Women's Decision of Making Power in The Households: A Demographic Study of Married Women in Indonesia

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Abstract: Women's roles in decision-making in the household are important aspects of women's empowerment and gender relations that have *cross-cultural* and household level relevance. This study aims to identify the relationship of demographic factors on the decision-making power among married women in Indonesia. The study examined data from 35.681 married women at the Indonesia Demographic and Health Survey 2017. Women's participation in household decision-making was based on questions asked of all women about: (1) their own health care, (2) major household purchases, (3) visits to the family or relatives. Bivariate and multivariate logistic regression for complex sample designs with adjusted for confounders were performed to analyse the association between decision-making power and demographic factors such as age, number of living children, education, employment, wealth status and place of residence. Overall, 71.96% of married women aged 15-49 participated in three household decision making. Women's education was the strongest predictor of decision-making power which higher educated women (OR: 2.05; 95% CI: 1.63-2.59) and secondary educated women (OR: 1.61; 95% CI: 1.43-1.81) had higher decision-making power compared with primary or less educated women. Women employed for cash (OR: 1.54; 95% CI: 1.37-1.73) had higher decision-making power than not employed women. Women's age, wealth index, and place of residence were also significant influencing decision-making power. Higher educated and employed women had better power to make decisions in their households. Improving women's education and increasing economic opportunities for women should be continuously enhanced to increase family resilience.
Keywords: Decision-making, Married Women, Education, Family Factors, Households.

Introduction

Decision-making is a dynamic process of human thought which consists of different variables and courses of action, with different outcomes, interfere in it. The decision-making process can be described into two perspectives. Firstly, the normative perspective outlines that the individual selection who act rationally in a challenge that involves decision making and predicts the responses of the subjects from the information given about each alternative using statistical models. Secondly, based on a descriptive point of view, decision-making process is described as how people actually choose such as using the psychological mechanism and the project and environmental characters (Lizarraga *et al*., 2007).

Women's roles in decision-making in the household are important aspects of women's empowerment and gender relations that have cross-cultural and household level relevance. Identifying the barriers of married women's decision-making power has significant relevance for family resilience. Women's participation in decisions related to health care can be used as an estimation for access to healthcare in each household (Alderman *et al*, 2006).

Health matters including maternal and child health are essential issues in many developing countries. Women who have independent decision-making or those who make decisions with communications with their spouse or husband on the use of family planning methods provide a major contribution to improving maternal health (Wado, 2013). According to the previous

studies, some factors affect the decision-making of women in their households such as age, parity, education, wealth status, employment status, and place of residence. The fact that age is one established variables influencing decision making in the previous studies (Lizarraga *et al*., 2007). Women's participation in the household's decision-making becomes one dimension to measure women empowerment. In avoiding unwanted pregnancy, maintaining access to family planning and empowering women to decide freely on the use of family planning is important (Countdown, 2012).

Producing information on women's decision-making power in health care at the household level has paramount importance to improve maternal and child health including improving women's access in health care. The goal of the present study was to examine the relationship of demographic factors on the decision-making power among married women in Indonesia.

Methods

Data for this cross-sectional study of women's decision-making power among married women in Indonesia come from the 2017 Indonesia Demographic and Health Survey (IDHS). IDHS is a national population-based survey in Indonesia. IDHS was conducted from July to September 2017. IDHS used two stages stratified sampling design. The first stage involved selecting census blocks from the 2010 Indonesian Population Census. Secondly, from these block censuses, the desired sample of 25 households was selected by systematic sampling methods. IDHS provides reliable and current data on fertility, family planning, infant and child mortality, maternal health care, child health, infant and young child feeding and HIV/AIDS. IDHS was conducted by the National Population and Family Planning Board, Statistics Indonesia and the Ministry of Health with technical assistance from the ICF under the Demographic and Health Survey (DHS) Program.

The study examined data from 35,681 married women at the Indonesia Demographic and Health Survey 2017. We used women's participation in household decision-making as the outcome variable. The outcome was categorised into participate in less than 3 decisions and participate in three decisions. Women's participation in household decision-making was based on questions asked of all women about: (1) their own health care, (2) major household purchases, (3) visits to the family or relatives. The independent variables included in this analysis were: women's age, parity, education, employment status, wealth index and place of residence. Women's age was categorised into 15-24, 25-34 and 35-49. Parity was categorised into 0-2 and three or more. Educational attainment was categorised into primary or less,secondary and higher. The values of wealth index were already given by the DHS Program in five categories: poorest, poorer, middle, richer and richest. The wealth status categories then recoded into three categories: poor (Included poorest and poorer), middle and rich (Included richest and richer).

The analyses were used a complex sample design. Bivariate and multivariate logistic regression for complex sample designs with adjusted for confounders were performed to analyse the association between decision-making power and demographic factors such as age, parity, education, employment, wealth status and place of residence. The results of logistic regression were presented by Odds Ratio (OR) with 95% Confidence Interval (CI). All statistical analyses were performed using Stata 15.1.

Result

Overall, 68.24% of married women aged 15-49 participated in three household decision-making such as their own health care, major household purchases, and visits to the family or relatives. Results showed among all married women, 55% of them were between 35-49 years of age. 70% of the respondents had two or fewer children, approximately 52% were living in rural areas, about 48% were employed for cash. About 52% of married women had secondary education as the last educational attainment. Almost 42% of married women were living in a good wealth status (Table 1).

Table 1. Characteristics of married women based on the number of decisions made either alone or jointly with husband

Characteristics	Percentage of number of decisions made either alone or jointly with husband			Total Column	
	0 (n=1.465)	1-2 (n=9.67)	3 (n=24.349)	n	%
Women's age					
15-24	5.45	32.07	62.48	4,017	11.3
25-34	4.34	27.7	67.96	12,119	34.0
35-49	3.68	26.72	69.6	19,545	54.7
Parity					
2 or less	4.07	27.63	68.3	25,029	70.1
3 or more	4.21	27.69	68.1	10,652	29.9
Education					
Primary or less	5.58	29.14	65.28	12,742	35.7
Secondary	3.53	27.87	68.6	18,563	52.0
Higher	2.27	22.41	75.32	4,375	12.3
Place of residence					
Urban	3.25	27.23	69.52	17,268	48.4
Rural	4.91	28.05	67.04	18,413	51.6
Employment status					
Not working	5.06	30.26	64.68	13,686	38.4
Employed for cash	3.02	25.66	71.32	17,039	47.8
Employed not for cash	5.19	27.38	67.43	4,929	13.8
Wealth status					
Poor	5.43	27.98	66.59	13,396	37.6
Middle	3.55	28.83	67.62	7,388	20.7
Rich	3.19	26.77	70.04	14,896	41.7

Multivariate analysis, in table 2, showed that age, education, place of residence, employment status, and wealth status were significant influencing decision-making power. After controlling for other socio demographic variables, women aged 25-34 years of age (OR: 1.2; 95% CI: 1.026-1.426) and aged 35-29 years (OR: 1.5; 95% CI: 1.314-1.824) had a significantly higher percentage of participating in three decisions than young women aged 15-24 years. Women's education was the strongest predictor of decision-making power which higher educated women (OR: 2.05; 95% CI: 1.63-2.59) and secondary educated

women (OR: 1.61; 95%CI: 1.43-1.81) had higher decision-making power compared with primary or less educated women. Women employed for cash (OR: 1.54; 95%CI: 1.37-1.73) had higher decision-making power than not employed women. Regarding to wealth status, the probability of participating in three decisions was about 33% higher among middle women and 17% higher among rich women compared with poor women. However, women who were living in rural areas were less likely to participate in three decisions compared with urban women (OR: 0.83; 95% CI: 0.732-0.929).

Table 2. Women's decision-making power in the households, IDHS 2017

Factors	Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Women's age		
15-24	Ref	Ref
25-34	1.270 (1.081-1.494)*	1.209 (1.026-1.426)*
35-49	1.509 (1.292-1.763)**	1.548 (1.314-1.824)**
Education		
Primary or less	Ref	Ref
Secondary	1.617 (1.450-1.802)**	1.609 (1.428-1.813)**
Higher	2.542 (2.055-3.145)**	2.052 (1.629-2.588)**
Place of residence		
Urban	Ref	Ref
Rural	0.649 (0.583-0.723)**	0.825 (0.732-0.929)**
Employment status		
Not working	Ref	Ref
Employed for cash	1.711 (1.524-1.923)**	1.539 (1.366-1.735)**
Employed not for cash	0.974 (0.841-1.129)	1.054 (0.906-1.227)
Wealth status		
Poor	Ref	Ref
Middle	1.558 (1.349-1.799)**	1.332 (1.149-1.546)**
Rich	1.743 (1.549-1.962)**	1.173 (1.021-1.348)*
Parity		
2 or less	Ref	
3 or more	0.963 (0.859-1.078)	

Note: *=p-value<0.05; **=p-value < 0.001

Discussion

Indonesia has enormous cultural diversity. In some ethnicities with patriarchal tradition, women are regarded in a subordinate or inferior position in their family or society. In some developing countries, most of husbands or spouses offer women inferior roles in all areas of the decision-making process in the household (Bogale *et al.*, 2011, Bourey *et al.*, 2012, Do & Kurimoto, 2012). The decision making of women has been explained as a nonlinear process that consists of four phases: contemplating, committing, critically evaluating and continuance (Theroux, 2010). It is important for women, especially in their reproductive age, to be able to take decisions related to their health. When women have greater household's decision-making powers in their health, so the health of the family is better protected which can contribute to the increase of productive power of the nation (Tadele *et al.*, 2019).

Women's decision-making in the households, together with ownership of land or house, membership in the community groups, proportion earning cash, and women's education, are the main indicators to develop a composite Women's Empowerment Index (Tuladhar *et al.*, 2013). Women's decision-making, which related to uncertainty, doubts and dynamism, is the relationship between a problem that need to be solved and a person who wants to solve it in a particular setting (Lizarraga *et al*., 2007). In the current study, almost 70% of married women in the reproductive age had greater decision-making power.

This study reveals multiple predictors of women's domestic decision-making power such as age, education, wealth status, employment and place of residence on women's decision-making on the households. The findings of this study suggest that there is a positive association between the age of married women and their participation in decision-making in their household. The results of this study are in line with previous study in Honduras. The decision-making process is related with women's beliefs in society with various cultural values that effected by the environment, how women look for more information and need more time to make a decision (Lizarraga *et al*., 2007). Young women have fewer experiences and less awareness in their life that affect the complexity of the decision-making process (Lizarraga *et al*., 2007).

The findings show that women, who have primary education or less, are lacking in the knowledge of health care compared with those with a better education. In the previous study, women's knowledge of reproductive health and women's exposed to formal education are associated with greater women's decision-making power (Tadele *et al*., 2019). The present study results are also supported by a systematic review article shows that highly educated women are more likely to be conscious of their own health and wellbeing, have more self-confidence, and be more assertive compared with those who have lower or no education (Tadele *et al*., 2019). Decision-making was related to women's perception on their position and status in the family. Therefore, increasing women's knowledge and education may influence the development of women's efficiency in decision making both within and outside their households (Erci, 2003).

This study finds out that women's employment status contributed to the decision-making power among married women in their households which may be explained by the differences of job opportunities among married women. Working women who work for cash are more likely to have independent decision-making in their household. Moreover, unequal socio-economic opportunities, together with other factors such as structural barriers and inadequate access to mentors and support networks, contributed significantly to the disparities of women's participation in the decision-making process (Hora, 2014).

Married women from urban areas have higher levels of women's decision-making power in their household compared with those who are living in rural areas. This result is similar to a study in Nepal (Tuladhar *et al*., 2013). However, parity has no significant effect on decision making. That is, women who have two or fewer children and women who have three or more children have equivalence in the decision-making process.

The major strength of this study is the use of the most current Indonesia Demographic and Health Survey which is a nationally representative dataset from 34 provinces in Indonesia and makes the results of the research generalizable to married women in their reproductive age in Indonesia. However, our study has some drawbacks concerning the cross-sectional design, so it cannot describe the causal relationship between variable. Women's decision-making process was influenced by cultural condition and the norms adopted by society. Both

essential factors were not described clearly in the survey, so the conceptualization of women's decision making was only based on their participation related with their own health care, major household purchases, and visits to the family or relatives. Data on women's decision making in households are based on self-reporting of the respondents, which may be subjected to social desirability bias.

Conclusion

Higher educated and employed women had better power to make decisions in their households. Improving women's education and increasing economic opportunities for women should be continuously enhanced to increase family resilience. It is recommended to conduct additional qualitative research to gain further understanding on women's decision making based on cultural point of views. In addition, future research should explore the impact of women's decision-making power on some essential health indicators especially related to maternal and child health.

References

Alderman, Hoogeveen & Rossi. 2006. Reducing child malnutrition in Tanzania Combined effects of income growth and program interventions. *Economics and Human Biology*, *4*, 1–23.

Bogale, Wondafrash & Tilahun *et al.,* 2011. Married women's decision making power on modern contraceptive use in urban and rural southern Ethiopia. *BMC Public Health*, 11(342): 1–7

Bourey, Stephenson, Bartel *et al.,* 2012. Pile sorting innovations: Exploring gender norms, power and equity in sub-Saharan Africa. *Global Public Health*, *7*(9): 995–1008.

Countdown. 2012. *Family planning & women's empowerment*. Fact sheet

Do, M., & Kurimoto, N. 2012. Women ' s Empowerment and Choice of Contraceptive Methods in Selected African Countries. *International Perspectives on Sexual and Reproductive Health*, *38*(1), 23–33. https://doi.org/10.1363/3802312

Erci, B. 2003. Women ' s Efficiency in Decision Making and Their Perception of Their Status in the Family. *Public Health Nursing*, *20*(1), 65–70.

Hora, E. A. 2014. Factors that affect Women Participation in Leadership and Decision Making Position. *Asian Journal of Humanity, Art and Literature*. 1(2), 97–118.

Lizarraga, Baquedano & Cardelle. 2007. Factors that affect decision making : gender and age differences. *International Journal of Psychology and Psychological Therapy*. 7(3). 381–391.

Tadele, A., Tesfay, A., & Kebede, A. 2019. Factors influencing decision-making power regarding reproductive health and rights among married women in Mettu rural district , south-west, Ethiopia. *Reproductive Health*. 16(155), 1–9.

Theroux, R. 2010. Women ' s decision making during the menopausal transition. *Journal of the American Academy of Nurse Practitioners*, *22*, 612–621.

Tuladhar, S., Khanal, K. R., K.C., L., Ghimire, P. K., & Onta, K. (2013). *Women's Empowerment and Spousal Violence in Relation to Health Outcomes in Nepal: Further analysis of the 2011 Nepal Demographic and Health Survey*. Calverton, Maryland, USA.

Wado, Y. D. 2013. *Women's Autonomy and Reproductive Healthcare-Seeking Behavior in Ethiopia [WP91]*. Calverton, Maryland, USA.