OIKOS : Jurnal Ekonomi, Manajemen, dan Bisnis
P-ISSN : 1979-4770

Decision-Making Power and Reproductive Health Access Among Indonesian Women

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Abstract

Indonesian women's access to reproductive health services is deeply influenced by their decision-making power within households. This study investigates the intersection of intra-household authority, socio-cultural dynamics, and institutional support in shaping reproductive autonomy. Drawing on qualitative data and theoretical frameworks of empowerment and intersectionality, the findings show that patriarchal norms, economic dependency, and regional disparities significantly restrict women's health-related agency. Even where healthcare services are accessible, cultural and religious expectations often inhibit utilization. Furthermore, national health policies, though expansive in scope, fall short of addressing the relational barriers women face at the household level. The study emphasizes the need for gender-transformative policies and community engagement strategies that involve men, address local norms, and institutionalize empowerment. By contextualizing global empowerment theories within Indonesia's plural society, this research offers actionable insights to enhance reproductive justice and promote inclusive, region-sensitive health reforms.

Keywords

women's empowerment; household decision-making; reproductive health; gender and development; Indonesia

INTRODUCTION

Women's access to reproductive health services is a cornerstone of sustainable development, gender equality, and human rights. Globally, reproductive autonomy enhances women's physical well-being, socio-economic status, and family health outcomes (World Health Organization, 2015). In developing countries, including Indonesia, access to reproductive healthcare remains uneven due to structural, cultural, and economic barriers (UNFPA, 2016). Despite national commitments to maternal health under the Sustainable Development Goals (SDGs), Indonesia continues to report regional disparities in reproductive health access, with rural and marginalized

communities being disproportionately affected (BPS–Statistics Indonesia, 2015). These challenges are intricately tied to gender norms and the social structures that limit women's participation in decision-making both within households and in the public domain (Kabeer, 1999).

Scholars have increasingly turned attention to the concept of women's decision-making power as a determinant of reproductive health outcomes. Women's ability to make informed choices regarding contraception, prenatal care, and birth planning is directly associated with improved maternal health and lower child mortality (Jejeebhoy, 1995; Bloom, Wypij, & Gupta, 2001). However, in Indonesia, such autonomy is often constrained by patriarchal traditions, religious interpretations, and socio-cultural expectations (Bennett, 2005, p. 112). The persistent influence of gendered power relations within households has been shown to limit women's access to information, financial resources, and freedom of movement, all of which are essential for reproductive health access (Achmad, 2011, p. 89). Consequently, evaluating decision-making power provides a critical lens through which to assess reproductive health disparities.

Theoretically, empowerment frameworks offer valuable tools to analyze these dynamics. Kabeer's (1999) model, emphasizing resources, agency, and achievements, has been widely applied to explore how structural inequalities impact women's autonomy. In parallel, Sen's (1999) capabilities approach underscores the significance of expanding freedoms as both the means and end of development. These perspectives align with empirical evidence suggesting that education, economic participation, and spousal communication enhance women's reproductive agency (Caldwell & Caldwell, 1987; Dyson & Moore, 1983). Nevertheless, there remains a lack of localized studies that investigate how these global theories interact with Indonesia's unique socio-religious context. For example, Islamic teachings, local adat traditions, and national family planning policies may simultaneously empower and constrain women's choices (Robinson, 2009, p. 43).

Existing literature has addressed various aspects of reproductive health, including service provision, maternal mortality, and contraceptive use. Yet, few studies comprehensively examine the intersection of decision-making power and reproductive health access from a socio-cultural perspective within Indonesia. This omission represents a significant research gap, particularly given Indonesia's decentralized governance system and diversity of local norms (Bappenas, 2016). Understanding how decision-making operates at the household level—and how it affects women's ability to engage with healthcare systems—offers critical insights for policymakers and health practitioners. Addressing this gap requires an integrative approach that considers both the structural and cultural dimensions influencing reproductive autonomy.

This study, therefore, investigates how Indonesian women's decision-making power influences their access to reproductive health services. The central research questions guiding this inquiry are: (1) How does intra-household decision-making affect women's ability to access reproductive healthcare in Indonesia? (2) What socio-cultural and economic factors shape this decision-making process? (3) How can institutional and policy frameworks better support women's reproductive autonomy? By examining these questions, the study aims to contribute a nuanced understanding of the barriers and enablers of reproductive health access in Indonesia. The research is significant not only for advancing academic discourse but also for informing equitable health interventions and gender-sensitive policies in the Indonesian context.

LITERATURE REVIEW

Reproductive health has been extensively studied as a pivotal component of women's rights and development, with access often framed through the lens of empowerment and socio-economic equity. Globally, the World Health Organization (2015) defines reproductive health as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system. Studies have demonstrated that autonomy in reproductive decision-making is linked with higher contraceptive use, lower maternal mortality, and improved neonatal outcomes (Bloom et al., 2001).

In the Southeast Asian context, including Indonesia, this discourse is further complicated by the intersection of tradition, religion, and public health policy. Research by Jejeebhoy (1995) and Caldwell and Caldwell (1987) has emphasized that while service availability is necessary, women's control over reproductive choices is equally vital. These findings highlight that the accessibility of healthcare services must be analyzed alongside the social structures that determine whether women can utilize them.

Several frameworks have emerged to conceptualize women's empowerment in health, most notably Kabeer's (1999) model which posits that empowerment encompasses resources, agency, and achievements. This approach has been instrumental in studies assessing women's reproductive autonomy in Asia and Africa. Scholars such as Sen (1999) and Malhotra et al. (2002) have further refined these frameworks by incorporating education, spousal negotiation, and economic status as key empowerment indicators.

Within the Indonesian context, researchers like Bennett (2005, p. 102) and Robinson (2009, p. 45) have examined how religious interpretations and local customs shape women's health choices, revealing complex layers of enabling and constraining factors. Although these works have illuminated crucial aspects of reproductive decision-

making, few have explicitly connected intra-household power dynamics with access to services, indicating a gap in culturally sensitive, context-specific analyses.

Furthermore, empirical studies in Indonesia often emphasize family planning policy outcomes without adequately exploring the lived experiences of women navigating these systems. Bappenas (2016) underscores the necessity of localizing reproductive health programs to reflect regional diversity and household-level variation in gender norms. Studies published in Sinta-Garuda indexed journals echo these concerns, arguing for an integrative approach that combines policy analysis with sociological inquiry. For instance, Achmad (2011, p. 91) critiques the centralization of health messaging that ignores the variability of women's empowerment across provinces. Thus, while the literature provides a solid theoretical and empirical foundation, a critical need remains for focused research that investigates the link between decision-making power and access to reproductive health within Indonesia's pluralistic social fabric.

Theoretical Framework

The concept of women's empowerment lies at the heart of analyzing reproductive health access, particularly in the context of decision-making within patriarchal societies. Naila Kabeer's (1999) empowerment framework is foundational in this regard, comprising three core dimensions: resources, agency, and achievements. Resources encompass material, human, and social assets that enhance women's capacity for decision-making; agency refers to the ability to define and pursue goals, and achievements denote realized outcomes in line with women's interests. Applied to reproductive health, this framework enables a comprehensive analysis of how structural constraints—such as income inequality, education gaps, and sociocultural expectations—interact with women's autonomy. Numerous studies have operationalized this model in both global and Indonesian contexts to assess women's reproductive choices (Malhotra et al., 2002; Bennett, 2005, p. 96).

Complementing Kabeer's framework is Amartya Sen's (1999) capabilities approach, which frames empowerment as the expansion of individuals' real freedoms to lead the lives they value. Within reproductive health, capabilities refer to the extent to which women are able to access contraceptives, make informed health decisions, and receive maternal care free from coercion or dependency. Sen's model emphasizes not only access to healthcare services but also the social conditions that enable or inhibit the utilization of these services. This perspective is particularly relevant to Indonesia, where gender norms and local customs may formally permit access but subtly undermine utilization (Robinson, 2009, p. 49). As such, the capabilities approach provides an

evaluative lens through which women's real opportunities to achieve reproductive health outcomes can be assessed beyond formal entitlements.

Another pertinent framework is the Gender and Development (GAD) paradigm, which critiques the limitations of Women in Development (WID) approaches that focus narrowly on service provision. GAD emphasizes relational power structures, advocating for systemic change to address the root causes of gender inequality (Moser, 1993, p. 25). In the Indonesian context, GAD helps explain how institutional arrangements—such as healthcare policies, religious interpretations, and familial hierarchies—reinforce gendered constraints on reproductive decision-making. For instance, Achmad (2011, p. 90) found that women in rural communities often defer to male relatives in health matters, despite policy frameworks that guarantee equal access. This indicates the importance of evaluating both formal structures and informal norms through a gender-relational lens.

Intersectionality theory also offers valuable insights into how multiple forms of discrimination—such as gender, class, religion, and geography—interact to shape women's reproductive experiences. Originally conceptualized by Crenshaw (1991), this approach underscores that women do not experience oppression uniformly. In Indonesia, women from poor households, minority ethnic groups, or remote regions often face layered barriers to reproductive health (UNFPA, 2016). Intersectionality, therefore, enables the study to move beyond one-dimensional analyses and consider the compound effects of socio-economic status and cultural diversity. This theoretical inclusion ensures that the study is sensitive to the heterogeneity of Indonesian women's experiences.

Together, these frameworks provide a multidimensional analytical foundation for this study. Kabeer's and Sen's models articulate the individual and structural dimensions of empowerment; the GAD paradigm explains institutional influences; and intersectionality brings attention to the diversity of women's experiences. Applying these theories enables a nuanced interpretation of how decision-making power affects reproductive health access in Indonesia, positioning the study to bridge theoretical models with empirical realities.

PREVIOUS RESEARCH

One of the earliest influential studies on women's reproductive autonomy was conducted by Dyson and Moore (1983), who explored the relationship between women's status and fertility control in South Asia. They found that increased female autonomy was associated with higher contraceptive use and better maternal health outcomes. Although not Indonesia-specific, their work laid the groundwork for

understanding how decision-making within households impacts reproductive behavior. This conceptual link between status and health continues to inform contemporary research globally.

Jejeebhoy (1995) extended this discourse by conducting a cross-national analysis across Asia and sub-Saharan Africa, emphasizing how education and spousal communication affect women's health-seeking behaviors. Her study concluded that even when healthcare services are physically available, women's autonomy is a crucial determinant of service utilization. The relevance of this research to Indonesia lies in its empirical demonstration that access is not merely about infrastructure but also about intra-household dynamics—an idea central to the current study.

Bloom, Wypij, and Gupta (2001) offered a more focused analysis using household survey data in North India. They found that women's involvement in household decisions significantly predicted antenatal care use. This finding parallels issues in Indonesia, where many women still rely on spousal or familial approval before accessing healthcare (Bennett, 2005, p. 105). Their quantitative method provides a methodological anchor for studies that seek to correlate empowerment with service utilization.

Bennett (2005), in her ethnographic work in Indonesia, investigated how religious and cultural narratives influence women's reproductive roles. She noted that religious interpretations often framed women's reproductive duties as divine obligations, which could either empower or limit them depending on the local context (p. 102). Her findings emphasized the need for culturally contextualized frameworks that move beyond generalized theories of empowerment, especially in pluralistic societies like Indonesia.

Robinson (2009) focused on Indonesia's decentralized health governance system and its implications for family planning initiatives. She found that local policies often reflected regional interpretations of religious norms, which affected how reproductive services were delivered and received (p. 48). Her study adds a policy dimension to the empowerment discourse, showing how local governance structures can mediate access to reproductive services. This insight is crucial for understanding institutional variations within the Indonesian archipelago.

Achmad (2011) conducted a localized case study on reproductive decision-making in Sulawesi. She found that economic dependency and customary law constrained women's ability to make autonomous health decisions, despite national-level policies guaranteeing access (p. 91). Her work highlights the disjuncture between formal rights and lived realities, a gap that this study seeks to further investigate by connecting household-level decision-making to health access across broader cultural settings.

Despite these contributions, there remains a critical research gap: while many studies have examined empowerment or reproductive health in isolation, few have investigated the direct intersection of household decision-making power and access to reproductive services within Indonesia's diverse socio-cultural landscape. Most studies either generalize empowerment without situating it locally or focus on service delivery without analyzing intra-household dynamics. This study addresses that gap by integrating theoretical models with localized socio-cultural analysis to explore how decision-making power influences women's reproductive health access across different regions of Indonesia.

RESEARCH METHODS

This study utilizes qualitative data in the form of textual and document-based materials, allowing for a deep exploration of complex social dynamics surrounding decision-making and reproductive health. Rather than numerical datasets, the study draws on empirical findings, policy documents, academic literature, and ethnographic accounts to analyze the nuances of empowerment and access. Such qualitative data are instrumental in understanding the meanings, interpretations, and lived experiences of Indonesian women in diverse socio-cultural settings. According to Silverman (2013, p. 112), qualitative data offer rich, contextualized insights that are often missed in quantitative surveys, particularly when analyzing gender norms and decision-making within households.

The primary sources of data in this study include peer-reviewed international journals, Sinta-Garuda indexed Indonesian articles, books, theses, and official government and institutional reports. These sources provide reliable, traceable, and context-specific information necessary to investigate both theoretical and empirical dimensions of the research problem. As highlighted by Creswell (2014, p. 186), drawing from diverse, reputable sources enhances the credibility and transferability of qualitative research. Indonesian governmental publications such as BPS–Statistics Indonesia and Bappenas documents supplement the academic literature by offering policy-level and regional insights into reproductive health infrastructure and gender-based development indicators.

Data were collected using document analysis and literature review methods. Document analysis involves systematically reviewing existing texts to identify patterns, relationships, and discursive themes relevant to the research questions (Bowen, 2009). This method allows the researcher to critically engage with the underlying assumptions and narratives embedded in public policies, religious commentaries, and academic debates. Literature review, as a complementary technique, facilitates the synthesis of existing research to trace conceptual frameworks and empirical evidence over time

(Hart, 1998, p. 13). Together, these methods provide a comprehensive understanding of how decision-making and access to reproductive services are represented, enacted, and contested in Indonesia.

The data analysis technique employed is thematic analysis, which involves identifying, analyzing, and reporting patterns within the data. This method is particularly well-suited for research that aims to unpack social meanings and power relations embedded in everyday practices and institutional arrangements (Braun & Clarke, 2006). Themes were generated inductively and deductively, aligning with both the research questions and theoretical frameworks discussed earlier. This dual approach allows for both theory-driven interpretation and openness to emerging insights from localized contexts, enhancing the depth and relevance of findings (Patton, 2015, p. 128).

The process of conclusion drawing in this study involves interpreting thematic patterns in light of the theoretical models and empirical context, thereby connecting data to broader social and policy implications. Following Miles, Huberman, and Saldaña (2014, p. 276), conclusions were validated by triangulating multiple data sources and perspectives. The findings are not meant to provide statistically generalizable outcomes but rather to offer transferable insights into how women's reproductive agency is shaped within Indonesia's plural socio-cultural landscape. These synthesized conclusions aim to inform policy, academic inquiry, and programmatic design in the field of gender and health.

RESULTS AND DISCUSSION

This study draws upon the theoretical foundations established by Kabeer (1999), Sen (1999), and intersectional feminist perspectives to analyze the relationship between women's decision-making power and their access to reproductive health services in Indonesia. As demonstrated in earlier sections, these frameworks emphasize the role of agency, structure, and diversity in shaping women's lived experiences. Engaging with these perspectives allows the study to interpret findings not as isolated incidents but as reflections of broader socio-cultural and institutional dynamics. Moreover, the review of previous research, especially by Bloom et al. (2001), Bennett (2005, p. 102), and Achmad (2011, p. 91), highlighted the persistent barriers that prevent women from accessing healthcare despite policy improvements. This section now builds upon those insights to explore new interpretations derived from the analysis of qualitative data.

Expert perspectives analyzed during the document review revealed that while formal health infrastructure has expanded significantly in Indonesia since the 2000s, cultural norms remain a formidable barrier to reproductive autonomy. For instance, although

contraceptive services are available in both urban and rural clinics, uptake remains low in regions where women require spousal or familial approval to use them (Bappenas, 2016). This phenomenon underscores the relevance of Kabeer's concept of "agency" as more than formal permission—it reflects a woman's real capacity to act independently. Additionally, new literature emphasizes the compounding effect of religious leadership on reproductive choices, particularly in Java and Aceh, where *fatwa* and religious endorsement influence public behavior (Robinson, 2009, p. 49).

The findings of this study support the assertion that reproductive health access cannot be separated from intra-household dynamics and local power structures. The presence of health services does not guarantee equitable utilization unless women's decision-making roles within families are strengthened. For example, in regions like West Nusa Tenggara and Papua, local adat customs have been found to reinforce male-dominated decision-making, even in matters directly concerning women's bodies (BPS–Statistics Indonesia, 2015). This insight demonstrates the necessity of rethinking empowerment not only as institutional inclusion but also as everyday practice. The dialogue between theory and data further reveals how intersectional barriers—such as poverty, ethnicity, and education level—create layered disadvantages for Indonesian women, making a one-size-fits-all policy approach ineffective.

By bridging the theoretical and empirical gap, this study contributes an integrative framework that positions reproductive health within the context of socio-cultural negotiation and gendered power relations. The analysis now turns to the three core research questions posed earlier, each addressed in thematic subsections. The first thematic subsection explores the connection between intra-household decision-making and reproductive health access.

1. Intra-Household Decision-Making and Women's Access to Reproductive Health

This section addresses how intra-household decision-making affects women's ability to access reproductive healthcare in Indonesia. In many Indonesian households, reproductive health decisions—such as contraceptive use, childbirth planning, and antenatal care—are often made jointly or exclusively by male heads of families. As documented by Jejeebhoy (1995) and reaffirmed in Bloom et al. (2001), the absence of autonomous female decision-making correlates strongly with delayed or foregone health-seeking behaviors. In the Indonesian context, BPS–Statistics Indonesia (2015) found that 53% of married women reported needing their husband's approval before accessing family planning services. This statistic alone signals how domestic power dynamics create obstacles to timely and appropriate healthcare.

Theoretical models by Kabeer (1999) and Sen (1999) emphasize that empowerment is not merely the provision of choice, but the ability to make meaningful decisions. This conceptualization aligns with ethnographic evidence from Sulawesi and West Java, where women's participation in reproductive decisions was contingent on economic dependency and customary norms (Achmad, 2011, p. 89; Bennett, 2005, p. 104). In many cases, even when women expressed a desire to seek health services, fear of conflict, financial control by husbands, or deference to elders prevented them from doing so. These findings demonstrate that decision-making power must be understood relationally—embedded within familial expectations, religious prescriptions, and economic conditions.

Additionally, household power dynamics intersect with education and income, reinforcing inequality. Women with secondary or higher education were more likely to report active participation in health decisions, suggesting that education fosters not only awareness but confidence and bargaining power (UNFPA, 2016). Conversely, low-income women often lack both the information and authority to negotiate reproductive choices, especially in extended family households where elder males or mothers-in-law exert control. These structural limitations limit the effectiveness of public health campaigns that assume individual decision-making without considering family hierarchies (Caldwell & Caldwell, 1987).

Policy frameworks in Indonesia have acknowledged the importance of family planning and reproductive health but have yet to directly address intra-household power asymmetries. Bappenas (2016) reports that most health interventions target women as service recipients, not as autonomous decision-makers. This oversight risks reinforcing existing dependency structures rather than challenging them. Empowerment-based approaches that integrate household dynamics into policy design—such as involving male partners in reproductive education—may offer more transformative results. Such approaches are already being piloted in parts of Yogyakarta and Bali with promising outcomes (Robinson, 2009, p. 52).

Furthermore, religious interpretations significantly mediate decision-making authority. In Aceh, for example, religious leaders have issued local *fatwa* discouraging certain contraceptive methods, which restricts women's choices regardless of their personal preferences (Bennett, 2005, p. 115). These institutionalized norms reinforce male authority and limit women's control over their reproductive lives. The intersection of religious authority and household dynamics thus compounds the barriers to reproductive autonomy, particularly in communities where state and religion are deeply intertwined.

In summary, intra-household decision-making is a pivotal factor influencing women's access to reproductive healthcare in Indonesia. As the findings illustrate, autonomy is constrained not only by direct control but by a web of economic, cultural, and religious dependencies. Addressing these complexities requires shifting from service delivery models to empowerment-based frameworks that center women's lived realities. Only by understanding the household as a site of negotiation, power, and resistance can reproductive health interventions achieve their intended impact.

2. Socio-Cultural and Economic Determinants of Reproductive Decision-Making

This section addresses how socio-cultural and economic factors shape the decision-making processes of Indonesian women in relation to reproductive health. While health policies aim for universal access, socio-cultural expectations deeply influence whether women can utilize available services. In many Indonesian regions, traditional gender roles cast women primarily as caregivers and reproducers, limiting their scope of autonomy in health-related matters (Bennett, 2005, p. 106). These roles are reinforced by both religious and customary beliefs (*adat*) that prioritize familial consent, especially from husbands or in-laws, over women's individual agency. For example, in North Sumatra and West Nusa Tenggara, local customs often assign men the role of household decision-makers, a dynamic supported by religious interpretations and social norms (Robinson, 2009, p. 51).

Economic status also significantly affects reproductive decision-making power. Women from wealthier households tend to have better access to health information, transportation, and quality services, enabling greater control over reproductive choices (UNFPA, 2016). Conversely, women in low-income households often depend on male earners, which limits their bargaining power in household negotiations about health (Jejeebhoy, 1995). In contexts where health costs are perceived as secondary to daily survival, reproductive health is deprioritized. These economic constraints are exacerbated when women lack their own income or education, reinforcing the intersectional nature of vulnerability (Sen, 1999).

Education emerges as a transformative factor that mediates both cultural and economic constraints. Women with higher educational attainment exhibit more autonomy in reproductive decisions, are more likely to question traditional norms, and demonstrate greater engagement with healthcare services (Bloom et al., 2001). Education also fosters greater awareness of reproductive rights and

available services, allowing women to navigate complex cultural terrains more strategically. For instance, educated women in West Java have been found to actively negotiate with their spouses and in-laws about contraceptive use and childbirth preferences (Achmad, 2011, p. 92). This contrasts sharply with findings in less-educated populations, where decision-making remains primarily male-dominated.

Religious institutions and interpretations further complicate women's reproductive autonomy. While Islam as practiced in Indonesia often emphasizes family welfare, its interpretations vary significantly across regions. In Aceh, for example, local *ulama* influence health behaviors through religious decrees, discouraging certain modern contraceptive methods and reinforcing male authority (Bennett, 2005, p. 115). These religious barriers can outweigh formal policy entitlements, especially when women internalize these teachings as moral obligations. However, in other regions like Central Java, progressive Islamic leaders have worked collaboratively with NGOs to promote reproductive rights as part of Islamic ethics, showing that religious engagement can either constrain or enable agency depending on interpretation (Robinson, 2009, p. 54).

Family structures also play a vital role. In extended households, especially in rural areas, elderly relatives often exert significant influence on young couples' reproductive decisions (Bappenas, 2016). Young brides may find themselves at the bottom of a decision-making hierarchy, unable to voice preferences even about their own health. These dynamics are not limited to tradition but are perpetuated by economic reliance and lack of intergenerational dialogue on gender roles. Thus, socio-cultural factors not only shape the norms but institutionalize them within family life, making change difficult without systemic intervention.

In conclusion, socio-cultural and economic factors deeply entrench gendered decision-making hierarchies that limit women's access to reproductive health services in Indonesia. These influences are layered and intersecting—religion, education, income, and family roles all interact to either enable or inhibit agency. The findings suggest that effective reproductive health policy must go beyond service delivery and address these embedded social determinants through education, community dialogue, and economic empowerment programs. Structural change, combined with cultural sensitivity, is essential for fostering meaningful reproductive autonomy among Indonesian women.

3. Institutional and Policy Support for Women's Reproductive Autonomy

This section addresses how institutional and policy frameworks can better support Indonesian women's reproductive autonomy. Despite policy strides under Indonesia's national family planning programs and maternal health initiatives, structural gaps remain in addressing the core issue of women's agency. Indonesia's decentralized governance system, while enabling regional autonomy, has also led to disparities in health service delivery and the inconsistent implementation of gender-sensitive policies (Robinson, 2009, p. 47). For example, while Java and Bali have more integrated health systems and outreach programs, provinces such as Maluku and Papua still face logistical, cultural, and infrastructural barriers that inhibit access and autonomous decision-making (BPS–Statistics Indonesia, 2015). These disparities underscore the urgent need for coordinated institutional strategies that go beyond quantitative service provision to target qualitative empowerment outcomes.

Governmental frameworks such as the National Medium-Term Development Plan (RPJMN) emphasize maternal health, but often overlook intra-household power dynamics that affect access (Bappenas, 2016). Programs tend to be women-centered in name but do not challenge patriarchal norms embedded in service delivery or provider attitudes. For example, reproductive counseling sessions are typically designed for women alone, excluding men from dialogues that could foster shared responsibility and shift gender norms. This approach fails to recognize that in many Indonesian communities, male consent or support remains a critical gatekeeper to women's healthcare choices (Achmad, 2011, p. 90). Thus, without involving men in educational outreach and community engagement, such policies risk reinforcing the very dynamics they intend to dismantle.

One promising approach is the integration of gender-transformative strategies into public health policy. These strategies aim to change the power imbalances by actively engaging both men and women in the process of challenging gender roles and inequalities (Malhotra et al., 2002). For instance, community programs that involve religious leaders and male household heads have shown to be effective in promoting contraceptive use and dismantling myths around reproductive health. In Yogyakarta, such programs led to measurable shifts in men's attitudes toward joint reproductive decision-making, improving women's access to family planning services (Robinson, 2009, p. 53). These case studies demonstrate that policy effectiveness hinges not just on service availability but on shifting the social conditions under which decisions are made.

Health workers and local authorities also play a pivotal role in supporting reproductive autonomy. Studies have found that provider bias and lack of training on gender-sensitive approaches can discourage women from expressing their health needs or preferences (Bloom et al., 2001). For example,

midwives in rural Sulawesi often prioritized the opinions of male family members over the woman in question during antenatal visits, a practice normalized by both tradition and professional culture (Bennett, 2005, p. 114). Thus, institutional reforms must include professional development modules that equip health workers to recognize and support women's agency rather than undermine it. Health service environments must be redesigned to facilitate confidential, woman-centered care that respects autonomy.

Another institutional pathway is through education policy, particularly reproductive health education in schools. When girls are educated about their reproductive rights, bodily autonomy, and health options early on, they are more likely to assert control over their health choices as adults (Caldwell & Caldwell, 1987). However, reproductive health curricula in Indonesian schools remain inconsistent and often avoid direct discussions on agency or contraception, due to socio-religious sensitivities. Including comprehensive, rights-based reproductive education—aligned with Indonesia's own commitment to gender equality—could help foster a new generation of empowered women and supportive men. Such systemic integration can reinforce autonomy before women are placed in vulnerable marital or familial settings.

In summary, institutional and policy support for reproductive autonomy must go beyond infrastructure and outreach. Empowerment must be institutionalized within health systems, educational programs, and community initiatives that engage both women and men. Indonesia's complex socio-cultural landscape demands that policies be localized and adaptive, yet grounded in principles of gender equality and agency. Without confronting the normative and relational structures that govern women's health decisions, reproductive autonomy will remain aspirational rather than actionable.

This study set out to examine how Indonesian women's decision-making power influences their access to reproductive health services, with attention to the socio-cultural and institutional dynamics that mediate this relationship. The findings from the Results and Discussion section offer a comprehensive answer to the three research questions posed in the Introduction, revealing significant insights into the structural and relational barriers that shape women's reproductive experiences in Indonesia.

First, the study found that intra-household decision-making power is central to women's ability to access reproductive healthcare. When women lack authority within the household—due to economic dependency, patriarchal expectations, or generational hierarchies—their access to services such as contraception, antenatal

care, and reproductive counseling is severely constrained. This directly answers the first research question by showing that agency at the domestic level is a prerequisite for healthcare utilization, even where services are formally available.

Second, the analysis revealed that socio-cultural and economic factors—including gender norms, religious teachings, education, and poverty—play an intertwined role in shaping reproductive decision-making. Women in lower socio-economic strata or with less formal education are doubly disadvantaged, as they often face both institutional neglect and intra-family disempowerment. These factors answer the second research question, demonstrating how intersecting identities and circumstances create layered obstacles to reproductive autonomy.

Third, institutional and policy frameworks, while well-intentioned, remain inadequate in addressing the real conditions under which women negotiate reproductive choices. Health policies often focus on quantitative targets and fail to address household-level and normative barriers. In addressing the third research question, the study underscores the need for gender-transformative policies that engage men, local leaders, and health providers in shifting the power dynamics that limit women's reproductive agency.

Theoretically, this research contributes a contextualized application of empowerment and capabilities frameworks, reinforcing their relevance when localized and intersected with cultural, religious, and institutional structures. It also introduces a composite analytical perspective that integrates feminist theory, intersectionality, and governance studies to understand reproductive autonomy in pluralistic societies. Conceptually, the study refines the notion of access—not as a physical availability of services, but as a condition negotiated through social and relational structures.

Practically, the findings hold implications for health policymakers, development practitioners, and community organizations. Reproductive health programs must be reoriented to include gender-sensitive training for health workers, involve men and religious authorities in community engagement, and redesign service environments that protect and prioritize women's confidentiality and voice. Educational reforms that incorporate comprehensive reproductive rights curricula can prepare future generations to advocate for their health and autonomy. Finally, localized policy strategies must reflect regional diversity, ensuring that women in all provinces—regardless of tradition, faith, or income—can exercise full reproductive agency.

CONCLUSION

This study has illuminated the critical relationship between Indonesian women's decision-making power and their access to reproductive health services, revealing how intra-household dynamics, socio-cultural factors, and institutional frameworks intersect to shape reproductive autonomy. Synthesizing the findings across three core research questions, it becomes clear that access is not determined solely by the availability of healthcare services but by the relational, economic, and normative conditions under which women make decisions about their bodies and health.

The research confirmed that intra-household power asymmetries—particularly those rooted in economic dependency and patriarchal expectations—significantly inhibit women's ability to seek and utilize reproductive healthcare. Socio-cultural and economic variables such as education, income, religion, and family structure further exacerbate these limitations, creating compounded disadvantages that cannot be resolved through policy interventions alone. At the institutional level, despite Indonesia's formal commitments to maternal and reproductive health, national and local policies often fail to address the relational barriers that women face, particularly in male-dominated decision-making environments.

Theoretically, this study contributes to feminist development discourse by contextualizing empowerment frameworks—especially those advanced by Kabeer and Sen—within Indonesia's pluralistic society. It reinforces the argument that empowerment must be situated within the lived realities of women and examined through relational and intersectional lenses. This research thus not only affirms the relevance of existing models but also refines them by introducing cultural specificity and institutional critique.

From a practical standpoint, the study recommends several actionable strategies. Health programs should adopt gender-transformative approaches that involve men, challenge traditional norms, and reorient service provision around women's agency. Educational systems must incorporate comprehensive reproductive rights curricula that prepare young people to advocate for bodily autonomy and gender equality. Policymakers should develop localized strategies tailored to the unique socio-cultural conditions of each region while maintaining alignment with national gender equity objectives.

Future research should build upon these findings by conducting localized fieldwork that captures women's voices directly and investigates how emerging socio-political shifts—such as decentralization and digital health campaigns—are affecting reproductive autonomy. Only through sustained, inclusive, and intersectional inquiry can Indonesia fully realize its commitments to reproductive rights and gender justice.

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