.id

Yogyakarta 1-09- 2015

Nomor : 070/ 6483
Hal : Rekomendasi izin penelitian

Yth. Kepala Dinas Perizinan
Kota Yogyakarta
Di-
YOGYAKARTA

Berdasarkan surat dari Yayasan Siklus Sehat Indonesia Nomor 0013/CP/ps/2015 Tanggal 20 Agustus 2015 perihal pada pokok surat, bahwa

Nama : Sdr Ciptasari Prabawanti dkk (5 orang)
Pekerjaan : Tim Siklus
Alamat : Jl. Anggrek VI/15, Malakasari, Duren Sawit Jakarta Timur

Dengan ini kami sampaikan bahwa pada prinsipnya kami tidak berkeberatan dan memberikan rekomendasi penelitian dengan judul :

Penelusuran Akses Terhadap Layanan dan Pengetahuan Anak Muda Mengenai Kesehatan Reproduksi , Dalam Konteks Program ASK (*Access to Service and Knowledge)*

Demikian rekomendasi penelitian ini dibuat untuk dapat dipergunakan sebagaimana mestinya.

a.n. Kepala
Sekretaris,

Agus Sudrajat,SKM, M.Kes
NIP 196505301988031006

Tembusan :
1. Kepala Puskesmas Gedongtengen Kota Yogyakarta

Ethical Clearance

KEMENTERIAN KESEHATAN
BADAN PENELITIAN DAN PENGEMBANGAN KESEHATAN
Jalan Percetakan Negara No. 29 Jakarta 10560 Kotak Pos 1226
Telepon: (021) 4261088 Faksimile: (021) 4243933
E-mail: sesban@litbang.depkes.go.id, *Website:* http://www.litbang.depkes.go.id

PERSETUJUAN ETIK (*ETHICAL APPROVAL*)

Nomor : LB.02.01/5.2/KE. 400 /2015

Yang bertanda tangan di bawah ini, Ketua Komisi Etik Penelitian Kesehatan Badan Litbang Kesehatan, setelah dilaksanakan pembahasan dan penilaian berdasarkan *Nuremberg Code* dan Deklarasi Hensinki, dengan ini memutuskan protokol penelitian yang berjudul :

"Penelitian Operasional untuk Menelusuri Akses terhadap Layanan dan Pengetahuan (ASK/Access to Services and Knowledge)"

yang mengikutsertakan manusia sebagai subyek penelitian, dengan Ketua Pelaksana / Peneliti Utama :

Ciptasari Prabawanti

dapat disetujui pelaksanaannya. Persetujuan ini berlaku sejak tanggal ditetapkan sampai dengan batas waktu pelaksanaan penelitian seperti tertera dalam protokol dengan masa berlaku maksimum selama 1 (satu) tahun.

Selama penelitian berlangsung, laporan kemajuan (setelah 50% penelitian terlaksana), laporan *Serious Adverse Event*/*SAE* (bila ada) harus diserahkan kepada KEPK-BPPK. Pada akhir penelitian, laporan pelaksanaan penelitian harus diserahkan kepada KEPK-BPPK. Jika ada perubahan protokol dan/atau perpanjangan penelitian, harus mengajukan kembali permohonan kajian etik penelitian (amandemen protokol).

Jakarta, 18 September 2015

Ketua
Komisi Etik Penelitian Kesehatan
Badan Litbang Kesehatan,

Prof. Dr. M. Sudomo

Annex 5. Research Tools (Interview Guides)

INTERVIEW GUIDELINE FOR HEALTH PROVIDERS IN YOGYAKARTA

City/District Code*	
Day/Date	
Interview location	
Interviewee Code**	
Interviewer	
Time Interview (real time)	**From:** **To:**

Questions

The aim is for the "positive examples" to take a central place in the research. The focus lies with those young people that have actually accessed services/contraception and to retrospectively study their pathway towards these service providers.

Service provision for young people

No	Detailed Questions	Answers
1	Number of SRH services provided by partner organizations of the ASK programme to young people and adults and by subcontractors/ government facilitated by partners • Based on your knowledge, how many SRH services which provided either by partners of ASK Program ASK or by sub-contractor/government which facilitated by partners? • Are the numbers of SRH services for young people sufficient to meet their needs? Why?	
2	Which SRH services do health providers (including public and private health providers) consider to be appropriate for young people at different stages of their reproductive life-course? • Among all services currently available, which one appropriate to fulfil people's needs in each of their reproductive life-course? • Why?	
3	When necessary (for young people who are sexually active), which contraceptive methods do private providers[14] consider to be appropriate for young people at different stages of their reproductive life-course? • Why	
4	• What barriers do public and private providers (clinicians and distributors) and the informal sector feel exist in providing SRH services and commodities to young people? • How do private providers deal with financial barriers for young people?	
5	What factors determine the success of certain providers in offering services to young people? • Why?	
6	Do the norms and values of health providers in SRH provision differ? In what way? Are there any specific issues that need to be addressed? • According to you, is it necessary to apply restriction on the	

[14] Only private providers will be asked due to the fact that they are the only ones providing contraceptives to (unmarried) young people in Indonesia

	provision of SRH services for young people? If yes, what kind of restriction? If not, why? • According to you, is there any exception in the implementation of this restriction? Please explain. • What is your opinion to young people who need SRH services which crossing the restriction? Why? • Would you mind to provide the SRH services which needed by young people, especially the SRH services which crossing the restriction? Why?	
7	What types of referral systems have been established by these service providers? How do provider attitudes affect young people's movement within referral systems? How do provider attitudes affect referrals made? • Did you have experience to refer patients (young people) who need SRH services? • To what type of SRH services young people's patients have been referred? • Why do you mind to refer young people to SRH services? • Do you apply certain condition or restriction before deciding to refer young people to SRH services? Please explain.	
8	What are effective ways to involve young people in quality improvement initiatives for SRH services?	
9	In a case of abortion, there are various terms used (menstrual regulation, *induksi haid*). Are health providers aware and understand the meaning and differences between the terms?[15]	

INTERVIEW GUIDELINE FOR HEALTH PROVIDERS IN YOGYAKARTA

City/District Code*	
Day/Date	
Interview location	
Interviewee Code**	
Interviewer	
Time Interview (real time)	**From:** **To:**

Questions

The aim is for the "positive examples" to take a central place in the research. The focus lies with those young people that have actually accessed services/contraception and to retrospectively study their pathway towards these service providers.

Service provision for young people

No	Detailed Questions	Answers
1	Number of SRH services and commodities (condom, contraceptives)provided by partner organizations of the ASK programme to young people and adults and by subcontractors/ government facilitated by partners	

[15] The purpose of this question is to understand 'appropriate and accepted' terminology for safe abortion due to current law situation in Indonesia on this issue, in order to provide safe abortion for young people in 'safer way' (not too discreet)

	• Based on your knowledge, how many SRH services and commodities which provided either by partners of ASK Program ASK or by sub-contractor/government which facilitated by partners? • Are the numbers of SRH services for young people sufficient to meet their needs? Why?	
2	Which SRH services and commodities do health providers (including public and private health providers) consider to be appropriate for young people at different stages of their reproductive life-course? • Among all services currently available, which one appropriate to fulfil people's needs in each of their reproductive life-course? • Why?	
3	When necessary (for young people who are sexually active), which contraceptive methods do private providers[16] consider to be appropriate for young people at different stages of their reproductive life-course? • Why?	
4	• What barriers do public and private providers (clinicians and distributors) and the informal sector feel exist in providing SRH services and commodities to young people? • How do private providers deal with financial barriers for young people?	
5	What factors determine the success of certain providers in offering services and commodities to young people? • Why	
6	Do the norms and values of health providers in SRH commodities provision differ? In what way? Are there any specific issues that need to be addressed? • According to you, is it necessary to apply restriction on the provision of SRH services for young people? If yes, what kind of restriction? If not, why? • According to you, is there any exception in the implementation of this restriction? Please explain. • What is your opinion to young people who need SRH services which crossing the restriction? Why? • Would you mind to provide the SRH services which needed by young people, especially the SRH services which crossing the restriction? Why?	
7	What types of referral systems have been established by these service providers? How do provider attitudes affect young people's movement within referral systems? How do provider attitudes affect referrals made? • Did you have experience to refer patients (young people) who need SRH services? • To what type of SRH services young people's patients have been referred? • Why do you mind to refer young people to SRH services?	

[16] Only private providers will be asked due to the fact that they are the only ones providing contraceptives to (unmarried) young people in Indonesia

	• Do you apply certain condition or restriction before deciding to refer young people to SRH services? Please explain.	
8	What are effective ways to involve young people in quality improvement initiatives for SRH services and commodities?	
9	In a case of abortion, there are various terms used (menstrual regulation, *induksi haid*). Are health providers aware and understand the meaning and differences between the terms?[17]	

INTERVIEW GUIDELINE FOR YOUNG PEOPLE IN YOGYAKARTA

City/District Code*	
Day/Date	
Interview location	
Interviewee Code**	
Interviewer	
Time Interview (real time)	From: To:

Questions

Perceptions of and demand for SRH services among young people

A. How do young people currently seek and obtain SRH services?

The aim is for the "positive examples" to take a central place in the research. The focus lies with those young people that have actually accessed services/contraception and to retrospectively study their pathway towards these service providers.

No	Detailed Questions	Answers
1	What do they understand about SRH problems? *(We may expect participants to mention menstrual irregularity, hormonal problems, stomach pain because of menstruation, reproductive tract infections, having sexually active but do not know where/how or shyness to get/use condom or other contraceptive methods, etc.):* • What do you know about reproductive health? • What do you know about sexual and reproductive health problem? (please mentioned the example as above)	
2	What type of services do they need to overcome these problems? • What created their demand?	
3	How did young people know where to go? • When do they seek services from service providers? • What encouraged them to go?	
4	From what sources do they get information regarding available services (*internet, friends, health providers, acquaintances*)?[18]	
5	What (in) direct strategies are used by young people to access public, private and informal sources of SRH services? • How did they manage to go there?	

[17] The purpose of this question is to understand 'appropriate and accepted' terminology for safe abortion due to current law situation in Indonesia on this issue, in order to provide safe abortion for young people in 'safer way' (not too discreet)

[18] In regards to these topics, the results of OR1 will be taken into account when developing the data collection instruments, to avoid redundancy

6	In a case of unwanted pregnancy/abortion (if any), from what sources do they get information regarding available services (*internet, friends, health providers, acquaintances*)? • How can they access these services? • Who was encouraging and/or accompanying them to visit the services?	
7	Where do they obtain SRH services (*e.g. for menstrual irregularity, hormonal problems, stomach pain because of menstruation, reproductive tract infections, unwanted pregnancy) and commodities (e.g., condoms or other contraceptive methods, emergency contraception*)? • Do they obtain these services from legal or illegal health providers?	
8	How do young people feel about the quality of SRH services provided? - What do you mean with quality services? - What is your recommendation to improve the quality of services? - Also probe: what about privacy, referral services, did they/you go and why, and what was your experience with the referral services recommended?	
9	Would they go again/recommend the service(s) to others?	
10	What are their recommendations to help improve the quality of services?	
11	What suggestions do young people have to increase youth's access to and use of SRH services and commodities?	
12	With regard to the ASK Program, what kind of services have been provided by the partners through the ASK Program? • Do you know about ASK program? • With regard to the ASK program, what type of services which have been provided by ASK partners? • How do you rate the quality of services? • Will you go to the same services or will you recommend the services to others?	
13	What is the role of peer educators in facilitating and improving young people's use of SRH services? • Did you get any information from your peers regarding sexual and reproductive health? • What do you mean with peers? Who are they? • Do they bring young people to SRH services?	
14	Who are the most important educators for disseminating knowledge of sexual and reproductive health among young people?	
15	Who are the most important educators for improving knowledge of sexual and reproductive health among young people?	
16	Does the information well accepted?	

B. *What are the perceived needs of young people regarding SRH services in DIY?*[19]

No	Detailed Questions	Answers
2	Based on the services mentioned above (please see 2A), what type of SRH services mentioned are in fact needed by young people but prohibited, not	

	available or limitedly available?	
3	In which circumstances do young people seek SRH services? - What kind of SRH services do they seek in general and exploring these further in order to determine the need and circumstances for more advanced SRH services (*e.g. unwanted pregnancy, condom use and/or contraceptive methods, etc.*).	
4	What are effective participatory approaches to support young people and communities to identify SRHR needs? • What are the effective ways can be used to involve young people therefore we would be able to identify SRHR needs of young people?	
4	Is their work effective in influencing young people's behaviour?	

C. *How do young people perceive SRH services (quality, accessibility, availability, relevance, etc.)?*

No	Detailed Questions	Answers
1	What public, private and informal sources of SRH services are currently identified/known by young people?	
2	Which SRH services do health providers (including public and private health providers) consider to be appropriate for young people at different stages of their reproductive life-course?	
3	• Which SRH services – from public, private and informal providers – are considered easier to be accessed? • Which SRH services are considered more difficult to be accessed? • What are the determining factors?	
4	Which public, private and informal sources of SRH services do vulnerable young people avoid? - Why?	

D. *What factors prevent young people from accessing SRH services and commodities, including those who are sufficiently informed about SRH issues? (Probe on social stigma, and bringing shame to families)*

No	Detailed Questions	Answers
1	Why young people/you do not go to any SRH services? (*Probe on their feelings, whether is there anyone prohibit them to come, accessibility issue - transport, financial issue, etc.*) • What factors usually prevent young people to visit SRH services? Why? • Do you have any kind of experiences? Why?	
2	If you go to SRH services, what do you think your family/friends/ acquaintances would think about you?	
3	Have you ever known someone (a friend of yours/acquaintance) has gone to SRH services? - What do you think of this person?	

Annex 6. Research Questions Covered in Data Collection Methods

Research Question No	Topics Covered by Research Question	SSI	FGD
A I	Manners in which young people seek and obtain SRH services	xxx	xx
A II	Factors preventing young people from accessing SRH services and commodities, including those who are sufficiently informed about SRH issues	xxx	xx
A III	Perceived SRH needs of young people in DIY	xxx	xx
A IV	Most important educators in improving knowledge of SRH and disseminating information of SRH services.	xxx	xx
A V	Perceived SRH services (quality, accessibility, availability, relevance, etc.)	xxx	xx
B I	SRH services considered appropriate for young people by health providers	xxx	
B II	Contraceptive methods considered to be appropriate by private providers	xxx	
B III	Barriers perceived by public and private providers (clinicians and distributors) and the informal sector in providing SRH services and commodities to young people, including addressing financial barriers for young people	xxx	
B IV	Factors determining the success of certain providers in offering services to young people	xxx	
B V	The norms and values of health providers in SRH provision	xxx	
B VI	Types of referral systems that have been established by service providers and how providers' attitudes affect young people's movement within referral systems and referrals made	xxx	
B VII	Effective ways to involve (underserved) young people in quality improvement initiatives for SRH services	xxx	
B VIII	In a case of abortion, there are various terms used (menstrual regulation, *induksi haid*). Are health providers aware of and do they understand the meaning of and differences between the terms?	xxx	

Annex 7. Overview Characteristics SSI Respondents

ID	Age	M/F	YP	MSM	HIV	UP	Disability & Violence	Married female YP	Married male YP	Female YP > 20	Male YP > 20	Female YP < 20	Male YP < 20	YP Urban	YP Sub urban	YP rural	HP (public)	HP (private)	HP Urban	HP Sub urban	HP rural
1	21	F	v		v	v	v	v		v					v						
2	21	F	v		v			v		v				v							
3	22	M	v	v	v						v			v							
4	22	M	v	v	v						v			v							
6	18	M	v	v	v								v	v							
7	42	F																v	v		
8	38	F															v		v		
9	24	F	v		v			v		v				v							
10	32	F																v		v	
11	48	F																v	v		
12	44	F															v				v
13	39	F															v				v
14	19	F	v									v		v							
15	23	F	v							v				v							
16	20	F	v			v				v					v						
17	18	F	v			v	v					v			v						
18	24	F	v							v					v						
19	20	F	v							v				v							
20	17	F	v			v						v			v						
21	32	F																v	v		

22	22	F	v			v				v					v						
23	35	F															v				v
24	23	F	v			v		v		v						v					
25	30	F																v	v		
26	18	F	v					v				v				v					
27	18	M	v	v	v								v			v					
28	20	F	v			v				v						v					
29	18	F	v			v						v				v					
30	24	F	v					v		v						v					
31	21	F	v							v					v						
32	23	F	v			v		v		v					v						
33	22	F	v			v		v		v					v						
34	30	F																v			v
35	18	F	v			v		v				v			v						
36	19	F	v			v		v				v			v						
37	32	F																v			v
			25	**4**	**7**	**12**	**2**	**10**	**0**	**14**	**2**	**7**	**2**	**8**	**11**	**6**	**4**	**7**	**5**	**1**	**5**