Quality of Care in a Safe-Abortion Hotline in Indonesia: Beyond Harm Reduction

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Objectives. To examine services offered by safe-abortion hotlines in contexts in which abortion is legally restricted and to document the experiences of women contacting a safe-abortion hotline in Indonesia.

Methods. We analyzed 1829 first-time contacts to a safe-abortion hotline in Indonesia as a part of routine service provision between January 1, 2012 and December 31, 2014.

Results. Nearly one third (29.9%) of initial contacts reported their age as between 18 and 24 years, and most (51.2%) reported being unmarried. When asked about their reason for calling the hotline, the majority of initial contacts stated that they were pregnant and not ready to have a child. More than one third reported gestational ages below 12 weeks, and nearly one fifth (18.3%) reported a gestation of 13 weeks or greater.

Conclusions. These unique data provide a window of understanding into who contacts safe-abortion hotlines and why, and enable exploration of future directions for research on the role of safe-abortion hotlines in women's access to safe abortion.

Public Health Implications. Safe-abortion hotlines should be evaluated not only for reducing harm but also for providing high-quality abortion care. (*Am J Public Health.* 2016; 106:2071–2075. doi:10.2105/AJPH.2016.303446)

In settings where abortion is legally restricted, as well as where it is permitted by law but not widely accessible, women are increasingly choosing medications to terminate their pregnancies outside of the formal health care system.[1] Use of the safe and effective medications for abortion (misoprostol and, where available, mifepristone) in legally restrictive settings has been shown to decrease the incidence of unsafe abortion,[2] the consequences of which can include acute and chronic complications and even death.

In the late 1990s, advocates and clinicians in Uruguay working to reduce mortality and morbidity from unsafe abortion developed an innovative strategy to provide women with evidence-based information from the World Health Organization (WHO) about how to safely terminate their own unwanted pregnancies using misoprostol,[3] and they adopted the terminology of public health harm reduction programs. More than a decade of experience with harm reduction in Uruguay has demonstrated that women who have access to evidence-based information about misoprostol for safe abortion can be empowered to terminate their own pregnancies with very low rates of complication.[4,5] Success in Uruguay led to innovations on the abortion harm reduction model, including safe-abortion hotlines, and Internet-based telemedicine counseling for abortion. Data from Latin America have shown that women who have access to the Internet are increasingly getting information about medication abortion online,[6,7] and that women who have access to accurate information and reliable medication abortion drugs can safely terminate their own pregnancies.[6,8,9] Safe-abortion hotlines have become central to women's access to information about safe medication abortion in restrictive legal contexts around the globe.[3,10]

Given the stigmatized and often criminalized nature of abortion in many countries where women's self-management of abortion using medications is common, it is not surprising that evidence is scarce regarding who accesses medications for abortion outside of formal settings, how they access them, what information they have, and what their experiences are. Information about women who contact safe-abortion hotlines may provide important insights into the characteristics and experiences of some women who use medications to terminate their own pregnancies in contexts in which abortion is legally restricted. Here, we explore the unique data collected by 1 safe-abortion hotline in Indonesia, in order to document the volume of calls received, gain a better understanding of who contacts the hotline and why, and explore future directions for research on the role of safe-abortion hotlines in women's access to safe abortion and abortion-counseling services.

METHODS

Legal provision of induced abortion in Indonesia is permitted only in cases in which a woman's life is at risk or as the result of rape. The restricted legal status of abortion, combined with powerful social and political stigma around the topic, has made abortion a difficult topic to study in Indonesia.[11,12] Misoprostol, which is registered in the country for gastric indications,[13] is available in many pharmacies and is widely available on

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the black market (Tirza Ong, Samsara project administrator, oral communication, August 2015). The most comprehensive analysis of abortion incidence in the country estimated that there were nearly 2 million abortions each year, most of which occurred outside of facility settings.[14]

In Indonesia, Samsara, a nonprofit organization, is dedicated to providing reliable information about safe abortion and pregnancy decision-making support for women with unplanned pregnancies. Women from anywhere in the world can send an e-mail or call a series of local Indonesian phone numbers and access the Samsara hotline 8 hours a day, Monday through Friday. For women seeking information about medication abortion, Samsara counselors provide women with information on how to follow the current WHO-recommended medication abortion protocols.[15] To provide high-quality counseling services to its clients, Samsara asks a routine set of questions to each person contacting the hotline. Samsara counselors are in contact with their clients throughout the abortion process, to the extent requested by the client; to date, however, data are not systematically collected at any point of contact after the initial contact.

Samsara collected data as a part of routine service provision between January 1, 2012 and December 31, 2014. Individuals contacting the hotline are informed that they are under no obligation to answer any or all of the questions asked, but that the questions are designed to provide hotline counselors with information that will help them provide compassionate, individualized counseling. All individuals contacting the hotline are asked to report their age, gender, relationship status, and place of residence. Individuals seeking information about abortion are additionally asked to report the gestational age of the pregnancy, whether an ultrasound has been performed, relevant details of the medical history of the person who is pregnant, and history of contraceptive use. When possible, counselors also record the reason stated for contacting the hotline and what information was requested.

We descriptively analyzed quantitative data using Stata version 12 (StataCorp LP, College Station, TX). We mapped geographic data using Google Fusion Tables API v1.0.

RESULTS

Between January 1, 2012 and December 31, 2014, Samsara recorded 6419 unique contacts. Nearly three quarters (73.9%) of contacts were made via cellphone calls, 22% via e-mail, and 4% via other technologies.

The sample for this descriptive analysis included data from 1829 "initial contacts" (28.5%)—those who were contacting Samsara for the first time. The remaining 4590 contacts (71.5%) were not included in analysis because of substantial missing data in all variables of interest. Of those contacts not included in this analysis, 2799 (61.0%) were "repeat contacts"—those who called back or e-mailed again for more information; 1371 (29.9%) were "follow-up contacts" that were made in the course of routine follow-up contacts with women having abortions; and 420 (9.1%) were contacts made for other reasons.

Sociodemographic and Geographic Characteristics of Initial Contacts

Nearly three quarters (74.0%) of those contacting the Samsara hotline for the first time reported their gender as female and almost one fifth (19.0%) as male; 6.9% did not report their gender, and 1 person identified as transgender (Table 1). Nearly one third (29.9%) of initial contacts reported ages between 18 and 24 years, most (51.2%) reported being unmarried, and most reported being either employed (30.3%) or a student (26.1%).

Although more than one third of initial contacts did not report their place of residence, most of those who did (62%) reported living in Indonesia. More than 30 Indonesian provinces were represented (Figure 1), with the largest proportion of initial contacts (17%) identifying their place of residence as the capital city of Jakarta followed by 8% reporting Yogyakarta. Individuals made initial contact with the hotline from 24 other countries, including 10 contacts from Malaysia, 9 from the Philippines, and 1 from the United States, all seeking information about abortion (Table 2).

TABLE 1—Sociodemographic Characteristics of Initial Contacts (n = 1829) to Samsara Safe-Abortion Hotline: Indonesia, 2012–2014

Characteristic	No. (%)
Gender	
Female	1354 (74.0)
Male	348 (19.0)
Transgender	1 (0.1)
Missing	126 (6.9)
Age, y	
< 18	59 (3.2)
18–24	546 (29.9)
24–28	317 (17.3)
28–35	277 (15.1)
> 35	115 (6.3)
Missing	515 (28.2)
Marital status	
Unmarried	937 (51.2)
Married	451 (24.7)
Missing	441 (24.1)
Occupation	
Employed	554 (30.3)
Student	477 (26.1)
Housewife	123 (6.7)
Other	54 (3.0)
Missing	621 (33.9)

Abortion-Related Characteristics of Initial Contacts

Just under one third (30.6%) of initial contacts reported obtaining an ultrasound before contacting the hotline and just over one third (36.1%) reported not obtaining an ultrasound; data for the remaining 33.5% were missing. More than one third of all initial contacts reported gestational ages below 12 weeks (≤ 6 weeks, 15.0%; 7–12 weeks, 23.4%), nearly one fifth (18.3%) reported ages of 13 weeks or more, and 43.4% either did not know or did not report a gestational age. Forty-one percent of initial contacts reported no use of family planning prior to calling the hotline and 15.6% reported using at least 1 family planning method; data for the remaining 43% of responses were missing. The most common method of family planning reported was condoms (7.8%). When asked about their reason for calling the hotline, most initial contacts stated that they were pregnant and not ready to have a child. Other common

Note. The figure is a visual representation of unweighted province-level data.

FIGURE 1—Province-Level Location of Initial Contacts to Samsara Safe-Abortion Hotline: Indonesia, 2012–2014

reasons included being pregnant and not wanting any more children, that the current pregnancy would conflict with their employment, and that the current pregnancy would cause financial hardship. The most common information requested by these initial contacts was on safe abortion (61.2%), medication abortion (50.5%), and options counseling for an unwanted pregnancy (34.2%; Table 3).

DISCUSSION

Although abortion is legally restricted in Indonesia, these data clearly demonstrate a need for safe-abortion services like those that Samsara provides. The volume of contacts to the hotline each month illustrates a strong demand for information on medication abortion among Indonesian language speakers from across the country of Indonesia and the world. From the data that Samsara has collected to date, most of those contacting the hotline for the first time were predominantly unmarried women aged 18 to 35 years, the large majority of women of whom were seeking information about safe-abortion services for an unwanted pregnancy. That a substantial minority of these initial contacts reported no contraceptive use, and that the most common method of contraception reported was condoms, raises questions about contraceptive access and availability. After increasing for decades, contraceptive use in Indonesia appears to have stagnated. Given the notable challenges to contraceptive access, it is possible that women in Indonesia—especially unmarried women such as those calling Samsara—experience insurmountable barriers to contraceptive access.[16] The reasons that callers to the Samsara hotline gave for seeking abortion services—family concerns, financial hardship, child spacing—are consistent with those given by women the world over.[17]

Data from Samsara also reveal that, despite legal restrictions, Indonesian women are indeed seeking abortion services. Evidence from restrictive settings around the world demonstrates that when women cannot access safe-abortion services, they often utilize abortion methods that endanger their health and safety.[18] Hotlines like Samsara are providing essential information for women on how to safely use medicines to have an abortion on their own. In doing so, these services have the potential to dramatically reduce unsafe abortion-related

TABLE 2—Initial Contacts to Samsara Safe-Abortion Hotline Made From Outside of Indonesia: 2012–2014

Geographic Region	Contacts per Region (n = 58), No. (%)
Sub-Saharan Africa	6 (10.3)
Asia	33 (56.9)
Middle East	2 (3.4)
Latin America	5 (8.6)
Europe	7 (12.1)
Oceania	3 (5.2)
North America	2 (3.4)

Note. Country-specific call volume was as follows: sub-Saharan Africa: Madagascar (n = 1), Namibia (n = 2), Nigeria (n = 3); Asia: Bangladesh (n = 1), India (n = 3), South Korea (n = 2), Malaysia (n = 10), Philippines (n = 9), Singapore (n = 2), Sri Lanka (n = 1), Thailand (n = 3), Timor-Leste (East Timor) (n = 2); Middle East: Bahrain (n = 1), Saudi Arabia (n = 1); Latin America: Brazil (n = 3), Chile (n = 1), Mexico (n = 1); Europe: Czech Republic (n = 1), Netherlands (n = 3), Poland (n = 2), Spain (n = 1); Oceania: Australia (n = 3); North America: Canada (n = 1), United States (n = 1).

TABLE 3—Abortion-Related Characteristics of Initial Contacts (n = 1829) to Samsara Safe-Abortion Hotline: Indonesia, 2012–2014

Abortion-Related Characteristic	No. (%)
Ultrasound	
No	660 (36.1)
Yes	557 (30.5)
Missing	612 (33.5)
Gestational age, wk	
1–6	274 (15.0)
7–12	428 (23.4)
>12	334 (18.3)
Missing	793 (43.4)
Contraception[a]	
None	758 (41.4)
Condoms	142 (7.8)
Calendar method	48 (2.6)
Pills	53 (2.9)
Injection	27 (1.5)
IUD	8 (0.4)
Multiple methods (condoms, calendar method, pills, IUD)	5 (0.3)
Other	1 (0.1)
Missing	787 (43)
Reason for contacting hotline[a]	
Pregnant and not ready to have a child	1143 (62.5)
Pregnant and finished with childbearing	187 (10.2)
Pregnancy conflicts with employment	131 (7.2)
Pregnancy would cause financial hardship	120 (6.6)
Pregnant and does not want children	104 (5.7)
Contraceptive failure	72 (3.9)
Pregnancy spacing is too close to previous child	71 (3.9)
Recently had an abortion	41 (2.2)
Pregnancy would cause conflict with parents or family	41 (2.2)
Medication abortion failure or incomplete abortion	45 (2.5)
Pregnancy would cause stigma in community	28 (1.5)
Rape or marital rape	28 (1.5)
Seeking counseling with decision to end pregnancy	26 (1.4)
Seeking information on use of herbs or Chinese pills to terminate pregnancy	9 (0.5)
Seeking information about continuing an unintended pregnancy	8 (0.4)
Domestic violence or violence against women	5 (0.3)
Other	15 (8.2)
Missing	342 (18.7)
Information requested[a]	
Safe abortion	1120 (61.2)
Medication abortion (protocol, access, availability)	923 (50.5)
Unwanted pregnancy and choices	626 (34.2)
Referral, referral protocol	154 (8.4)
Surgical abortion	144 (7.9)
General reproductive health information	100 (5.5)
Postabortion care (complete, incomplete, complication or infection signs)	79 (4.3)
Confirmation of pregnancy signs and symptoms	68 (3.7)
Confirmation of abortion completion	67 (3.7)
Shelter	42 (2.3)
Adoption	32 (1.7)
Counseling for emotions following abortion	5 (0.3)
Counseling	2 (0.1)
Miscarriage	1 (0.1)
Other	15 (0.8)
Missing	98 (5.4)

[a]More than 1 option was permitted, which may yield percentages totaling greater than 100%.

harms for women worldwide, yet little evidence exists in the published literature documenting the work of safe-abortion hotlines,[19,20] and no studies have been undertaken to evaluate their impact. Perhaps the dearth of literature reflects the fact that the large majority of safe-abortion hotlines in existence today operate in a legal gray area by providing publically available information about safe and effective abortion medications that is protected under the Declaration of Human Rights but not by local law.[10]

A growing body of evidence suggests that some women may have a preference for medication abortion over surgical abortion[21]; that, especially in restrictive settings, women value the privacy and "natural" feel of medication abortion[7]; and that, regardless of legal setting, at-home administration of medication abortion is as safe, effective, and acceptable to women as medication abortion in a clinical setting.[22] The work of safe-abortion hotlines to provide information and counseling for women who intend to use medications to terminate their own pregnancies[23] appears to fall within the umbrella of "home-based medical abortion." This is a model in which women, under the care of a health care provider, take abortion medications at home, which allows for more privacy and gives women more control over the timing of the abortion process.[22] How we understand the role of safe-abortion hotlines should be evaluated not only from the framework of harm reduction but also with respect to their work in providing the highest possible quality of abortion care for women who need their services.

Because Samsara's service statistics are collected neither for research purposes nor by trained researchers, there are inevitably questions about data quality. Data quality could be much improved by developing strong collaborations between researchers and hotlines—for example, to design intake and follow-up forms to track clients anonymously, or to develop hotline-specific protocols for data collection. Nevertheless, Samsara's hotline data demonstrate a clear and compelling need for such services in Indonesia. More research, done in close collaboration with safe-abortion hotlines around the world, is needed to help develop a better understanding of what information women need about abortion in restrictive settings; how women access information about medications for abortion; how and where women access these medications; the range of experiences that women have using safe and effective abortion medications without formal medical supervision; how women use and perceive the services offered by safe-abortion hotlines; women's levels of satisfaction with such services; and which care models offered by safe-abortion hotlines women prefer.

In conclusion, women's health advocates are not only combatting mortality and morbidity from unsafe abortion but also empowering women with information about the use of medications for safe abortion. The public health community must undertake research efforts that shed light on the importance of services that safe-abortion hotlines provide, not only for the reduction of harm from unsafe abortion globally but also for the provision of quality abortion care

services where abortion is legally restricted. AJPH

CONTRIBUTORS

Both authors contributed equally to the conceptualization of this article. C. Gerdts designed and implemented the analysis. I. Hudaya oversaw data collection.

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HUMAN PARTICIPANT PROTECTION

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