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Chapter Eight

Abortion and politics in Indonesia

Terence H. Hull and Ninuk Widyantoro

Abortion presents a confused challenge to the public health and legal systems of Indonesia. While it is variously argued that one to two million abortions take place each year, there are no representative statistics on the characteristics of women seeking pregnancy termination and few sources of data on morbidity and maternal mortality related to abortion. Since the mid 1970s, committed activists around the country have pressed to have the legal status of abortion reformed and the clinical setting of procedures improved, but to little avail. This chapter tells the story of efforts at abortion law reform carried out by NGOs led by the Indonesian Women's Health Foundation (YKP). Since 2001 the group has lobbied the legislature (DPR) and health ministry, stressing the importance of legal change to prevent the thousands of deaths annually associated with septic abortions. They were able to persuade a majority of political parties to support their efforts in 2004, and in the dying days of President Megawati Sukarnoputri's regime, they succeeded in gaining legislative endorsement of the draft amendment to the health law that would have made abortion safer and more easily available. However, it was not signed by the President before the end of her term and thus lapsed. When President Susilo Bambang Yudoyono came to power in 2004 as the first popularly elected President of Indonesia, the amendment went back to the DPR. Unexpectedly in late July 2005, two political parties who had supported the change sud-

denly announced that they were opposed to abortion, and would now fight the issue as a matter of public morality. The story is not finished, and it appears that the abortion issue will not be resolved soon. In Indonesia, as in many other countries, abortion is not simply a public health problem, but also a touchstone political issue setting up conflicts of identity, morality and social control.

Induced Abortion in Indonesia: Some Historical Background

The practice of abortion in Indonesia stretches back before any recorded history. The earliest artisans and scribes did not regard such routine domestic practices such as abortion as being worthy of note. When it did attract attention, it was related to some important personage, or an attempt to impress a ruler with the description of his realm.

In the cultural context of colonial Netherlands Indies, the guardians of morality were not agreed on the reasons for either opposing or supporting abortion. The Dutch colonial servants were largely Christians and looked to the puritanical traditions of their churches for guidance on what was acceptable behaviour. The native populations professed beliefs in Islam, Buddhism, Hinduism and animism, with all the complexity of interpretation that these brought to the question of pregnancy, personhood and propriety. The one thing that moral leaders of both the colonisers and the colonised had in common was their agreement that termination of pregnancy was wrong because, in the context of the traditional medical practices of the day, it was extremely dangerous. Each year thousands of women died either in childbirth or following attempts to terminate a pregnancy. Leaders thus called for measures to forbid practitioners from carrying out the abortions, calling this a form of medical malpractice. For many of these same leaders abortion was also a crime against the person of a foetus, and was thus akin to murder. These perspectives implied a need for laws to be promulgated and implemented to protect the lives of women and children. In the nineteenth century the responsibility for abortion was thought to be shared between both the practitioner and the woman. Under many laws both were culpable and subject to prosecution and heavy punishment. This stance was codified in the Netherlands in 1881 in the *Wetboek van Strafrecht*, which came into force in 1886. The Netherlands Indies colony followed suit in 1918 with a comprehensive

Criminal Code (called the *Kitab Undang-Undang Hukum Perdana – KUHP*), establishing the criminalisation of abortion. Ironically, while abortion was decriminalised in the Netherlands in 1981, Indonesia continues to follow colonial criminal law over six decades after Independence. However criminal actions against practitioners and clients are rare so the law appears to stand more as a moral statement than a practical tool of social control. Considering that government officials quote the numbers of abortions in terms of millions of cases annually, it is strange to think that the number of arrests and prosecutions amount to no more than a handful each year.

The dusty archives do reveal one case that can be regarded as emblematic of the way the law against abortion has frequently been used as a tool of persecution. It involves Dr Suzanne Houtman, possibly the first Indonesian woman to gain a medical degree (details courtesy of Dr Houtman's daughter, Mrs Madelon Harland, 2007). She was an 'Indo' or mixed race woman whose father was a rich spice trader in Batavia. Dr Houtman gained her medical degree in Amsterdam around 1908 and became involved in the political activities of the Indonesian expatriate community in Europe. She married Sam Ratulangi, who was later to become one of the heroes of the Indonesian struggle for independence. They wrote extensively on issues of progressive thought, but her contribution to these publications is today often forgotten because she used the name 'Dr S. Ratulangi' rather than Houtman, with the result that articles she wrote on women's rights came to be attributed to her husband. Their relationship produced two children and on their return to Indonesia, the couple worked assiduously to contribute to the welfare of their compatriots. Suzanne established a Tuberculosis Hospital in Menado, and Sam taught mathematics in secondary schools and built up businesses. They moved around the country, making contacts, promoting political consciousness and irritating the colonial government.

Officials did not stand idly by: secret dossiers on Sam and Suzanne reveal they were being watched as security risks. Eventually their relationship broke up when Suzanne left Sam after hearing that he had been having an affair with a young Menadonese woman. Suzanne returned to her family home on Java and reverted to using the name Houtman. Whether the rumour of the affair was true or simply the result of cunning action by a Dutch official is not known. However the effect was to lead Suzanne to open a medical practice in a large house with airy pavilions where patients could be healed in comfort and safety. The practice flourished. Before long she mar-

ried again, this time to Koenraad Schelts van Kloosterhuis, a Dutchman who had been a planter, but who took up a job as a district level official in West Java.

At this point, the records in the archives and the memory of surviving family members become hazy. After the birth of another two children, the relationship broke down, perhaps because Dr Houtman's husband was being transferred to the eastern islands and she wanted to keep up her medical practice. This time she was able to keep her children. She refused to treat Dutch families or any men, concentrating instead on the problems of indigenous women and children. Her daughter still has memories of the bustling atmosphere of the household, of the Sundanese, Javanese and Chinese descent families coming and going, and of the time in 1933 when her mother told the children that she would have to go away for a while and they would be cared for by their aunt. It was at this time that Dr Houtman was arrested and tried for persistently carrying out abortions. She was sentenced to five years in the women's prison in Semarang.

On the face of the evidence, this appeared to be a very unusual case. Why was Dr Houtman arrested when so many other doctors were also carrying out abortions surreptitiously but without similar reactions from the authorities? This is a question deserving careful study of the archives and newspapers of the day, but it is probably fair to speculate on three facts of the case. Firstly, Dr Houtman was a woman, a part indigenous person, and a prominent member of society from a wealthy family. Secondly, in both her marriages and in her young adult life she had demonstrated a rebellious streak, often displayed in direct confrontation with conservative leaders. Thirdly, in 1933 she lacked protectors. She was divorced from a prominent nationalist, divorced from a minor Dutch official, and was running her clinic on her own. To her family, friends and neighbours she must have appeared reckless in her insistence on providing abortions to poor native women. To her accusers she must have been regarded as a threat to the state.

This case reveals an important lesson about the way abortion laws are used in Indonesia. They are seldom enforced in a way that would seek to identify and punish all instances of the 'crime'. Instead they are a tool applied to rare cases where individuals have become bothersome to officials, or where they represent political minorities with little power to avoid legal sanction. Dr Houtman's case is not remembered by current generations of doctors. It is a pity that she has been forgotten since the same dynamic is played out every year or so across the archipelago. Accusations under the criminal code are brought against traditional practitioners of abortion who lose a patient to bleeding or infection. Even in such extreme circumstances, however, the perpetrator is seldom charged. Skilled doctors charged under the code generally are caught in a web of intrigue triggered by jealous colleagues, sometimes being publicly excoriated with charges that they are carrying out the crime in order to enrich themselves. The police, the press and politicians condemn abortion in general moralistic terms, but never face the realities of relative numbers. They are charging one person while at the same time they say there are millions of abortions being carried out. It is in this context that feminist organisations have for decades called for reform of the legal provisions that are used to harass doctors but fail to protect women. To understand their arguments, we need to consider how laws and policies have been made in the six decades of Indonesian independence.

Structures of Governance and Politics of Governing Independent Indonesia

The Indonesian Constitution of 1945 provided the foundation for the formation and workings of the government of the Republic, but this foundation was often shaken and sometimes ignored. The original design was relatively straightforward, and was based on institutional forms familiar to European governments. There were three branches of state: the legislature in the form of the People's Representative Assembly (*Dewan Perwakilan Rakyat* or DPR) to make laws; the executive under the control of the President to carry out laws; and the judiciary in the form of the highest court, the *Mahkamah Agung* (MA) to interpret and apply laws. The branches hold equal status though they obviously have different powers in line with the functions they perform. Indonesia instituted the People's Consultative Assembly (*Majelis Perwakilan Rakyat* or MPR) to oversee this structure. It consists of the members of the DPR and additional members drawn from various social organisations or functional groups. The MPR was responsible for the selection of the President and the confirmation of the membership of the MA. It is the MPR that is responsible for any amendments to the Constitution.

While each branch was given distinctive powers with the intention that there would be checks and balances in the exercise of power, from the earliest days there were frequently conflicts as leaders jockeyed for advantage in struggles between different political

groupings across the nation. A proliferation of political parties based on religion, ethnicity or culture exacerbated tensions as participants appealed to identity rather than ideology to define their interests.

Sukarno, the first President of the Republic, regarded the structure and value base of the 1945 Constitution as too Western and unwieldy. He pressed for various amendments throughout the 1950s but political parties were jealous of the control they could muster in the DPR and resisted the blandishments of the President. Coalitions of interests waxed and waned and Indonesia found itself buffeted by influences of the Cold War with foreign powers vying to write their own interests in Indonesian institutions. The U.S.A. and European countries supported the military and some liberal political parties while the USSR and the People's Republic of China poured resources into the Indonesian Communist Party (*Partai Komunis Indonesia* — PKI) and supported many initiatives of President Sukarno. In the course of this rambunctious action the President moved to neuter the DPR and control the MA to concentrate power in the hands of the executive. He also attempted to project Indonesia into a position of world leadership with collaborations across Asia and Africa. Issues of health, education and economic development at home took a back-seat to global politics. While there were many professionals and community groups calling for action to address maternal mortality through the provision of contraception, the government ignored the daily routine of women's distressing reproductive health, taking notice only when a case threatened to have a political impact.

Tensions building through the 1950s and early 1960s exploded in 1965 with an ill-defined attempted coup that precipitated a sea change in Indonesian politics. Over the course of two years, the PKI was outlawed and millions of its members and supporters either killed or imprisoned. Sukarno hung on to the title of President for a while, but his powers were usurped by a group of military leaders. In 1966 General Suharto assumed most of the powers of the presidency and formed a New Order government with a hastily convened 'provisional' MPR. In March 1967, he was appointed the 'Acting President' and in 1968 was elected to the first of six five-year terms that he was to serve before being toppled in May 1998, just months into his seventh elected term. Where Sukarno had pushed aside the DPR, Suharto and his supporters saw advantage in giving formal acknowledgement to the institution, while ensuring that the members remained totally loyal and unquestioning of the executive.

Political parties were rolled into two aggregate groupings roughly representing nationalist and Islamic interests. A huge organisation of 'Functional Groups' called GOLKAR was formed; mass membership included all civil servants and military and it became the political vehicle to contest elections. Suharto treated the entire bureaucracy and legislature like a military unit and instituted a web of training activities to foster discipline, uniformity and commitment to the basic principles of a secular political system. The New Order saw the emergence of very strong, centralised systems of governance, and these fostered improvements in health, education and economic prosperity. Nonetheless, some underlying ethnic, religious and personal tensions remained close to the surface, producing regular blemishes on the idea of political stability. It was in this context that reproductive health policy was shaped.

The Abortion Debate in the Political Maelstrom

Over the course of both the Old and New Order, abortion was a constant irritant to the body politic. While never dominating the political debates of the time, it was an abiding problem. In the 1950s contraceptive technologies were crude, only a handful of doctors were trained to assist women with fertility control, and politicians like Sukarno were quoted in public as being supporters of high fertility as a means of expanding the national workforce. In the 1970s, the development of the oral contraceptive pill made birth control cheaper and more effective. The establishment of international assistance agencies to promote family planning guided countries like Indonesia into programmes of population control. Abortion was problematic in this time of transition. In Jakarta, groups of doctors campaigned to prevent septic abortion deaths through the legalisation of medically indicated procedures. In 1964, the Indonesian Association of Obstetrics and Gynaecology and the Indonesian Medical Association held a symposium to discuss the impact that illegal abortions had on the rate of maternal mortality. A decade later the *Indonesian Journal of Obstetrics and Gynaecology* published a special issue (vol. 1 no. 2) on abortion, in honour of the 1974 United Nations Population Year. The presentations in both venues were consistent in a number of ways. There was recognition that unsafe abortions were a major cause of maternal morbidity and mortality. Hospital maternity wards were found to be straining from the pressure of

septic abortions. Doctors were limited by law in what they could do to prevent these problems but they were also concerned about the implications if they did not provide safe pregnancy termination. In the absence of full legalisation, they sought protection from the courts to avoid prosecution for what was regarded as a vital medical need in Indonesia.

The United States Agency for International Development (USAID) provided assistance around some of these dilemmas. Equipment to support vacuum aspiration, or what came to be called menstrual regulation (MR), was distributed across the country. Paramedics and doctors were trained to carry out safe procedures on women between six and fourteen weeks' gestation. A technical distinction was made between the concept of inducing a delayed menstruation (MR) and termination of an established pregnancy (abortion). For doctors carrying out the procedures, however, it was clear that a conception had occurred and in most cases pregnancy was well established. However, in the absence of a positive pregnancy test the patient and the doctor could maintain the assumption that a delayed period was being regulated, rather than a pregnancy terminated.

Students in medical schools were taught the new techniques, and over the course of the 1970s it became easier for urban residents to find a doctor who would provide a safe abortion, even if the name had been changed to MR. For a time it appeared that the stipulations of the criminal code would be overcome by a combination of new technology and assiduous coalition building. Doctors and lawyers pressed the Attorney General, Justices of the High Court and government Ministers to accept MR as a medically approved procedure, while continuing the criminal sanctions against abortions carried out by non-medically trained people. Word spread among the medical profession that prosecutions would not occur so long as procedures adhered to high medical standards and no harm was done to the woman.

This informal compromise might well have progressed to firm case law in Indonesia but for two developments: the rise of conservative policies in the United States, which resulted in the reversal of programmes of development assistance for MR, and a related rise in active policies opposing abortion. While American Right to Life debates were not widely known or understood in the Indonesian community, the impact of anti-abortion rhetoric was strongly reflected in the international conferences and meetings attended by Indonesian policy-makers.

First Attempts at Legal Reform

The medical professions in Indonesia found the inconsistencies in policy carried out by the national family planning programme to be both vexatious and potentially dangerous to doctors. Protection for abortion activities was initially offered by the government policy of birth control so long as the USAID programme of training was in place. However, it evaporated when the international debate changed direction with the so-called Mexico City Policy under President Ronald Reagan. During the 1980s international attacks on abortion rights reshaped the critical environment for domestic debates in countries that shared none of the political context supporting the American positions. Many political forces took up anti-abortion positions as a means of establishing identities defined by opposition to any governmental efforts to use liberalised abortion laws to promote women's welfare.

In Indonesia, it was Islamic groups that took such positions to oppose the New Order government. The family planning programme was charged with contributing to lax morality by promoting 'free sex and abortion'. While Suharto had a firm grip on power, such critiques were muted and could not substantially inhibit the contraception programme, but they did draw attention to the abortion provisions in the criminal code. For many citizens the discussion served to sharpen the questions about the rule of law and the roles of religion in a country enjoying unprecedented economic growth.

Advocates for family planning and safe abortion faced a dilemma. On the one hand they were not enamoured of the authoritarian government and agreed with many of the criticisms put by Islamic groups. On the other hand, even though they shared many of the religious beliefs and moral values of the critics, they placed much greater stress on the plight of women. Consequently they embarked on a complicated strategy to coopt the largest Islamic groups to support the cause of women's reproductive health, while at the same time lobbying government departments to change the legal framework surrounding the issue of abortion. Throughout the 1990s they pursued an active programme of workshops, publications and public discussions to promote their aims, often with funding from international NGOs, UN agencies and sympathetic government units.

In both these strategies they initially experienced moderate success. Activists from the largest Muslim mass organisations, *Nahdlatul Ulama* (NU) and *Muhammadiyah*, were enlisted into the cause

of improved reproductive health care for women, including support for safe abortion. While they did not reflect the ideology of more fundamentalist groups, the fact that they were able to bring the imprimatur of orthodox Islam to the advocacy meant that the debate surrounding the implementation of the 1994 ICPD Programme of Action could not simply be dismissed as a 'Western' plot. Reproductive health had been re-defined as a central issue for socially minded Muslims. With this broader constituency, the call for legal change to deal with unsafe abortion became less of a touchstone issue of political conflict. The first opportunity for reform came as the DPR considered a draft law concerning health. While this could best be described as an aspirational statute rather than black-letter law, it opened an opportunity for abortion to be shifted from a criminal issue to one of medical regulation. Working with the Department of Health, activists pressed for a statement that would make abortion legal if performed by licensed, trained medical personnel. The DPR in 1991–2 was no longer the supine institution that Suharto had maintained since 1971. Review of laws in the committee system was increasingly fractious. When the Draft Health Law was examined by legislators, they immediately challenged both the language and the content of the clauses touching on abortion. Transcripts showed arguments from Islamic and military factions questioning the propriety of any steps that would legalise abortion.

Officials from the Department of Health and advocates of reproductive health were shocked to see the law that emerged from the DPR (see Appendix 8.1). The so-called rubber stamp turned out to be a sledgehammer. The word *'aborsi'* in the Department of Health's draft had disappeared completely and instead of liberalising the situation, the final draft appeared to reconfirm that abortion was criminal, and the neologism 'certain medical procedures' would be a practice that was severely regulated. What these procedures might be was unclear, since they were said to be related to saving the life of a mother and/or her foetus, a nonsensical perspective when talking about pregnancy termination. With the Health Law of 1992 abortion had become illegal through two statutes – the colonial criminal code and the confusing health law.

The impact on women was not as great as might have been expected. Indonesians had grown used to laws that appeared strict but could be 'managed' in everyday life. The legal confusion offered more loopholes for doctors, more opportunities for graft by police officers, and more cynicism among the activists. When we published a paper highlighting the problems of the 1992 Health Law (Hull, Widyantoro, and Sarsanto 1993) colleagues in Indonesia were bemused. They could see that the system was dysfunctional, but they argued that so long as Indonesia was ruled by ignorant legislators and an authoritarian president, dysfunction offered protection to progressives.

Transition to Hope

The collapse of the New Order government in 1998 inflated the hopes of intellectuals and activists. Suharto's reputation appeared to have gone from 'Smiling General' to 'ex-dictator' overnight, and throughout Jakarta reformers looked to a future of democratic development. Among those with sharpened ambitions were feminists and public health professionals. Although the new government contained many old faces from the New Order, there was no denying that the spirit of the time was characterised by talk of reform. Abortion was not the central concern of politicians, but it remained on the back burner, bubbling away with regular meetings discussing the tragedy of maternal mortality caused by the all-too-common occurrence of unsafe abortion. The discussions took on a new character, however, with increasing attention to numbers, as demographers and epidemiologists pointed out the population dimension of pregnancy termination with calculations aimed at clarifying the human dimensions of the problem.

Estimates of Abortion at the Turn of the Century

While discussions of abortion had been regularly held between the 1960s and the 1980s, it was only in the 1990s that serious attempts were made to estimate the annual number of terminations. In part this was the result of a shift away from the clinical to the population perspective. While doctors could easily describe the phenomenon in terms of septic abortion patients in hospital or characteristics of women coming through the semi-legal clinical services, the concept of abortion rates and ratios was beyond their grasp.

Our attempt to estimate the annual number of procedures in 1993 (Table 8.1) arose out of frustration felt in observing the debates over the 1992 Health Law. Parliamentarians seemed to have no understanding of the immensity of the issue. Our estimate of 750,000 procedures appeared large in comparison with the estimated five

Table 8.1 Estimates of annual numbers of abortions in Indonesia

Time	*Estimate of Annual Incidence of Induced Abortion*	*Method of estimation*	*Source*
1992	750,000 to 1 million	Inference from numbers of professionals and traditional providers multiplied by assumed numbers of cases per provider.	Hull, Widyantoro and Sarsanto 1993.
1999	1.3 million induced and 1 million spontaneous	Survey of four sites (n=529)	Association of Obstetricians and Gynaecologists (POGI) and Department of Health (Jakarta Post 2000)
2000	2 million (induced and spontaneous)	Service Delivery point social mapping	UNFPA funded study (Utomo et al. 2002)
2002	2.5 to 3.0 million	Using a 'tip of the iceberg' reasoning: If the measured number was 2 million, then the real number must be bigger.	Tjitarsa (*Kompas* 2002)
2005	2.3 million	No method indicated.	Azrul Azwar (Mitra Inti Indonesia 2005: 97)

million births each year. While our estimate was impossible to substantiate, it had the benefit of being based on logical assumptions about the sort of practitioners who were known to carry out abortions, and reasonable assumptions about the proportion that did so regularly. At the time we argued that any alternatives to these estimates would have to be based on detailed research at the community level.

Within months newspapers were quoting experts who took our estimate as a base and inflated the numbers upwards, on the theory that any estimate would have been conservative and the numbers would naturally rise rapidly. Certainly the estimates were changing the nature of the debate. It was possible to use the estimates of total procedures to say something about the relative importance of

different types of providers and the characteristics of the women demanding the services. Whether the estimate was 750,000 or 1.2 million, it was clear that most abortions were provided to married women, not the stereotypical unmarried teenager. Also, it was likely that large numbers of procedures were conducted by people who had no medical training, sometimes in ways designed to simply provoke bleeding so women could go to hospital to have the abortion completed by a trained professional. With those parameters set, the case studies published by clinicians concerning septic abortions had a firmer context than had been possible previously.

The most reliable estimate of abortion numbers was carried out in 2000 and 2001 by Budi Utomo and colleagues working across the country in urban and rural settings. Using an innovative approach to verify the reports of selected service providers, they calculated that a minimum of two million abortions occurred in 2000 of which over half were induced and around 40 per cent were spontaneous. Just as in 1993 it didn't take long before experts, including staff of the Department of Health, were misquoting the data to imply that there were two million induced abortions annually.

Fired up by the figures appearing in Table 8.1, activists campaigning for legal change became increasingly hopeful that lawmakers would reconsider the situation of abortion in the criminal code and the confusions of the 1992 Health Law. They believed that the Reform Era beginning in 1998 would live up to its name and women would gain the protection of certainty under law and access to safe abortion technologies.

Catalysts for Abortion Law Reform

The removal of the leader who had maintained authoritarian constraints did not mean that democratic rights would arise automatically. The basic institutions of government established in the 1945 Constitution of Independent Indonesia needed to be reinvented, and in this context all attempts at reform required changes in procedures and the webs of relationships in government. In the New Order period of President Suharto, the DPR had grown increasingly restive and many members had ambitions of power based on more than patronage. Parties chafed under the goading of presidential instructions and mass membership threw up candidates for election who increasingly regarded the votes they received as a mandate to represent their followers rather than their leaders.

The transition from New Order to Reform Era took place in 1998 during a period of street riots, mass protest and anger over the collapse of the economy. Suharto's allies deserted him, and on May 20 he announced to the nation that he was stepping down. The following day Vice President Habibie took control, and soon after confirmed a Cabinet consisting largely of previous Suharto appointees. In the subsequent three presidents' terms (Habibie, Wahid and Sukarnoputri) the DPR became the main stage for the reconstruction of democratic institutions while the executive branch remained a haven for New Order–era officials. At the same time, the call for reform encouraged members of the executive branch to embark in directions very different from Suharto's. While there may not have been much change in the players, they proposed changes that were startlingly dramatic.

In January 1999, President Habibie announced a referendum in East Timor to decide on the fate of the province. He appeared to be simply fed up over the international criticism of Indonesian rule in the territory, and assumed that the Timorese would confirm his belief that Indonesia was popular in Dili. They did not. Tragically, this led to violence which marred the creation of an independent Timor Leste in 2002 and tarnished Indonesia's international reputation. It also discredited ABRI (the armed forces), eventually leading to a transformation of the military into the TNI (Indonesian National Military) the separation of the police force into an autonomous unit, and the de-politicisation of the forces.

In February 1999, the DPR passed a law allowing the free establishment of political parties. Within weeks over forty parties were formed to contest legislative elections scheduled for later in the year. In May 1999 laws creating a radically decentralised governmental system were passed, with provisions to shift most government functions from the central government to the level of the district, thus bypassing the province. At face value, these laws overthrew Suharto's carefully crafted authoritarianism.

By October 1999, such changes had begun to show results in the transformation of the government. A new MPR and DPR had been elected by popular vote for candidates from the newly formed parties. The MPR selected Abdurrahman Wahid as President with Megawati Sukarnoputri as Vice President. There was hope that democracy would pave the way to social reform. Among those pushing for change were the feminist activists inspired by the 1994 Cairo Conference on Population and Development. They called for a human rights–based reproductive health policy in contrast to the population control principles underlying the New Order family planning programme. They hoped that the Wahid regime and a rejuvenated DPR would embrace these ideas, and they were delighted when the President appointed a young, energetic woman to be responsible for women's issues as the Minister for Women's Empowerment. This was particularly interesting when it was revealed that she had set a condition that she would take the post only if it included responsibility for the National Family Planning Program, and that she had the intention to use this position to promote reproductive rights. The activists were somewhat cautious, however, because the minister was from a religious party regarded by some observers as conservative, so they were apprehensive as to whether she would support abortion rights or not.

In November 2000 activists were shocked by the news that one of their colleagues, Dr Sarsanto Sarwono, had been arrested at his clinic on charges of carrying out abortions. It had been unheard of previously for the police to arrest a doctor on such charges without evidence of harm to a patient or complaint from an irate spouse. It was also unusual for police to target a person with strong personal connections. Sarsanto is the son of two of the pioneers of the Indonesian family planning movement, and was well known as an officer of national professional medical associations. As he sat in the police station patiently answering the vague questions being put by arresting officers, his interrogators became more unsettled by the string of professors, civil servants, activists and former patients who came demanding to know what was going on. Clearly the police were caught in a situation they little understood.

Within days the matter was resolved. Somehow a disgruntled university colleague had motivated the police to arrest Sarsanto. The charge of abortion had nothing to do with the true complaint, and it took only a short time for senior police to see that their underlings had been used for frivolous purposes. The event mobilised the activist community, and found them making common cause with police, legal experts and key health officials. It was clear that the vagaries of the laws concerning abortion served no good purpose for women's health. As in the case of Suzanne Houtman seven decades earlier, the law had been used as an instrument of personal attack.

Within weeks the activists had revised their attitude towards abortion laws. Whereas before they had hoped to convince the Department of Health to ignore the strong anti-abortion language of the Criminal Code and the vague double talk of the 1992 Health Law, now they declared that nothing short of wholesale reform would

protect patients and doctors from arbitrary interventions by the police and courts. They thus resolved to work with the legislature to amend the law. At the start of 2001 a coalition was formed including supporters from all major political parties and a key official from the Ministry of Health. By July this coalition had become the Indonesian Women's Health Foundation (*Yayasan Kesehatan Perempuan – YKP*), had raised money for a secretariat and had begun the task of drafting the clauses needed to redefine the position of abortion in the health law.

Laws in the New Order government had been drafted by individual government departments or ministries and passed on to the legislature for debate and endorsement. In the Reform Era, the legislative committee responsible for health matters (in 1999–2004 it was called Commission VII, becoming Commission IX in 2004–2009) decided to take the novel approach of drafting a law specifically on reproductive health to be presented to the government as both a challenge and a practical means of forcing positive change to the flawed 1992 law. Both legislators and activists were quickly advised that this could be a dangerous course of action since the bureaucracy retained substantial latent powers to distract or delay DPR initiatives.

In June 2002 the Minister of Health was approached privately and directly to elicit his support; he gave his blessing to the initiative and delegated the Director General for Community Health to assist. That person, though a long-time supporter of family planning, proved less than helpful in promoting the proposal. He said that the department had received threats from conservative religious leaders who were concerned about the moral implications of abortion. If it was easy to terminate a premarital pregnancy, they had argued, immorality would flourish. This was an argument he found hard to refute. The Ministry was finding that the Reform Era provided space for forces concerned with a variety of views on abortion, and officials were apt to try to satisfy all of them.

YKP replied that they would undertake research on the demand for abortion to show that most procedures were sought by married women whose contraceptive methods had failed. They could do this easily by examining the records of the largest network of abortion clinics in the country, the Indonesian Planned Parenthood Association (IPPA). Ironically, at that time the head of the Association was none other than the Director General who was warning them about the religious opposition and counselling them to drop the issue. He ordered the IPPA clinics not to participate in the research. As so often happens in the very small world of reproductive health activism

in Indonesia, the YKP was closely connected to the doctors working for the IPPA. All the clinics adopted a policy of passive resistance. They said they would participate in the study but without using the IPPA name. The study went ahead and was published in 2004 (Widyantoro and Lestari).

While the researchers were in the field in 2002 the YKP staff went to the DPR to discuss the need for amendments to the Health law of 1992, in order to clarify the legal status of abortion. They met with Commission VII, the source of the original law, but now composed of a new group of motivated legislators keen to make a mark on the health system. They immediately put the amendment of the health law on to their agenda. Discussions dragged on for two years. In the end, as the parliament reached the end of their term, there was agreement that the abortion amendment should be very simple as set out here in Document 8.1.

Document 8.1. 2004 Indonesian Draft Amendment to Health Law 23/1992, Article 80

Article 80

(1) Government is obliged to prevent, protect and save a woman's lives from unsafe and irresponsible abortion practices through applicable laws and regulations.

(2) Unsafe abortion practices, as stated in paragraph (1), includes procedures:

a. Performed with force and without the consent of the woman;
b. Performed by unskilled health workers;
c. Performed without the application of professional standards; or
d. Performed in a discriminatory fashion or prioritising the fees charged rather than the welfare of women.

In February 2004, all political parties signed a Letter of Agreement supporting the draft law including the abortion amendment (YKP, 2004) and the matter was sent to the full DPR for confirmation. Soon, though, the DPR was distracted by the elections held in April 2004 under which all seats were up for grabs. The entire nation became mesmerised by the 'festival' of democracy as, in short order, new DPR members would take their seats. Then in July the first round for the first direct election of the President was carried out. As incumbent Megawati failed to gain an absolute majority in the first round, the election was required to go to a second round. Megawati faced a challenge from former general Susilo Bambang Yudhoyono, a formidable opponent whose promises were appealing to the electorate.

In August 2004, the draft amendment of the Health Law was still sitting on the desk of President Megawati. She called in members of YKP to have lunch with her and to discuss the implications of the legal change. They stressed the realities of women's health conditions and explained the confusion that had arisen concerning the legal status of abortion. The President said she would sign the law. But in order to follow proper procedure she would first need a letter from the Minister of Health supporting the amendment, particularly since she was in something of a lame duck position following the first round of election results.

The second round of voting took place on 24 September and Susilo Bambang Yudhoyono won by a substantial margin. When he was sworn in on 24 October 2004, the draft amendment had not been signed by Megawati and thus it expired. There had been no letter from the minister, despite many reminders from the YKP. Rumour had it that the task of drafting a comment had gone down into the bowels of the organisation where an anti-abortion official ensured that it could not be completed. Whether true or apocryphal, the result was the same: YKP and the network of reproductive health advocates were back to square one. The amendment would have to make its way through the DPR again.

The new legislature included many more rigid people from religious oriented parties than the previous DPR. Also many of the strong supporters of health reform had failed in their election attempts or had retired. In August 2005, the nature of the debate shifted. The *Hizbut Tahir* Islamic group sent a message calling on the President to put a stop to any proposal to legalise abortion in any form. They linked the call to their campaign to promote *Syariah* law across the country, and claimed to have sent 'a million' messages to the President's SMS address. While they are only a very small political group, they were able to command public attention through application of communications technologies and recruitment of sympathetic journalists. This changed the emotional tone of the debate. A newspaper article from that time captures the feeling:

> **The Masses of HTI Reject the Legalization of Abortion.**
>
> Hundreds of supporters of Hisbut Tahrir Indonesia (HTI) carried out coordinated protests across a number of cities... The issue that they raised is the rejection of legalised abortion, that is the amendment of the Health Law of 1992. A spokesman for the protesters, Muhammad Riyan said that before the legalization of abortion the government had to resolve the question of why there is any demand for abortion. First, legalization of abortion cannot be regarded as a solution to the problems of maternal mortality and unwanted pregnancy. Second, even if abortion is allowed under [some interpretations of] Islam, it can only be done to save the life of the mother and can only be allowed before 'ensoulment'. Third, unregulated legalization of abortion will only serve to increase the number of people offering abortion services. Fourth, HTI strongly rejects efforts at legalizing abortion such as those found in the draft amendment of the Health Law. Only by a return to Islamic systems of law will all these issues be resolved. (www.depkes.go.id/index.php?option=news&task=viewarticle&sid=1244&Itemid=2)

Despite the strong language of this attack, and the attempt to organise street protests and SMS 'attacks' on the mobile phones of activists, the HTI group carried little force in the parliament. Nonetheless, when the amendment was discussed in the newly formed Komisi IX DPR committee for Population, Health, Labour Force and Transmigration, it was totally revised with many negative references to abortion as a concept, and complex language surrounding conditions under which women might obtain abortions from trained medical staff. Examples of this language, found in the draft, are shown in Appendix 8.2.

If history is any guide, the outcome of passing such an amendment will be a contradictory mixture of values, rules and moral declarations that will do little to provide legal surety to either doctors or the women seeking to terminate unwanted pregnancies. As a result, women will continue to rely on ambiguity and secrecy to provide options for their reproductive health.

People are afraid to be seen opposing statements of religious leaders even if they defy them in their private behaviour. There is a huge element of self-deceit that has been reinforced by three decades of 'rigid official' religiosity. This has been translated into grass-roots movements in favour of Islamic legal practices that would control women's behaviour and particularly the behaviour of the unmarried. Some groups teach that family planning is evil. Women are made to feel that they are 'unfaithful' to their husbands if they decide to adopt a contraceptive or have an abortion without his permission. While this may indeed reflect the preferences of some women, the problem is that such ideas are being translated into law by members of conservative religious movements.

Even as the Health Law was being debated, the draft Law on Population that had been working its way through the DPR for six years was still mired in committee discussions and interdepartmental ri-

valry. Originally focussed on family planning, over the years it gained sections dealing with vital registration, migration and labour force. Anti-abortion fundamentalists in the DPR in 2007 added clauses concerning abortion to the mix. It is uncertain if the law will ever pass and be submitted to the President, but if it did, it would mean that Indonesia could have three contradictory laws concerning the termination of pregnancy. The Health Minister in the 2004–9 Cabinet came from a Muhammadiyah background and encouraged YKP to obtain a reform of the law. The reformers included many strong Islamic groups including Rahima and the Fatayat Nahdlatul Ulama. However, nothing is easy in the Indonesian legal jungle and it remains unclear what will emerge. Parliamentary elections in April 2009 produced a new line up with fewer religious fundamentalists and more women, but the lack of clear party policies or publicly announced ideologies means that it is always difficult to predict how the parliamentary committees will behave.

Conclusion

Two centuries of legal arguments over abortion have not clarified Indonesian women's reproductive rights. They continue to die due to unsafe abortions. Unwanted pregnancies continue to place women in highly disadvantageous social dilemmas. If students become pregnant, they are expelled from schools. If workers experience a contraceptive failure, they face the unenviable choice of leaving their job or having an illegal pregnancy termination. Poor couples attempting to limit their family size are denied the option of safe abortion in a cultural context that condemns the practice. Medical practitioners and patients face vague but emotional moral declarations from other community members. The political culture of the bureaucracy remains hierarchical, authoritarian and mechanistic, producing high levels of corruption. It is in this context that over one million women obtain abortions each year in Indonesia, with no guarantee of safety. It is impossible to obtain accurate data on either the number of abortions or the harm caused by unsafe practices. The Ministries of Health and Women's Empowerment are unable to provide data on the numbers of unlicensed practitioners arrested, charged or convicted under the different laws regulating abortion. Despite a huge industry of traditional medicine claiming to bring on late periods there is no information about the use of these concoctions or the impact they have to either terminate a pregnancy

(through the induction of menses) or alternatively the impact they have on a foetus exposed to these materials. What is clear though is that women are disadvantaged by the lack of clarity in the law.

In one hundred and fifty years, abortion technology has improved to the point where it is one of the safest medical procedures available. Social changes in the twentieth century have produced greater education, higher employment and greater pressure for gender equality. For Indonesian feminists, all these changes appear to be a mirage – safe abortion appears within reach, but continues to disappear just as they seem to reach their goals. The politics of abortion law reform and arguments over reproductive moralities remain major barriers and women continue to suffer.

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Appendix

Document 8.2 Translation of Indonesian Health Law No. 23/1992

Article 15

(1) In case of emergency, as an effort to save the life of the pregnant woman and or her foetus, 'certain medical procedures' (*tindakan medis tertentu*) can be performed.

(2) Certain medical procedures, as stated in paragraph (1), may only be performed if:

a. Based on medical indications the procedures are required;

b. [The procedure must be] performed by a health worker possessing the necessary skills and authority, under the guidance of an expert team;

(continued)

c. Under the consent of the pregnant woman or her husband or family;
d. Must be performed in a certain health-care facility.

(3) Other regulations on the subject of a certain medical actions, as stated in paragraph (1) is enacted under the government regulations.

Explanations of the paragraphs:

(1) Medical procedures in the form of 'abortion'(*pengguguran kandungan*), for any reason are forbidden because they violate legal norms, religious norms, ethical norms and norms of propriety. Nevertheless, in case of emergency, and with the purpose of saving the life of a pregnant woman and / or the foetus in her womb, it is permissible to carry out certain medical procedures.

(2) [Certain medical procedures referred to in Paragraph (1) can only be carried out if]:

a. A medical indication is a condition that truly requires a certain medical procedure to be carried out, because without the certain medical procedure the pregnant woman's and/or her foetus's life would be threatened.
b. Health workers allowed to carry out certain medical procedures are workers who have the skills and authority to do so, that is a specialist obstetrician-gynaecologist. Before carrying out certain medical procedures the health worker must request the approval of an expert team with members drawn from various fields such as medicine, religion, law and psychology.
c. The primary right to give consent [to certain medical procedures] rests with the pregnant woman herself except in cases where she is unconscious or otherwise unable to give her consent, in which case it can be given by her husband or her family.
d. Approved health facilities are those which possess adequate staff and equipment to carry out such medical procedures, and which are approved by the government

Document 8.3 2006 Indonesian Draft Health Law

Article 84

(1) All persons are prohibited from carrying out abortion.

(2) Prohibition, as stated in paragraph (1), may be excepted under the following circumstances:

a. Emergency medical indications detected during early pregnancy, which could harm the life of the mother and/or the foetus may suffer from a fatal genetic illness and/or genetic retardation that cannot be cured and may threaten (*menyulitkan*) the life of the baby.
b. Emergency medical indication, on the subject that the foetus suffer from a fatal genetic illness and/or [severe] disability which cannot be cured, as stated in letter (a), must be performed with the consent of the mother and/or the father of the foetus.
c. Pregnancy due to rape that may cause psychologic trauma for a victim referred by an institution or by a local religious expert or leader according to the religious norms; and
d. Counselling and advice pre procedure and ended with counselling post procedure, performed by trained counsellor.

(3) Other regulations on the subject of emergency medical indication and rape, as stated in paragraph (2) letter (b) and letter (c), [will be] addressed by Ministerial Regulations.

Article 85

(1) Abortion, as stated in article 84, may only be performed, if:
a. it is carried out before the pregnancy reaches 6 weeks, counting from the first day of the last menstruation, except in case of medical emergency,
b. it is performed by a health worker possessing the necessary skills and authority, as certified by the Minister;
c. it is carried out with the consent of the pregnant woman;
d. it is carried out with the consent of the husband, except for victims of rape, and
e. it is performed in a health-care facility which meets conditions determined by the Minister.

Article 86 [based on the 2004 amendment]

(1) Government is obliged to protect women from inadequate, unsafe and irresponsible abortion practices, which also against the religion norms and the applicable laws and regulations.

(2) Inadequate, unsafe and irresponsible abortion practice includes practices:
a. Performed with force and without the consent of the woman;
b. Performed by unskilled health workers;
c. Performed without the standard of professions and services;
d. Performed with discrimination; or
e. Prioritising the fee charged by medical providers.

(3) Adequate, safe and responsible abortion should be performed based on the medical emergency indications determined by authorised health workers and advised by an institution or head or expert of a religious organization in accord with religious norms.

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Chapter Nine

Access to Abortion Services in Malaysia

A Rights-Based Approach

Rashidah Abdullah and Yut-Lin Wong

Despite relatively liberal abortion laws in Malaysia, there are widespread misconceptions among Malaysians that abortion is illegal. Access to abortion services remains restricted in the public health care system. In contrast, expensive private-sector services, while widely available, cannot be accessed by low-income women. Disadvantaged women, such as those in violent relationships, poor women and unmarried women who have unwanted pregnancies experience difficulty accessing abortion despite their legal rights. In 2003, the incidence of abortion in Malaysia was reported as thirty-eight per one thousand women aged fifteen to forty-nine (Family Care International, 2003:4). However, due to the current legal and moral ambiguities surrounding abortion, data on incidence and prevalence patterns are not readily available.

The Penal Code Amendment Act (1989) allows a medical practitioner registered under the 1971 Medical Act to 'terminate the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant women or injury to the mental and physical health of the pregnant woman greater than if the pregnancy were terminated' (Penal Code [Amendment Act] 1989,