Adolescent Pregnancy in Indonesia: A Literature Review

Executive Summary

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1. Introduction

The theme of World Population Day 2013 is "Adolescent Pregnancy". Globally, it is estimated that 16 million girls aged 15-19 give birth each year (World Health Organization 2011). As part of UNFPA's review of this theme, Dr. Babatunde Osotimehin, UNFPA Executive Director has highlighted that adolescent pregnancy is not simply a health issue because it is deeply rooted in fundamental rights concerns such as poverty, gender inequality, violence, child, forced marriage, power imbalances between girls and their partners, lack of education, and the failure of systems and institutions that otherwise should be protecting their rights. It is also clear that adolescent pregnancy is barrier to achieving effective development outcomes. Ultimately, the cost of adolescent pregnancy is lost potential, both for the girls and their communities. Pregnancy in young women often means they must give up goals of finishing secondary school and therefore the opportunities that would have otherwise been available to them.

In many parts of the world, adolescent pregnancy is closely associated with unsafe abortions. Across developing countries, complications from pregnancy and unsafe abortion are the leading cause of death for girls aged 15-19 (Gennari 2013; Gray, Azzopardi, Kennedy, Willersdorf, and Creati 2013). An estimated 3 million unsafe abortions occur annually among girls in this age group across developing countries (World Health Organization 2011). The health repercussions of adolescent pregnancy are staggering given the fact that pregnant teenagers face double the risk of dying from pregnancy-related complications relative to women in their 20s (Gennari 2013). Further, adolescent pregnancy derails young women's future economic opportunities. With the number of young people aged 10-24 being 63.4 million (Statistics Indonesia 2010), the largest cohort of young people in the country's demographic history, addressing adolescent pregnancy is now an important challenge in Indonesia. The UN's 2010 World Population Prospects estimated that 1.7 million women and girls under the age of 24 give birth annually in Indonesia, and almost half a million are teenagers (United Nations 2011).

Data from the Indonesian Demographic and Health Surveys (IDHS) indicated that the Age Specific Fertility Rate (ASFR) for women aged 15-19 had fallen from 67 births per 1000 married women in 1991, to 39 births per 1000 married women in 2007 (Statistics Indonesia and Macro International 2008). However, despite the declining trend in adolescent ASFR, sizeable disparities among provinces, regions, and socio-economic segments of the population continue. Preliminary estimates from 2012 IDHS suggests an increase in the adolescent ASFR to 48 births per 1000 (Susanto 2013). This matches what is happening in the rest of the developing world, where the adolescent birth rate had been on the decline between 1990 and 2000, but since then, the decline has either slowed or even reversed (Stewart 2013).

The consequences of limited policy responses in sexual and reproductive health following significant demographic change can be observed with the increasing number of HIV/AIDS cases among young people (Diarsvitri, Utomo, Neeman, and Oktavian 2011), teenage pregnancies and premarital abortions (Aryanty 2013).

This review on the state of knowledge about adolescent pregnancy in Indonesia has been divided into two major sections. First, there is an outline of recent media reports on adolescent pregnancy, induced abortion and risky sexual behaviours. Second, there is a summary of the academic literature about adolescent pregnancy and its related issues in Indonesia. That latter discussion is in two parts, based on the methods of data collection: studies based on survey data collections, and studies based on qualitative data collection,

including case-studies, focus group discussions, and in-depth interviews. Mapping large-scale survey results along with unpublished micro studies, qualitative insights, and the popular discourse as gauged by media reports will provide a more comprehensive picture of the current state of problems surrounding adolescent pregnancy in Indonesia. The media coverage illustrates that young Indonesians engage in sexual behaviour but that the consequences of adolescent pregnancy for girls can be extreme - including death. The combination of sexual behaviour by young people on one hand, and not having adequate knowledge including safe sex practices on the other, disproportionately affect young girls as they face the risks and consequences associated with unwanted adolescent pregnancies.

2. Research on Adolescent Reproductive Health, Adolescent Pregnancy and Consequences in Indonesia

2.1. Media coverage

Prof. Yurnalis Uddin from Yarsi University, Jakarta, stated that annually there are 2.5 million abortions in Indonesia (Suryanto 2008). It is estimated that 20-60% of the abortions are induced. Age of abortion clients ranged from 20-29 years old. Despite legal prohibition on abortion, it is still being practiced (Suryanto 2008). In 2013 so far, there have been eight murders of young women who were pregnant out of wedlock, for example in Tasikmalaya (tvOneNews 2013b) and in Moguwohardjo, Depok Sleman District, Yogyakarta (Tabloid Nova 2013).

Media coverage also includes news on premarital abortion as well as the role of modern technologies relating to sexual behaviour among young people. There have been reports of girls living in Jakarta (Widjaya and Pratama 2012) and Situbondo, East Java, (tvOneNews 2013) being raped by those they had communicated with on Facebook. Dissemination of pornographic video through the mobile phones is not a new phenomenon and has been found among junior high school students. Other reports show girls as young as 15 years old are involved in procuring sexual services was found in Jakarta, Surabaya and Lombok, West Nusa Tenggara (tvOneNews 2013a).

2.2. Academic Research

2.2.1. Quantitative Studies on Adolescent Sexual and Reproductive Health, Pregnancy and Consequences

Utomo and McDonald (2009) argued that although extended schooling had led to a significant decline in rates of early marriage among Indonesian women in the 1990s, more young people are now sexually active outside of marriage. Situmorang (2001) noted the increasing incidence of premarital sex (9% of females and 27% of males) and pregnancies in Medan, North Sumatra. Nursal (2008) suggests that in Padang, West Sumatera, 16.6% of senior students engaged in unsafe sexual behaviour. In West Papua, 38% of senior high school students had pre-marital sex. Among sexually-active female students, 32% have been pregnant and most resorted to induced abortion to end the pregnancy (Diarsvitri, Utomo, Neeman, and Oktavian 2011). A survey of 4,500 teenagers across 12 cities conducted by the Child Protection Commission (KPA) in 2010 reported that 63% had had sex, and 21% had had abortion (cited in Kusumaningsih 2010). The Indonesian Planned Parenthood Association (PKBI) in Central Java suggests that in a month about 8-10 teenagers on average come for consultation concerning unwanted pregnancies (cited in Kusumaningsih 2010).

a. Demographic Indicators: Adolescent Fertility and Adolescent Marriage

With changing socio-economic conditions, notably prolonged duration of schooling and increasing female employment, there is a clear increasing trend in the age at marriage in Indonesia (Jones, Hull, and Mohamad 2011). Kurniawan (2000) analysed the relationship between the proportion of women aged 15-24 attending schools with those who were married between 1971-1997. His results suggests that the proportion of women attending schools has increased upward continuously and the age of those who were married across three decades has increased from 16 in 1971, to 17 in 1980, to 18 in 1990 and to 19 in 1997 and it is still increasing. He concludes that there is a rising proportion of single women, with the median age of single women increasing from 17.7 years old in 1971 to 20.9 years old in 1997. The strong upward trend of age at marriage is evident in the data; for females, the singular mean age at marriage (SMAM) has steadily increased from 19.7 in 1964 to 23.4 in 2005 and SMAM for males rose from 23.5 to 27 (Jones, Hull, and Mohamad 2011:26).

Along with the rising age at marriage, there is a corresponding decline in the prevalence of teenage marriage. A cohort analysis based on the IDHS 2002-3 indicates that over the period of 30 years, the proportion of teenagers married before age 15 had declined from 23 to 4% (Jones and Gubhaju 2011). However, despite the downward trend, teenage marriage remains prevalent in Indonesia (Jones 2011; Jones and Gubhaju 2011). In 1997, the cumulative percentage of ever married women below 18 years old is 9.1 percent (Kurniawan 2000). Similarly, 9% of women aged 15-19 were ever married at the time of the Population Census 2000 (Jones 2011). There is also a considerable variation in the speed at which different regions in Indonesia are moving away from teenage marriage.

b. Premarital Sexand Premarital Births

The 2003 and 2007 IYARHS (Indonesian Young Adults Reproductive Health Survey) conducted among unmarried respondents aged 15-24 years old indicated that 1% of females and 5% of males (2003) and 1% of females and 6% of males (2007) reported that they engaged in premarital sex. In 2012, the percentage was similar for females but significantly increased for males (4.5% for males aged 15-19 and 14.6% for males aged 20-24) (Central Bureau of Statistics et al., 2004; 2008; Statistics Indonesia 2013a and 2013b). The 2010 Greater Jakarta Transition to Adulthood Survey (GTAS) showed that in Jakarta, Bekasi and Tangerang,11% of never married respondents had had sex. There is a significant difference between males (16%) and females (5%). Other studies found similar results (Diarsvitri, Utomo, Neeman, and Oktavian 2011; Purdy 2006; Situmorang 2001; Utomo 1998).

Further multivariate analysis on sex before or after marriage from the GTAS 2010 suggests that rate of first intercourse outside of marriage is significantly lower for females. Older respondents (those aged 25-29) had higher rates of first intercourse within marriage, while younger respondents had higher rates of first intercourse outside of marriage. The time-varying variable of whether the respondent was studying or not, is a significant predictor of first intercourse overall and of first intercourse within marriage.

Data from the GTAS was also used to analyse the timing of conception of children in relation to the date of marriage. Of all respondents in the 2010 GTAS, 1,386 respondents have at least one child and had been married at least once. From1,382 respondents, 10% of births were premarital conceptions and 5% were premarital births. These percentages were higher for those who had conceived at younger ages. The date of conception was defined as the date of birth minus nine months. There was also a comparison of premarital

conceptions patterns from survey data with six IDHS carried out over two decades from 1987-2007. All of the surveys show similar results regarding the proportion of conceptions occurring before marriage. The relatively high proportions pregnant at marriage indicate that the nuptials may be a direct result of the pregnancy.

c. Contraceptive Use among Young People

The 2010 GTAS results show that among single, sexually active respondents, 34% used contraception with the majority using condoms (32%) at the time of first intercourse. The 2012 IDHS preliminary report revealed that among married girls aged 15-19 years old, only 47% were using any modern method of contraception, lower than those aged 20-24 year-old (59%). The most common modern contraception used by married girls aged 15-19 and 20-24 was the pill (8.8%; 10.9%) and injectables (37.3%; 42.7%) (Statistics Indonesia et al. 2013: 12). The percentage of young girls who used any modern method of contraceptive dropped by three precent (44.6%) compared to 2003 but stabilized for those aged 20-24 (Statistics Indonesia et al. 2003). These figures do not account for those who were single and sexually active but did not use any type of contraception.

d. Safe Sex and Contraception Knowledge

The 2010 GTAS revealed that respondents with higher education felt that they had enough knowledge about contraception and safe sex at the time of first intercourse. The determinants of having enough perceived knowledge about contraception were very similar to the determinants of having enough perceived knowledge about safe sex. The main predictors of having enough knowledge about each topic at the time of first intercourse were the respondent's current level of highest education and their age at first intercourse.

The 2003, 2007 IYARHS and 2012 IDHS studies indicate that knowledge of family planning among unmarried young people (15-24) is high (more than 91.1% in 2003; 92.8% in 2007 and 93.3% in 2012), and higher among unmarried females compared to unmarried males. Older unmarried women and men (20-24) are more likely to know about family planning compared to their younger counterparts (15-19). The most commonly known contraceptive methods among unmarried females are injectables, pill and male condom; among unmarried males the most commonly known contraceptive methods are condom, pill and injectables.

In 2003, 24% of unmarried respondents aged 15-24 stated that family planning should be made available for this age group. The percentage increased to 50% in 2007. The majority of unmarried young people aged 15-24 wanted family planning services made available in the forms of family planning information (80.2%-87.9%) or counseling (72.3%-80%) (Central Bureau of Statistics et al. 2004; 2008).

e. Abortion

Utomo et al. (2001) estimated that 2 million abortions per year occurred in Indonesia, with a ratio of 43 abortions to 100 live births, or 30% of pregnancies. Women who had an abortion were aged 20 or older (92%) and abortion incidence was higher at the district level (60%) than in the city (30%). Of the respondents, one-third in the cities and half in the districts who had had an abortion did so during their first pregnancy; of these, the majority were still single. Of patients admitted to hospitals in Yogyakarta City due to abortion related problems, 4.6% were single or only in a religious marriage relationship with her husband (*nikah siri*).

Hull and Hartanto (2009) estimated that young women below the age of 19 years of age account for 10% of abortion at a service delivery point and unmarried women account for 33%. The percentage of women below 19 years of age that undertake unsafe abortions is expected to be higher and especially more common in rural areas (Sedgh and Ball 2008). Young women experiencing unwanted pregnancy would first try to self-abort by taking overdoses of Cytotec tablets (a stomach-ulcer medication), menstrual regulation drugs, herbal concoction (*jamu*) or young pineapple juice, which is thought to have abortive effects. If those attempts are not successful, they would go to a traditional healer or traditional birth attendant, who often use forced stomach massage to effect an abortion (Utomo and McDonald 2009).

In Medan, female respondents (49%) were more likely than male respondents (44%) to tolerate abortion (Situmorang 2001: Table 6.2). Utomo's study (1998) of respondents never married aged 15-24 showed that 23.3% of respondents aged 15-19 knew someone who experienced premarital pregnancy and got married because of the pregnancy; the number doubled among older respondents aged 20-24 (68%). Respondents also said they knew friends who were pregnant outside of marriage but had an abortion (5.5% among those aged 15-19 years old and 9.6% among those aged 20-24 years old) (Utomo, 1998: Table 5.5). The 1995 Indonesia Household Health Survey found that 11% of maternal deaths were due to complications following abortion (Widyantoro and Lestari 2004). It is reasonable to assume that a higher proportion of maternal deaths among single women are caused by unsafe abortion.

2.2.2. Qualitative Studies on Adolescent Reproductive Health, Adolescent Pregnancy and Consequences

Bennet (2001) found that in Lombok, while abortion for married women was 'tacitly accepted', premarital pregnancy and abortion among young women was highly stigmatised. One observation was that for the respondents, the only option for legitimising teenage pregnancy was through marriage; but if no marriage offer was presented, the young women resorted to abortion.

a. Adolescent Pregnancies: Incidence and Associated Factors

In a study of 147 Year 11 students from an unnamed high school in 2010, 9% of the respondents had had sex, and 1.9% had dropped out due to premarital pregnancy in the previous year (Kusumaningsih 2010). Data collected from testing the urine of brides-to-be in the Cilimus district of West Java indicated that 41 out of 428 couples were pregnant (Heriana, Hermansyah, and Solihati 2010). In one of the villages in the district, 11 out of 20 brides-to-be were pregnant; out of those 11, 7 were still students. A case-control analysis between pregnant adolescents and the comparable control group suggests that there is a significant relationship between reproductive health knowledge and family environment, and the incidence of premarital pregnancy.

A study in Manado by Ginting and Wantania (2012) also highlighted the low level of reproductive health, pregnancy and child health knowledge among pregnant teenage mothers (aged 16-19) because the most common source of information for their respondents was the mass media. This was also found in Nargis (2008) and in Khomsatun, Trisnawati, and Pantiawati (2012).

b. Abortion: Attitudes and Experiences

Views on abortion in a study of young people at university were polarised, particularly along religious lines (Widyastuti 2002). Respondents interviewed at a café were more tolerant to abortion and attached high

importance to the need and well-being of the mothers. In contrast, respondents who were interviewed at a mushala attached high value to the rights of the foetus. The latter group consisted of students belonging to Islamic study groups.

Juminawati (1994) outlined the stories of three teenage respondents who had had abortion. All respondents did not inform parents of their pregnancy and they attempted to self-abort. When their attempts failed, they went to abortion clinics during gestational months of 2 to 3 months. The primary reason cited for abortion was that they were not morally and financially ready to have children and that fear of parents' reactions was a factor behind their decision to abort.

c. Teenage Mothers - Early Childbearing

A study of 3 teenage mothers reported these respondents decided to keep their babies because they felt that abortion is morally wrong. Their decision to continue the pregnacy was rationalised along these two reasons: first, because their religion forbids the 'killing' of foetus and second, they were afraid of the prospects of death due to failed abortion (Lestari 2001). In a study of 8 teenage mothers and their families, seven families whose adolescent daughters fell pregnant attempted to do the 'ideal' thing to 'save face' by holding a wedding celebration. Having an unwanted adolescent pregnancy in the family is ultimately stressful and places a strain on the families' physical and psychological well-being, financial situations and social relations (Widyoningsih 2011).

3. Conclusion

To date, international studies have established that adolescent pregnancy brings many disadvantages to the girl's health, mental and psychological wellbeing, economic and career opportunities, poverty and future life prospects (Gray et al. 2013). The health consequences of teenage pregnancy is very high as it can lead to many health risks, physiologic risks, obstetric fistula, and if the young women is from a poor background then the pregnant young women can experienced pregnancy nutritional depletion (Chandra-Mouli, Camacho, and Michaud 2013). As UNFPA has pointed out in its discussion of the theme for World Population Day 2013[1] , adolescent pregnancy is also a human rights issue and a signficant barrier to achieving development goals.

The quantitative suveys on adolescent pregnancy in Indonesia suggest that although age at marriage is rising, and teenage marriage is declining, unmarried young men and women are engaging in sexual relationships that leave them at a higher risk of unwanted pregnancies. Low levels of reproductive health knowledge and unsafe sexual behaviour are predisposing factors behind adolescent pregnancies, induced abortion, STIs and HIV/AIDS. The National Law Concerning Population and Family Development (No 52 of 2009) only allowing married couples to access family planning services is an additional factor that contributes to the problem of the prevention of pregnancy among unmarried adolescent in Indonesia.

The qualitative and micro studies of adolescent pregnancies in Indonesia shows some of the consequences that arise as a result of adolescent pregnancy. Social and religious stigma regarding

[1] http://www.unfpa.org/public/world-population-day

premarital pregnancy in Indonesia leads to health and psychological burden for young women. The negative consequences of adolescent pregnancy follows through to the stigmatisation and socio-economic adversities for babies borne to teenage mothers.

Statistical estimates and academic research help capture the scale and underlying factors of the adolescent pregnancy in Indonesian communities. They serve as a solid base to formulate sound policies and programmes for adolescent reproductive health to uphold their rights. The increasing visibilities, complexities, and social repercussions of adolescent pregnancy have been reflected in recent Indonesian media coverage. Reports about girls being murdered for becoming pregnant and dying as a result of unsafe abortion shows the extreme risks that arise from the stigmatisation of adolescent pregnancy in the community.

Despite media coverage of these tragedies, there has been limited policy response to the issues arising from adolescent pregnancy in terms of both proactive measures to prevent teen pregnancy and also support services to assist young women who face unwanted pregnancy. It is necessary for the government to invest in policy and programs on adolescent reproductive health. Providing comprehensive reproductive health education as early as possible, reproductive health services for those who are still single, and cultural and religious values education that promotes gender equality can contribute to overcome these problems.

Addressing issues related to adolescent pregnancy requires an approach that encompasses the empowerment of young women but this cannot be achieved without the education of boys and the wider community (including parents and families). This means creating a more supportive society where young women have the ability to reach their fullest potential through access to education and sexual reproductive health services, and where the community understands the importance of such factors. This response will require the involvements of all stakeholders and has to include the prevention of child marriage, which will mean advocating for a change of the law to increase the minimum age of marriage for young women as well as to ensure that young women go to school and attend beyond the primary level.

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