Women's Involvement in Decision Making and Unmet Need for Contraception In Indonesia

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Abstract

Background: The issue of gender inequality in reproductive health has a role in determining contraceptive use in women. Gender issues related to inequality in decision making are the main context in family planning interventions. The purpose of this study is to assess women's participation in decision making and its relation to unmet need.

Method: A cross-sectional study was conducted using IDHS data in 2012. The study involved 1516 women of childbearing age (15-49 years) with married categories in areas with high unmet need (West Papua) and the lowest unmet need area (Bangka Belitung).

Results: Married women in the Bangka Belitung region have more power in decision making than married women in West Papua. Involvement in economic matters and the decision to use contraception as the most dominant factor and involvement in the household have a significant relationship with the occurrence of unmet need, as well as education, wealth, and experience in using contraception related to unmet need. while age, fertility preference, husband's desire to have children, and involvement in health and mobility were not directly related to unmet need.

Conclusions: Better participation in decision making is higher for women in the Bangka Belitung region than in Papua. Empowerment of women in terms of the economy and the use of contraception needs to be improved so that they have power in decision making.

Keywords: *Unmet Need, Modern Contraception, Decision Making, Involvement.*

Introduction

Contraceptive use is one of the government's policies to reduce the total fertility rate. Decline in TFR was not followed by a decrease in unmet need. Based on the 2012 IDHS data, the unmet need figure is still stagnant at 11%. Unmet need disparities still occur in every province in Indonesia. The highest unmet need reached 23.7% in the West Papua region while the lowest unmet need was in Bangka Belitung with a figure of 5,6% [6]. This is thought to have social and cultural influences that influence decisions in family planning.

Unmet need is associated with client needs that have not been fulfilled regarding the expectation of being able to delay pregnancy or the desire to be able to limit pregnancy. The desire to fulfill these needs is based on the desire/unwillingness to have children, determine the ideal number of children and use contraception[21]. Related to the existence of gender issues, it shows the occurrence of inequality in terms of equality of reproductive rights. This can be seen in the differences in the desire/unwillingness to have children, the determination of the ideal number of children and contraceptive use between men and women as couples who should have a joint decision on this matter[14,15].

Based on the desire to have children, almost 50% of married women say they do not want to have more children (including those who have been sterilized). But around 15% of women show the fact of pregnancy

when they don't/don't want children[6]. The desire to have children and determine the ideal number of children greatly affects the subject of contraceptive use. To achieve this desire, men and women must have a decision to use contraception or not to use[11].

Indonesia is one of the developing countries that is still influenced by social and culture which places women in a position below men [14]. This affects women's participation in making decisions in all aspects. Indonesia is a patriarchal society that believes that women are inferior to men[23].

This is supported by The Conference on Population and Development (ICPD) in Cairo 1994, a testament to the commitment of the international community on issues of gender, population and development with a new perspective. Decisions in contraceptive use and fertility are thought to be the influence of gender inequality especially in patriarchal societies [1]. Studies in Ethiopia show male dominance of women leads to an increase in the number of children[20]. Studies in sub-Saharan Africa also illustrate that there are indications of decision-making problems that affect contraceptive use by women without their partners knowing [3].

The disparity in the number of unmet need may be caused by the existence of a strong patriarchal system in several regions. Therefore, the aim of this study is to assess women's participation in decision making and its relation to unmet need in regions with high and low unmet need in Indonesia.

Method

Study area and setting: The cross-sectional study was conducted using IDHS data in 2012. Data measurements were carried out in two regions, namely Bangka Belitung as the area with the lowest unmet need numbers and West Papua as the highest unmet need number.

Sampling: This study involved 1516 women of childbearing age (15-49 years) with married categories. Using data from the Indonesian Demographic and Health Survey (IDHS) in 2012, the research design used was cross sectional.

Measurement: Participation in decisions is an independent variable measured using the autonomy index obtained based on the literature[4,9,12,22]. Questions related to participation followed the questionnaire in the Indonesian IDHS survey which included women's participation in decision making in terms of economy, household, mobility and health. Questions related to decision making are categorized as having high autonomy in decisions if women are involved in all aspects of decision making. Moderate autonomy if there is ≤ 2 decision aspect involvement and does not have autonomy in the decision if there is ≤ 1 decision aspect involvement. Contraceptive use is a dependent variable with unmet need categories and not unmet need. Unmet need is indicated if women have the desire to postpone pregnancy or do not want to have more children, but do not use any contraception to prevent pregnancy. Other variables that are indirectly related to women's decision participation will also be measured such as age, employment, education, resident, fertility preference, and wealth.

Statistic Analysis: Data was processed using Statistical Package for the Social Sciences (SPSS) software version 15.0. Univariable, bivariable and multivariable analysis was carried out. Chi square will be useto see the closeness of the relationship between variables and logistic regression test to identify the most significant of variable.

Result

Sosio demographic characteristics: Most of the respondents in the two regions were in the age group 25-29. The majority of married women have education at the primary and secondary levels in both regions. But in West Papua more women with higher education than in Bangka Belitung. While the economic level in West Papua is lower than Bangka Belitung (see table 1).

Reproductive Health Characteristic: Regarding contraceptive use, it turned out that the dominant women used traditional method to delay pregnancy in both groups. About 27.2% of women in Bangka no longer want children, while 22.8% still plan to become pregnant. In contrast, in West Papua, there are fewer women who do not want children (17%) compared to women who still want to add children (20.1%). For more details can be seen in table 1.

Table 1. Socio demographic variabels of married women (N= 1516)

	Bangka Belitung (%)	West Papua (%)	Total (%)
Age Group			
15-19	23(1,5)	33(2,2)	56(3,7)
20-24	119(7,8)	101(6,7)	220(14,5)
25-29	162(10,7)	139(9,2)	301(19,9)
30-34	156(10,3)	149(9,8)	305(20,1)
35-39	154(10,2)	114(7,5)	268(17,7)
40-44	97(6,4)	95(6,3)	192(12,7)
45-49	102(6,7)	72(4,7)	174(11,5)
Educational Level			
No	30(2)	36(2,4)	66 (4,4)
Primary	394(26)	(196)12,9	590(38,9)
Secondary	323(21,3)	364(24)	687(45,3)
Higher	66(4,4)	107(7,1)	173(11,4)
Wealth Index			
Poorest	75(4,9)	221(14,6)	296(19,5)
Poorer	165(10,9)	115(7,6)	280(18,5)
Middle	168(11,1)	159(10,5)	327(21,6)
Richer	218(14,4)	145(9,6)	363(23,9)
Richest	187(12,3)	63(4,2)	250(16,5)
Ever Used to Delay			
No	90(5,9)	224(14,8)	314(20,7)
Yes outside calendar	55(3,6)	84(5,5)	139(9,2)
Yes, used calendar	668(44,1)	395(26,1)	1063(70,1)
Fertility Preference			
Have another	337(22,8)	298(20,1)	635(42,9)
Undecided	56(3,8)	70(4,7)	126(8,5)
No more	402(27,2)	252(17)	654(44,2)
Sterilized	15(1)	28(1,9)	43(2,9)
Infecund	2(0,1)	19(1,3)	21(1,4)
Husband Desire for Children			
Both want same	548(38,4)	256(17,9)	804(56,3)
Husband wants more	119(8,3)	139(9,7)	258(18,1)
Husband wants fewer	37(2,6)	18(1,3)	55(3,9)
Don't know	90(6,3)	220(15,4)	310(21,7)

Decision making power in both area: Overall, the power of decision making in the West Papua region is lower than Bangka Belitung. There were no significant differences in decision making in the aspects of health services, household and mobility in both groups. But in the economic aspect, the involvement of women in West Papua was lower (39.6%) compared to Babel (48.1%). Likewise with the decision in contraception, as many as 27.8% of women in West Papua and 19.7% of women in Babylon were not involved in the decision.

Factor Related unmet need of contraception:

Unmet need and socio demographic:

Table 2. Unmet need and characteristic of socio demographic of married women (N= 1516)

Socio Demographic	No Unmet need	Unmet need	p value
Age in Group			0,000
15-19	26(1,7)	10(0,7)	
20-24	69 (4,6)	24(1,6)	
25-29	69 (4,6)	27(1,8)	
30-34	32 (2,1)	30(2,0)	
35-39	32(2,1)	25(1,7)	
40-44	12(0,8)	29(1,9)	
45-49	2(0,1)	22(1,5)	
Education Level			0,082
No Education	11(0,7)	6(0,4)	
Primary	61(4,0)	60(4,0)	
Secondary	134(8,9)	79(5,2)	
Higher	36(2,4)	22(1,5)	
Wealth Index			0,000
Poorest	55(3,6)	48(3,2)	
Poorer	48(3,2)	31(1,1)	
Middle	50(3,3)	36(2,4)	
Richer	59(3,9)	24(1,6)	
Richest	30(2,0)	28(1,9)	
Ever used to delay			0,000
No	126(8,3)	60(4,0)	
Yes outside calendar	17(1,1)	25(0,9)	
Yes, used calendar	99(6,5)	82(5,4)	
Fertility preference			0,000
Have another	180(12,2)	58(3,9)	
Undecided	33(2,2)	25(1,7)	
No more	28(1,9)	84(5,7)	
Sterilized	0	0	
Infecund	0	0	
Husband desire for children			0,000
Both want same	124(8,7)	73(5,1)	
Husband wants more	47(3,3)	30(1,1)	
Husband wants fewer	4 (0,3)	6(0,5)	
Don't know	66(4,6)	56(4,0)	

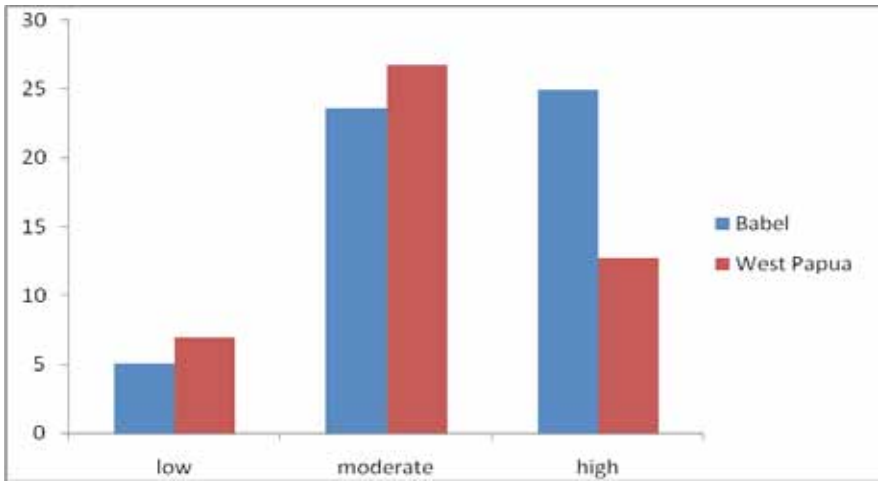

Figure 1. Power of Decision Making on Merried women in Bangka Belitung and West Papua, Indonesia 2012

Unmet need and decision making: Involvement in health service, household and mobility aspects in both groups showed that women without cases of unmet need had better involvement than unmet need groups. Similar to the low number of women's involvement in these three aspects, there were more women who did not experience unmet need. There are 13.9% of women in the group without unmet need involved in economic matters while in the unmet need group only around 9%. And as much as 7.5% of women without unmet need have better involvement in contraception compared to 5.2% of the unmet need group.

Table 3. Unmet need and involvement decision making of married women (N= 1516)

Decision Making	No Unmet need	Unmet need	p value
Health care			
Low Involvement	34 (2,2)	20 (1,2)	0,073
Better Involvement	208(13,7)	14,7(9,7)	
Household			
Low Involvement	48(3,2)	26(10,1)	0,159
Better Involvement	194(12,8)	142(11,2)	
Movement			
Low Involvement	47(3,1)	32(2,2)	0,713
Better Involvement	195(12,9)	135(9)	
Economy			
Low Involvement	32(2,1)	31(2,1)	0,050
Better Involvement	210(13,9)	136(9)	
Contraception			
Low Involvement	147(9,7)	132(9,4)	0,000
Better Involvement	113(7,5)	79(5,2)	

Discussion

Table 4. Logistic regression analysis : dependent variable-unmet need

	Significance	Odds ratio (95% confidence interval)
Education Level		
No Education	0,000	1
Primary	0,156	0,56(0,25-1,24)
Secondary	0,070	0,47(0,21-1,06)
Higher	0,040	0,39(0,15-0,97)
Wealth Index		
Poorest	0,000	1
Poorer	0,049	1,63(1,00-2,68)
Middle	0,008	1,92(1,18-3,13)
Richer	0,001	2,32(1,40-3,82)
Richest	0,060	1,67(0,97-2,86)
Ever used any contraception		
No	0,000	1
Yes, outside Calendar	0,000	0,17(0,11-0,28)
Yes, with Calendar	0,000	2,30(1,58-3,35)
Involvement in Household		
Low involvement	0,000	1
Better involvement	0,058	0,63(0,39-1,01)
Involvement in Economy		
Low involvement	0,000	1
Better involvement	0,007	1,90(1,19-3,03)
Involvement in Contraception		
Low involvement	0,000	1
Better involvement	0,000	1,80(1,30-2,48)

The results in this study to prove the assumption of participation or involvement of women in decision

making in all aspects are closely related to the incidence of unmet need.

The results of this study indicate that the dominant factor affecting the unmet need is the involvement of women in decisions in the economy and contraception. This is consistent with the research conducted by another research that Decision-making was found to be positively associated with contraceptive use and not having unmet need for contraception[5,18].

Decisions in terms of economics influence decisions in contraceptive use, allegedly because finance affects authority. This is consistent with the study of Palamulenithat employment status factors influence contraceptive use in women[19]. This research is also found that there were no significant differences between the two regions in terms of decision making in health services and mobility. This is presumably because the government has been maximal in its efforts to equalize health both in terms of facilities and officers. While for decisions in terms of mobility, now it may have become a thing that is not rigid and taboo to do, so that cases of mobility related to visits to relatives and friends are not the dominant thing to discuss.

This study also found that low involvement in household-related decision making, economy and contraception was more dominant in the West Papua region. This is allegedly related to economic growth. This study found that the middle to upper class people based on wealth index were more dominant in the Bangka Belitung region. The situation of economic growth affects the economic level of the family. Possibly in the West Papua region, the status of work is more for men than women[15]. So that women in the region depend on their husband/partner's livelihood. This is also affects household decisions and contraceptive use.

Contraceptive use can be influenced by external factors related to the position of women in social life [9,10]. The assessment of women's position has been assessed by gender differences that place women and men in accordance with their functions and their respective roles [2]. Problems arise when there are gender inequalities that limit each other's rights [13]. Gender-based power inequalities can limit open communication between partners about reproductive health decisions and women's access to reproductive health services, which contributing to poor health outcomes The importance of partner communication is often emphasized in family planning and research programs, this is the first step in making rational fertility decision processes [17]. In developing countries some women have low bargaining positions. In fact, women who are either under collective decision making with their partners or completely dependent on the decisions of male partners on the issue affect their reproductive lives[8].

Conclusion

The findings indicate that creating conditions for women who can improve their financial status by increasing women's empowerment in terms of economy can increase autonomy in maintaining the right to reproductive health itself. This research is limited by data available to measure women's empowerment. Other limitations of this study are uses cross sectional which cannot determine the temporal relationship between two variables.

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Conflict of Interest: None declared

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