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# Negotiating the Body: Reproductive Autonomy and Gendered Power in Family Planning Program

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**Abstract**
The research aims to understand how women's reproductive choices, especially contraception, are shaped by family dynamics, social norms, and personal experiences. A qualitative approach was used, and in-depth interviews were conducted with seven women in the family planning program. The data were analyzed thematically to identify patterns in the participants' experiences. Women's contraceptive decisions are still influenced by their husbands and cultural norms, with the main burden falling on women, including the side effects of hormonal contraception. The lack of male participation reflects gender inequality in reproductive decisions. This study concludes that women's reproductive autonomy remains restricted by patriarchal norms and suggests further research on male involvement in family planning programs and the development of male contraceptive methods. This study is a reference to gender power dynamics in family planning practices, especially the negotiation of women's reproductive autonomy in patriarchal spaces.

**Kata Kunci**
Keluarga Berencana;
Politik Tubuh;
Otonomi Tubuh Perempuan;
Gender dan Kekuasaan;
Konstruksi Tubuh

**Abstrak**
Penelitian ini bertujuan untuk memahami bagaimana pilihan reproduksi perempuan, khususnya kontrasepsi, dipengaruhi oleh dinamika keluarga, norma sosial, dan pengalaman pribadi. Pendekatan kualitatif digunakan dengan melakukan wawancara mendalam dengan tujuh perempuan yang terlibat dalam program KB. Data dianalisis secara tematis untuk mengidentifikasi pola dalam pengalaman peserta. Keputusan kontrasepsi perempuan masih dipengaruhi suami dan norma budaya, dengan beban utama pada perempuan, termasuk efek samping kontrasepsi hormonal. Minimnya partisipasi laki-laki mencerminkan ketimpangan gender dalam keputusan reproduktif. Studi ini menyimpulkan bahwa otonomi reproduksi perempuan tetap dibatasi oleh norma-norma patriarki dan menyarankan penelitian lebih lanjut tentang keterlibatan laki-laki dalam KB serta pengembangan metode kontrasepsi laki-laki. Studi ini menjadi rujukan dinamika kuasa gender dalam praktik KB, khususnya negosiasi otonomi reproduksi perempuan dalam ruang patriarkal.

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## INTRODUCTION

The use of contraceptives should be part of women's reproductive rights and bodily autonomy. However, in practice, the decision to participate in family planning programs is still heavily influenced by power relations within the household and patriarchal gender norms. Women still do not have complete freedom to choose the contraceptive method they will use. Women are required to consult with their husbands, families, and even health workers before deciding on a contraceptive method. In addition, even though Family Planning (KB) methods are now available, such as condoms and vasectomies, women still bear the main physical and psychological impact of using contraception. This reflects the gap between the ideal of gender equality in the Family planning program and the social reality experienced by women.

The Family planning program originated as a response to the population explosion recognized by Thomas Malthus, an English economist. His theory posited that food production grows asymmetrically while population growth is geometric. This means that population growth far outpaces food production, as noted by Anderson (in Udasmoro, 2004). As a solution, contraceptive technology was developed and disseminated almost worldwide to address the population explosion. Indonesia's Family planning program movement emerged as a new phenomenon in the early 1970s. A non-governmental organization pioneered this movement, the Indonesian Family Planning Association (PKBI), established in 1957. The Family planning program eventually expanded extensively through revolutionary socialization efforts and political intervention by the government through the National Family Planning Coordination Agency (BKKBN) (Udasmoro, 2004).

Nurullah (2021) explains that the Family planning program aims to regulate childbirth, the ideal spacing and age for childbirth, and pregnancy through promotion, protection, and assistance by reproductive rights to achieve a quality family. In line with this, Setiadi and Iswanto (2015) state that forming a small, advanced, prosperous, and independent family is closely related to the optimal implementation of the family planning program. This means that the Family planning program is not only related to demographics but also touches on social welfare and fundamental individual rights.

The success of the Family planning program in Indonesia is inseparable from the intense political commitment since the 1970s. BKKBN and UNFPA (2012) noted that through intensive behaviour change communication campaigns and the provision of integrated clinic and community-based services, BKKBN played a significant role in facilitating a decline in birth rates, a decline in maternal mortality rates and contributing to improved health and economic participation of women. Strong campaigns promoting the idea of small families with aggressive messages such as "Two Children Are Enough" helped shape social perceptions about the ideal family size.

In the Indonesian context, the Family planning program has developed rapidly and remains actively promoted by the government. This has also been aligned with the policies of those in power. According to Udasmoro (2004), the implementation of the Family planning program in Indonesia is distributed on a mass scale, with women as its primary consumers through education, health services, and media representation. This perspective aligns with Hardon's (1994) view that, in a global context, women's experiences with the side effects of contraception are often overlooked, and the technology of the Family planning program continues to be developed without considering the voices and comfort of women as the primary users. Thus, there remains a gap between the normative principle of gender equality promoted in family planning programs and the social reality that still places women as the primary bearers of both physical and psychological burdens.

Various literature and policies described above show that family planning programs play an important role in improving the community's quality of life and health. However, there is still a gap between the principle of equality and the social reality in which women do not have complete autonomy over their reproductive decisions. The biological and psychological burdens are borne disproportionately, while male involvement in contraceptive methods remains minimal. Additionally, the dominant narrative in Family planning program campaigns tends not to alter the existing power

structures within households, which are traditionally male-dominated (patriarchal). Therefore, this paper aims to examine in depth how power relations and social norms influence the decision-making process of the Family planning program at the domestic level, as well as how women respond to and negotiate their roles in this context. This paper offers a new contribution to understanding the Family planning program, which is not only viewed as a public health issue but also as an arena of body politics and power relations within the discourse of gender and sexuality.

**METHOD**

This study was conducted in the coastal area of Watukarung, Pringkuku District, Pacitan Regency. This area was selected as the research location because it reflects a unique social context in the practice of the Family planning program. The region has a local culture and social values that are still patriarchal, making it relevant to examine how power relations within households influence women's decisions to participate in the Family planning program. The selection of this coastal area also considered the economic dynamics of households that depend on the informal sector, such as fishing, small-scale tourism, or seasonal work, which can influence how young women navigate the Family planning program. On the other hand, Watukarung is known as an area undergoing social transformation due to the rapid development of tourism. This makes the location an ideal place to observe how young women navigate their traditional roles in the face of social change, including reproductive health.

The research took place in May 2025 because, during this period, social conditions tend to be stable (not during busy holiday periods or major religious celebrations), allowing the author to collect data optimally. In addition, these conditions also give informants free time so that interviews can be conducted without disrupting their daily activities. Thus, the data collection process can be conducted thoroughly and reflectively.

The informants in this study were young women aged 18-24 who were married, had children, and participated in a family planning program. There were seven informants in this study. The informants were selected using snowball sampling, starting with one key informant who recommended other relevant informants. Of the seven informants interviewed by the researcher, all were homemakers who did not work in the formal sector. This situation made them economically dependent on their husbands or families, which also influenced their position in decision-making regarding the use of contraceptives. Regarding education, most informants were high school graduates (5 people), one informant was a junior high school graduate, and one informant did not complete junior high school. This level of education and economic dependence is an important context in assessing the extent of their knowledge, access to information, and autonomy in choosing family planning (FP) methods.

This study uses a qualitative approach with an ethnographic research design to deeply explore the experiences and perspectives of young women in decision-making regarding contraceptive use. The data collection technique was semi-structured in-depth interviews to allow informants to share their personal narratives. All informants' names were anonymized and protected by informed consent or interview consent. The researcher also allowed informants to withdraw from the interview if they felt uncomfortable. In addition to interviews, the researcher also conducted a literature review to strengthen the analysis.

After the interviews were completed, the next step was to transcribe the recordings of each informant's interview and then categorize them to facilitate data analysis. From there, the researcher could map the results of the interviews obtained from each informant thematically. The next step is to map the data and then code the findings. This is done to facilitate the description of the data findings. After this stage, the researcher analyzes the data about the theory and literature review that have been determined.

## RESULTS AND DISCUSSION

### Result

1. Decision-making in family planning programs: between women's initiative and husbands' consent

Most informants stated that their decision to participate in the Family planning program was made by themselves but still within the framework of consultation or requiring their husband's consent. This was felt by each informant in their experience when deciding to participate in the Family planning program as a means of preventing pregnancy. One informant named Pingkan, for example, stated, "I, on my initiative, wanted to switch to the injectable Family planning program. But yes, my husband's consent was also required." (Pingkan, interview on May 15, 2025). This experience was not unique to one informant. Other informants also had experiences similar to those of Pingkan. For instance, the two other informants, Dian and Sinta, also revealed that although they felt they had made the decision independently, power dynamics within the household remained in the form of strong approval or encouragement from their husbands. They could not decide independently without discussing it and obtaining their husband's approval.

On the other hand, another informant mentioned that besides the husband, the family also plays an important role in the informant's decision to participate in the Family planning program. As the closest people besides the husband, the family has the power to determine the child's decisions regarding reproduction. This indicates that even though the informant has been released from parental responsibility, they still influence important decisions within the child's family. One informant named Mila mentioned that the decision to join the Family planning program came from her parents, as reinforced in the following quote: "My parents told me to do it because if I did not join the Family planning program, what would happen? The child is still young, not ready to have another child yet." (Mila, interview on May 15, 2025). Rista's story is different, as she revealed that her decision to use the Family planning program was due to the recommendation of health workers, in this case, community health workers, who consistently promote the use of the Family Planning implant program as the government is currently promoting it. This shows that the decision to use the Family planning program is not always the result of women's autonomy but is also influenced by family structure and social expectations.

2. Side Effects of Contraception and the Burden on Women's Bodies

The use of contraceptives such as Family Planning (FP) injections, pills, and others, while providing positive effects such as delaying pregnancy, actually has significant side effects on the bodies of the informants. The adverse effects experienced after consuming or using the chosen Family planning program are diverse, both physically and emotionally. Most informants experienced physical and emotional effects from hormonal contraceptives, ranging from weight changes, acne breakouts, and dull skin to mood disorders and prolonged fatigue. Dian, one of the research informants, mentioned that she experienced many adverse effects, such as hair loss, facial spots, and a drastic increase in weight. Another informant named Mila reinforced this view with the following statement: "With the Family planning program, the effects are that if you are overweight, you get even more overweight, and if you are underweight, you get even more underweight. I became extremely underweight like I am now." (Mila, interview on May 15, 2025).

It does not stop there, as the informants face many other side effects. Each informant experiences different side effects from one another. Like Pingkan's experience, she adds another dimension to these side effects: "So it is like feeling lazy to do anything, the whole-body hurts, even when waking up." (Pingkan, interview on May 15, 2025). Meanwhile, Sinta also mentioned a significant impact on her self-confidence: "Hormonal changes cause acne, make the skin dull, and I am afraid to switch to the IUD." (Sinta, interview on May 12, 2025). Another informant, Dela, explained that she often experienced

delayed menstruation after using the Family planning program, and she also felt that her body continued to gain weight compared to before.

The overall experiences of the informants described in the quotes above show that while hormonal contraception is available and considered practical, its physical and psychological effects on women are significant and often tolerated in silence, even by the women themselves. They expressed no objection to dealing with the side effects of their choice to use the Family planning program. They expressed their willingness to endure the adverse effects of using the Family planning program. Instead of deciding to stop the program, they preferred to switch to another method, even though the changes were not significant, and they continued to experience adverse effects in different forms.

3. The Lack of Husbands' Involvement in the Consequences of Family Planning Programs

The informants' decision to use family planning programs was based on their husbands' unwillingness to use male contraception such as condoms or vasectomies. The husbands' unwillingness to use condoms, as explained by the informants, is because using condoms during sexual intercourse reduces pleasure and causes discomfort. Additionally, the informants mentioned that using condoms not only causes discomfort but also does not guarantee the prevention of pregnancy. Many experiences shared by the informants indicate that even when using condoms alone, there is still a chance of unintended pregnancy.

Furthermore, in addition to reasons related to comfort, there are other reasons why husbands do not want to participate in the Family planning program, namely, related to male strength and fear of side effects. One informant named Dian shared her opinion on the presence of the Family planning program in the form of vasectomy, saying, "The thought is that if men participate in the Family planning program, it is a pity, there is no... strength." (Dian, interview on May 15, 2025). Sinta expressed a similar view: "Mostly here it is the women. Men do not want vasectomies; they are afraid." (Sinta, interview on May 12, 2025). Even when there is discussion of male participation, as in Salindri's case, ignorance about the side effects of vasectomy means that the decision falls back on women, as in the following quote: "I want to be involved in the Family planning program for men, but not yet, because I do not know what the side effects of the Family planning program for men are." (Salindri, interview on May 16, 2025).

The interview quotes above show that instead of considering the side effects they have personally experienced, the informants prioritize the adverse effects their husbands might face when deciding to participate in the Family planning program. This situation causes the informants to 'give in' and endure the suffering from using the Family planning program they have chosen rather than imagine their husbands suffering when deciding to use the Family planning program.

4. The decision to participate in the Family Planning Program as a form of submission to social and family norms

Some informants mentioned that they participated in the Family planning programnot solely because of personal desire but to meet the expectations of society, family, health workers, and the surrounding community. Mila and Sinta, the two informants, shared similar experiences, stating that they joined the Family planning program due to pressure from their parents or because they had young children who were not yet ready to be left behind. This indicates that decisions regarding the Family planning programare often not purely individual but rather a form of adaptation to strong social norms.

From interviews with seven informants, it appears that young coastal women do not have complete control over their bodies and reproductive decisions, including the decision to use the Family planning program. Although some stated that they made the decision themselves, it was always accompanied by their husband's approval, fear of other methods, and social expectations that remained the dominant factor. Additionally, women tend to tolerate the harmful physical and psychological side effects of contraception, while alternatives such as male family planning programs are considered unsuitable or too "risky" for men. This reflects how family planning programs are still implemented within unequal power relations.

Based on the overall results described above, the author acknowledges that limitations still need to be considered. One of these is the study's limited scope, which focused on women living in coastal areas with specific cultural backgrounds who may have different views on gender roles and reproductive decisions. The number of informants was also limited to only seven individuals. This naturally affects the generalizability of the study's findings to a broader population. Additionally, the interview method used in this study may also introduce bias, particularly regarding sensitivity to topics related to sexuality and reproductive health. Therefore, the results primarily reflect the perspectives of informants willing to discuss their experiences openly.

In the future, the scope of the research should be expanded to include more diverse areas, including an increase in the number of informants interviewed. This can be done using a mixed-method approach that combines in-depth interviews with quantitative surveys to obtain a more comprehensive picture of the social, economic, and cultural influences on family planning program decisions and measure the extent of men's role in making those decisions.

**Discussion**

1. Pseudo-Reproductive Autonomy: "Independent" Decisions That Are Still Based on Consent

The results of the study show that decisions regarding contraceptive use by women are not entirely free and autonomous. Most informants stated that they chose the type of family planning program themselves, but in the process, they still had to obtain their husband's consent or follow the advice of their parents and health workers. This indicates that women's reproductive autonomy remains under the control of patriarchal power structures. Even when decisions appear to originate from the individual, women must consult with their partners or other parties around them first. This condition reflects the existence of pseudo-reproductive autonomy. This is reinforced by Udasmoro's (2004) opinion, which emphasizes that family planning programs are not only considered the responsibility of individuals or couples but also the responsibility of the state and its agents to implement them across all levels of society. National interests in development and nationalism are said to succeed because women achieve them by becoming participants in the Family planning program.

The research findings used in this paper confirm that women's bodies are not only confined to the domestic sphere and personal relationships but also become objects of state policy. Family planning programs cannot be separated from national development projects that position women as the primary implementers. Here, women's bodies become the focal point of state policy in controlling the population, while husbands and the state are in a controlling position. In his book The History of Sexuality, Foucault (1978) states that sexuality is no longer a phenomenon that must be avoided, punished, or tolerated. Instead, sexuality is a phenomenon organized within a specific system. The government must control the population, bodies, and reproduction by establishing a bio-power to achieve its goals (Foucault, 1978).

Foucault's concept of biopower reinforces the analysis that women's bodies are regulated through health and development policy systems (Al Syahrin et al., 2020). Through family planning programs, the state advises and creates technical and social mechanisms to regulate how and when women can become pregnant. Interviews with informants in this study show that although the state does not explicitly force women to participate in family planning programs, women feel they "must" participate due to social pressure, parental orders, or health worker recommendations.

As Suryakusuma (2011) outlined, State Motherhood's concept describes how the state, particularly during the New Order era, shaped and regulated women's roles as the ideal 'wife and mother.' In this role, women were primarily positioned within the domestic sphere to support social stability and national development. This is evident through organizations formed by the government, such as Pemberdayaan dan Kesejahteraan Keluarga (Family Empowerment and Welfare) and Dharma

Wanita. Through these activities, women were domesticated and used as instruments of social reproduction that perpetuated the patriarchal structure of the state.

The concept of state feminism describes how the state shapes women as 'instruments of development' rather than autonomous individuals. Through family planning programs, women are encouraged to control the number of children they have to create prosperous families. This shows that women's bodies are regulated by the state's development agenda (Mulyani, 2018). In the context of using the Family planning program, this can influence women's choices regarding using the Family planning program. The choice for the Family planning program is often not a personal decision but is influenced by the husband's decision. Additionally, it is also influenced by the state through PKK cadres, health workers, and the media.

Besides state factors, decisions regarding the Family planning program use are also shaped by cultural norms, religion, and power dynamics within the household. In interviews, women indicated that the choice of Family planning program is often based on parental advice, assumptions about the "pity" of husbands if men carry out Family planning program, and fear of alternative Family planning program. Even when experiencing side effects, such as hormonal changes, fatigue, acne, or drastic weight gain or loss, women continue to use medical Family planning programs without considering other options for their male partners.

The findings of this study are supported by the opinions of Setiadi and Iswanto (2015), who revealed that the decision to use contraceptives is not only influenced by individual characteristics, family, or resources but also by religion and customs, given that Indonesia has a diverse religious and cultural background. For example, the decision to use contraception by wives is often influenced by their husbands. This aligns with the views of Mulyana and Hasanah (2017), who noted that women's participation in family planning programs is often determined by their husbands (men).

Based on this explanation and the data used, it can be seen that the informants' informants' decision to use family planning programs shows a power relationship within the household, which means that women's decisions regarding their bodies must be negotiated. This reinforces the view that although the Family planning program is presented as a reproductive right, this right can only be exercised with the permission or support of the male head of the household.

This aligns with the research by Mboane and Bhatta (2015), which found a significant influence between a husband's or partner's decision-making and a woman's intention to use contraception, particularly in rural areas. This is reinforced by research (Dehlendorf et al., 2017) stating that women who discuss contraceptive methods with their partners for joint decision-making are more satisfied with the contraceptive method used. This explanation emphasizes the importance of equal involvement of partners in contraceptive decisions. However, in the case of the research informants, the 'discussions' that took place were not always equal. Instead, they served as confirmation or validation of decisions that women should be able to make on their own. Thus, women's reproductive autonomy is still limited by patriarchal power structures, both within families and in state policies.

2. Side Effects as a Burden on Women

Globally, contraceptive use has become a common practice among women of reproductive age. Khatimah et al. (2022) revealed that in 2019, there were 1.1 billion women of reproductive age (15–49 years) worldwide with family planning needs. Of this number, 842 million women used modern contraceptive methods, and 80 million women used traditional contraceptives. This data shows that family planning programs are a local issue and a global reproductive health policy. However, despite the widespread use of contraceptives, women's experiences with contraceptive side effects are often overlooked, including in Indonesia.

Based on field findings, most informants in this study use the injectable family planning (FP) method, which, although considered practical, affordable, and easily accessible, has significant side effects on their bodies. Many of them complain of physical changes such as weight gain or loss, acne,

dark spots, irregular menstruation, and prolonged fatigue and lethargy. These findings align with what Fitriyani (2016) explained, that women are naturally capable of becoming pregnant and giving birth, making them the primary target for contraceptive use compared to men. Additionally, contraceptives available in the community are more frequently used by women than men.

In terms of accessibility, injectable contraceptives are the primary choice for women, especially those who are unemployed or economically disadvantaged. This is because the Family Planning (FP) injection program is more accessible and available free of charge in health services. Handayani and Rianti (2021) mention that injectable contraceptives are a method of preventing pregnancy through hormonal injections. Hormonal contraception in the form of the Family planning program injection program is increasingly used in Indonesia because it is effective, practical, relatively inexpensive, and safe. Mothers who are not working and have limited economic conditions tend to choose injectable contraception because it is easier and cheaper to obtain, especially since there are free services from health facilities for users of injectable contraception.

However, the side effects of contraception are often not taken seriously. This finding is reinforced by Fitriyani (2016), who asserts that women who participate in family planning programs have unpleasant experiences and feel uncomfortable due to various side effects from using contraceptives, which are immediately apparent from changes in their bodies. What is important when women (wives) feel uncomfortable with the effects of contraceptive use is whether or not their husbands are involved in the decision to participate in the Family planning program. Husband involvement in the Family planning program remains very low.

In some cases, husbands even object to these side effects. Nuryana et al. (2023) revealed that most women acknowledge the use of short-term contraceptive methods such as pills and injections to cause headaches and feelings of weakness when taking the pills, while the side effects of injections include weight gain and irregular menstruation. This also leads husbands to oppose the use of contraceptives, as they are concerned about the side effects and dislike the idea of their wives gaining weight. Some men also state that they know little about other contraceptive methods.

Furthermore, the side effects that arise are often viewed as suffering that women must endure as part of the consequences of participating in the Family planning program. This explanation can be found in Fitriyani's (2016) perspective, which states that the emergence of side effects from various types of contraceptives is due to the lack of detailed information provided by family planning or health service providers in rural areas, leading women (wives) to perceive these effects as suffering and consequences that women must endure. If women have sufficient knowledge, there will be no excessive worry that causes stress.

This is also in line with the opinion of Setiadi and Iswanto (2015), who state that decisions to use contraceptives that are not made voluntarily, coupled with limited information, lead to incompatibility with the contraceptives used, especially concerns about health risks. This situation shows that women not only bear the biological effects of contraceptives but also the psychological burden due to lack of information and minimal involvement of their partners.

Criticism of the global contraceptive system for being insensitive to women's experiences was also raised by Hardon (1994), who stated that: "The process of developing contraceptives through clinical trials is also poorly equipped to identify and evaluate the extent of side effects that women in trials do experience (Hardon, 1992). Menstrual disturbances, mood changes, weight gain, headaches, or dizziness are often dismissed as minor or not clinically relevant" (Hardon, 1994). This statement makes it clear that even in a global context, women's experiences with their bodies in the use of contraceptives are often ignored by medical institutions and policymakers. Women's voices and experiences are not considered important enough to influence the development of safe and comfortable contraceptive technology.

3. Lack of Male Participation and Maintained Masculinity

One of the main findings of this study is the lack of male participation in family planning programs. Fitriyani (2016) states that reproductive functions are the responsibility of women. This is reflected in the attitude of less involved men in the reproductive system. Women are also seen as beings who can continue the lineage through reproductive functions because humans are in the womb before birth. This is why women are expected to bear the responsibility in a population explosion.

This concept aligns with the perspective (Udasmoro, 2004) that women are seen as occupying private roles related to household matters, child-rearing, and family. Women are automatically considered to have the responsibility to manage their reproductive affairs, which is a collective symbolism of women's private aspects. Meanwhile, men who occupy the public sector are automatically not considered to have obligations related to reproduction, which is more of a private matter.

Fitriyani (2016) also highlights how society only understands that the purpose of family planning using contraceptives is to improve the welfare of society without realizing the inequality between men and women. Women, who are the owners of the womb, are responsible for their reproductive functions without realizing that this is a shared responsibility between husband and wife. Furthermore, the contraceptives available to the public are primarily intended for women and suitable for women, without providing many options or opportunities for men to participate in the decision actively.

This is emphasized by the opinion of Mulyana and Hasanah (2017), who mention the limited availability of modern contraceptives for men, which causes many men to be reluctant to participate in family planning programs. Similarly, traditional contraceptives are also perceived as inconvenient and disruptive to comfort; furthermore, the strong influence of patriarchal culture in society positions men as leaders. Men's authority as heads of households allows them to freely determine the direction and goals for themselves and their families. Women, as part of the family, must submit to men. As a result, in family planning programs, men often designate women to participate in the program instead of themselves.

4. Contraception as a Social Instrument, Not Just a Medical One

The decision to participate in family planning programs and choose a type of contraception is often seen as the responsibility of individual women. However, contraception should be seen as a joint decision between husband and wife, given that both share responsibility for the reproductive health of the family. Therefore, there needs to be a broader understanding of how this decision should be made jointly and not unilaterally by one party.

Fitriyani (2016) states that the choice of contraceptive method or participation in family planning programs is a shared responsibility between husband and wife, as the use of contraception is a shared need between the two. As a complete family, men and women must make decisions and take responsibility for their reproductive health; in other words, the rights and obligations of husbands and wives to participate in family planning are the same, not to cause discrimination and inequality in roles and responsibilities within the family. Discussing with one's partner and family at least provides a general idea or temporary choice regarding the contraceptive method to be used. This is important to note because decisions regarding family planning, particularly contraception, should not only involve women in a subordinate position but must be a shared responsibility equal to that of the husband. Through this approach, active participation from both parties in the family can support equality in decision-making.

In discussions about participation in family planning programs, attention is often focused on the role of women. At the same time, it is often forgotten that the success of these programs also depends heavily on family support, especially from husbands. Family involvement in family planning program decisions is important so that women's participation is not seen merely as an obligation but as a joint effort that benefits the entire family.

Mulyana and Hasanah (2017) state that the success of the Family planning program is highly dependent on community participation. A high level of community participation in the Family planning program is expected to achieve the objectives of the Family planning program. One indicator of the success of the Family Family planning program is a decrease in population growth rates. Additionally, it is explained that other family members must support women's participation in the Family Planning Program. Women's participation in the Family planning program should not be merely forced participation due to women's subordinate status within the family and power imbalances. Women's participation in the Family Planning program should instead catalyze to enhance women's empowerment in making decisions for themselves and their families (Setiawan, 2023). Therefore, women's participation in the Family Planning program is closely linked to women's empowerment in two ways: first, women, in this case wives, should become more empowered after participating in the Family Planning program. Women's participation and choice of contraception should be a joint decision between husband and wife.

From this explanation, it is important to emphasize that decisions regarding family planning and active participation in this program are not only the responsibility or obligation of women but should also involve husbands as part of the decision-making process (Nurhayati & Widanti, 2013). Decision-making based on joint discussion will empower women more, ultimately reducing power imbalances within the family. Along with the understanding that the Family planning program should be a shared responsibility between husband and wife, the understanding of women's reproductive rights is equally important. The use of contraception is not only a matter of individual choice but also includes women's right to make decisions about their bodies without coercion (Aldila & Damayanti, 2019). It is increasingly important to consider ensuring that women can exercise their rights over their bodies by human rights principles.

BKKBN and UNFPA (2012) explain that the right to family planning is not just about the use of contraceptive methods. It concerns how a person, especially women, can exercise their rights over their bodies and make decisions such as when to start having sex, when and with whom to marry, when is the right time to have children, how many children they want, and how far apart the births should be. The family planning approach from a rights-based perspective places women at the centre of decision-making regarding their health.

In addition, BKKBN and UNFPA (2012) also revealed that there is a Law on Human Rights (Law No. 7 of 1984) and a new Health Law (Law No. 36 of 2009). In the articles on family planning, it is stated that everyone has the right to choose their method of contraception without coercion and that each choice will be tailored to the health condition of each individual. Another point mentioned in the article is that a husband should support his wife and participate in family planning programs, including using contraception for men. Understanding women's reproductive rights is closely related to state policies and social norms that should give women the space to make decisions freely, including choosing a contraceptive method that suits their health and preferences. Thus, husbands' involvement in supporting this right is significant, especially in the context of family planning programs.

Referring to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979), which was ratified by Indonesia in 1984, it emphasizes the importance of equality in health services, including family planning services. Article 12(1) states: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, based on equality of men and women, access to health care services, including those related to family planning." Through CEDAW, a legal basis has been established that affirms that the state is obliged to ensure that women have the same rights in accessing family planning (FP) services without discrimination based on gender. This legal guarantee must be part of implementing policies ensuring equal family planning access.

Although decisions regarding contraception should be a shared right between husband and wife, social reality often shows that women remain the primary subjects in reproductive regulation, which in

many ways is driven by social norms and state policies. Gender and existing social norms clearly influence who is considered responsible for decisions regarding contraception, as well as who has complete control over their bodies in terms of reproduction (Rochimah et al., 2023).

Butler (1990) states that gender is not an innate identity but a series of socially repeated actions. In the context of the Family planning program, this explains why women continue to be placed as the primary subjects in reproduction and contraception, a construction regulated and maintained by social norms and state policies. Women's bodies become a field of power where these norms operate, as Butler (1993) emphasizes, that bodies are shaped through discourse and power relations, not merely biological entities. Thus, the social construction of gender that defines women as more responsible for reproductive issues contradicts international commitments that demand equality in access to health, including in matters of family planning decisions. Existing state policies and social norms often do not align with the principles of human rights guaranteed by international conventions, which should provide space for women to make reproductive decisions more freely.

## CONCLUSION

This study examines women's decision-making in using contraceptives, as well as the factors that influence their reproductive autonomy, with a focus on the role of husbands, the state, cultural norms, and contraceptive side effects. Based on the findings of the study, it can be concluded that although the decision to choose contraceptives is nominally recognized as a woman's right, in reality, this decision is still heavily influenced by patriarchal power structures. In many cases, even though women feel they have freedom of choice, these decisions often still require the approval of their husbands or are influenced by prevailing cultural and social norms, as well as recommendations from the state through health cadres or family planning programs. Therefore, women's reproductive autonomy is still hindered by the control and influence of other parties, both from the family and the state.

Additionally, the side effects of contraception experienced by women become an additional burden, both physically and psychologically. Many women experience discomfort due to the use of family planning (FP) methods, but they lack adequate alternatives or spousal support to address these issues. The reliance on contraceptive methods that involve women more extensively indicates that men's participation in reproductive planning is minimal. At the same time, masculinity and social norms place women as the sole party responsible for family reproduction. This further reinforces inequality in decision-making regarding family planning.

Decisions regarding contraceptive use should be viewed as a shared responsibility between husband and wife. However, the husband's role is often limited to confirmation or approval rather than being an equal partner in decision-making. Therefore, society and state policies need to encourage men's active participation in family planning programs and ensure that these decisions are made jointly and equally, without gender-based discrimination.

### Recommendations

Based on the findings of this study, several recommendations for further research and policy implementation are as follows. It is recommended that further research be conducted to identify the role of husbands in contraceptive decision-making, as well as the social and psychological impacts experienced by women related to contraceptive side effects. In addition, there needs to be an in-depth study of the role of the state in facilitating policies that are more supportive of women's reproductive autonomy. Furthermore, regular education and socialization must be carried out. In this case, it is essential to improve women's and men's education and socialization programs related to reproductive rights to reduce inequality in family planning decision-making. This will help build public awareness of the importance of involving both parties in determining the appropriate contraceptive method.

Male involvement is also needed through family planning programs that are designed to be more inclusive, emphasizing the active role of men in decisions regarding reproductive health. The state

needs to provide equal access to contraceptive methods for men and eliminate the stigma surrounding masculinity that prevents them from participating more in family planning programs. Additionally, improvements in health policies are needed. In this regard, the government and relevant institutions must address the often-overlooked side effects of contraceptives and ensure clear and comprehensive information about their use. A rights-based approach to reproductive health should be applied, giving women the freedom to choose contraceptive methods that suit their health conditions. Ultimately, this research contributes to understanding how social, cultural, and state policy factors influence women's reproductive autonomy and provides important insights into the need for changes in family planning policies that are more oriented toward gender equality and human rights.

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