Title of the project	**The Incidence of Abortion in Indonesia: Result of A Community-Based Survey in 10 Major Cities and 6 Districts**
Conducted by	Center for Health Research, University of Indonesia
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Collaboration with	University of Atmajaya, University of Udayana, IBI, POGI, and PKBI
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Sample size	328 SDPs in 10 cities and 232 SDPs in 6 districts
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The problem of abortion and unwanted pregnancies in Indonesia has been associated with the women's complex social dimensions involving controversial moral and religious issues (Muhaimin et al., 1993). Moreover, the problem is compounded by lack of legal clarity. The continuing ambiguities in the status of abortion under the Indonesian law, including the 1992 Health Law, discourages attempts to control dangerous practices or to promote an improvement in the quality of reproductive health care (Hull et al., 1993). Up to now, abortion remains a controversial issue with probably equally pro and contra views, even for health reasons.

For significantly improving the women's reproductive health status and right, it is essential to continually address the problem of unsafe abortions. In this regard, information on the extent and spread of abortions is required as the basis for advocating the need to control or supervise it. Several estimates on the magnitude of abortion in Indonesia have been made, but they have so far been based on small-scale studies, conducted in health facilities rather than community-based settings (Moeloek, 1998). This study used an innovative design that facilitates yet the most comprehensive and methodologically sound estimate of the incidence of abortion in the country.

It was surely impossible to select sites that satisfactorily represent a huge regional variation in the extent of abortion in the country. After a long discussion within the study team members and other colleagues, sites to be selected for fieldwork should represent urban and rural areas, Java and outside Java, and also west, central and east Indonesia. Finally, the selected sites included six different regions: (1) Sumatra, (2) Java, (3) Kalimantan, (4) Bali, (5) North and south Sulawesi, and (6) Eastern Islands, represented by West Nusa Tenggara and East Nusa Tenggara. In each selected region, major cities and districts were then identified. As abortions might occur more in the city (urban) than in the district (rural), the study selected 10 major cities and 6 districts for fieldwork (See Table 1). Of these major cities and districts, 5 cities and 2 districts were in Java, where most population live.

It is certainly difficult to estimate the incidence of abortion in the population. Theoretically, a community household survey can be done to ask reproductive age women on their pregnancy history, including abortion. Besides being very expensive and requiring a large number of respondents, this type of survey would still underestimate abortion, not only due to recall errors, but also most women would not tell openly about their abortion experience due to the associated stigma.

Incidence of abortion can also be estimated through abortion statistical records that supposed to be available in facilities providing reproductive health services, such as hospitals, maternity clinics, and family planning clinics. The data in these facilities, however, is normally incomplete and often inaccurate. Many abortions, especially induced ones, are simply not recorded or recorded as something else. Moreover, many more abortions are conducted outside of health care facilities, without any statistical record. Thus, counting the number of abortions from the health facilities would be far from adequate. Another common way to estimate the incidence of abortion is by employing multi-level indirect estimates involving number of reproductive age women, rates of contraceptive use, pregnancy, and birth. The results, however, would be less convincing as they much depend on the estimated inputs provided and also the assumptions used in the exercise.

In this study, we used a social mapping procedure that comprehensively identifies all abortion service delivery points (SDPs) in the population, and then directly estimates the number of abortions performed by these SDPs during a defined time period. If the information on the number of abortions per SDP is sufficiently accurate, the procedure would provide adequate data for estimating the incidence of abortion in the population.

We actively mapped all abortion SDPs in the designated population using multiple sources and informants. These sources included not only health care providers, but also household women, adolescents, *calo* (the intermediary person who would connect the client with the service), taxi driver, *ojeg* driver, public transportation driver, female sex workers, and other persons who have the information. The informants were those who are thought to likely know where one could get an abortion. In many situations, a 'snowball technique' was used to gather as many SDPs as possible, which included not only hospitals and maternity/ family planning clinics, but also private practice providers, including traditional providers. The mapping procedure included direct multiple checking from the relevant personnel and/ or the clients on whether or not the SDP really provided abortion services. The mapping also gathered information on the average number of abortion clients per month.

For improving the accuracy of the number of abortion clients per month reported at the mapping, we verified this number of abortion clients, but in a sample of SDPs. Of all the SDPs identified at the mapping, five in each site were selected for prospective verification through a two-week period of observation. The selection criteria took into account the SDP type and also the willingness of the SDP personnel to cooperate with the study. The difference in the reported number of abortion clients between the mapping and the verification was used to adjust the number of abortion clients for all the SDPs identified at the mapping to obtain the incidence of abortion. In addition, a survey of clients was also conducted in these verified SDPs to identify the clients' characteristics and reasons for an abortion. Nonetheless, only those who accepted the interview were interviewed.

This study attempted for the first time to get national estimates of abortion incidence based on fieldwork in 10 major cities and 6 districts. The fieldwork consisted of social mapping of abortion service delivery points (SDPs) and verification on the number of abortion clients served by the SDPs. Difficulties in carrying out the fieldwork reflect the sensitivity of the abortion issue. Induced abortion has been and is stigmatized with immorality and often a criminal act. Consequently, providers and community members were fear, unwilling and reluctance to providing abortion related information. The recent media exposure of abortion incidences also made data collection difficult. Although efforts had been made to comprehensively list all the abortion SDPs, some others could not be listed due various reasons. Thus, the resulted incidence might still be a conservative estimate.

The incidence of 2 million abortion cases per year means a ratio of 43 abortions to 100 live births or 30% of pregnancies. Thus there is a large number of unwanted pregnancy in Indonesia. Other national data showed that three-fourth of currently married women either wanted no more children or wanted to space births. Many of abortions in Indonesia were unsafe abortions. The data showed the sustaining role of TBA in attending abortion cases and many other providers also operated illegally to serve the clients who sought abortion services.

Only 71% of the abortion clients in the city and 39% in the district admitted having an induced abortion. This percentage would likely be an underestimate, as many clients were unwilling to tell their abortion experience. The majority of the clients were aged above 20 years and married. Surprisingly, more than half of the clients had relatively high education, either finished senior high school or Academy/ University. One-third of the clients in the city and half in the district were in their first pregnancy. The majority of those with first pregnancy were in unmarried status. The majority of clients were not using contraceptive. Thus, most of these women wanted no more children but not using contraception. The majority of clients reported first time abortion, 9% second time abortion, but several clients admitted frequent abortions. The most cited reasons for an abortion included enough number of children, especially among the older clients; not yet ready to marry or still studying, especially among the young clients; and lastly still too young or not yet ready to have a child.

In conclusion, data resulted from the study support the ICPD 1994's recommendation on the need to improve access of family planning information and services and also to frame policies and programmes to address unsafe abortions with a commitment to women' health.