

Access of Family Planning Services among Urban Poor Women in the City of Yogyakarta

Ratu Matahari^{*}, Fitriana Putri Utami, Sri Sugiharti and Sari Kistiana

Faculty of Public Health, Universitas Ahmad Dahlan, Warungboto, Kota Yogyakarta 55164, Indonesia

(*Corresponding author's e-mail: ratu.matahari@ikm.uad.ac.id)

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Abstract

Aim: The barrier factors of family planning programs are divided into individual, household and community level factors. Urbanization and poverty are also conditions related to lack of access to family planning programs. According to the explanation of Green's theory, the behavior of individuals or groups in accessing health services is determined by 3 factors: Predisposing, enabling and reinforcing factors. This study aimed to explain the factors related to family planning programs among poor couples in the city of Yogyakarta. **Subject and method:** This survey used stratification and multistage random sampling to select the required sample. The units of analysis in this study were women of childbearing age (15 - 49 years), residing in the districts of Tegalrejo, Mergangsan and Umbulharjo, which are poor areas in the city of Yogyakarta. The sample size was 247 women. **Results:** The factor related to the selection of places to gain access to family planning services for the urban poor in Yogyakarta City is peer support, with a p -value = 0.028. **Conclusions:** the peer support factor is a factor that is significantly related to the selection of access to family planning services for the urban poor in the city of Yogyakarta. It is recommended to form a community group or local institution that focuses on contraception, so that it can become a form of education and a support system.

Keywords: Access, Family planning, Urban poor, Women, Yogyakarta

Introduction

Indonesia is the 4th highest ranked country in terms of population, with more than 261 million inhabitants in 2016. The rate of population growth has increased sharply in urban areas, with an increase of 11 % in 10 years (as much as 31 % in 1990, 42 % in 2000, and 50 % in 2010, and which is expected to increase by 57 % in 2020). Data from the National Development Planning Agency (Bappenas) explains that urban living in Indonesia has increased, with an indicator of ownership of basic sanitation facilities at 56 % in 2011, even though these conditions have not reached the 2015 target of 69 %. The number of poor people has also declined from 16 % in 2007 to 12 % in 2011 [1]. Yogyakarta City, as a research location, is an area with a population of around 2.5 million, with 16 % of the total population below the poverty line [1,2].

Poverty (economic problems) is one of the factors that affect the rate of population growth (fertility), along with education, religiosity, use of contraceptive methods and family planning programs [3]. Poverty and population correlate with family size. A study in Uganda explained that reducing the number of family members can increase family income and improve the quality of children. Another study also explained that the total fertility rate (TFR) is more strongly related to education than economic situation, but that family economy is related to the quality of meeting the reproductive needs of a family [4]. Economy is related to the ability of individuals to access family planning services, so that it has an impact on reducing maternal and child mortality rates [5]. A strategy to improve the quality of life for married couples or women of childbearing age is a family planning program. Family planning programs are very effective in reducing the number of maternal and child deaths; however, poverty is an inhibiting factor in family planning programs, meaning that the poor are often an unmet need group [6].

A study in Uganda explained that poverty makes the poor vulnerable to unmet need [7]. This is supported by the results of a study in Malawi, which explained that groups with high wealth status use modern contraceptives more than poor groups do [7]. The method of contraception is a way to limit the number of children or provide birth spacing. A study explained that increasing the number of family planning acceptors in several developing countries has implications for decreasing maternal mortality cases [8]. The use of contraception is an indicator of global family planning program achievements. The number of family planning users throughout the world increased sharply from 35 % in 1970 to 63 % in

2017 [9]. This is supported by data from the 2017 Indonesian Health Democratic Survey (IDHS), which explained that as many as 64 % of women of childbearing age aged 15 - 49 use contraception; 57 % use modern contraception, and 6 % use non-modern contraception. A total of 13 % women of childbearing age in Indonesia use long-term contraceptive methods, namely IUDs, implants, and tubectomy (MoW). 29 % of women in childbearing age in Indonesia discontinued use of contraception on the grounds of side effects. The number of unmet needs was explained by 11 % in 2017 [10]. This fact explains that the family planning program is still a challenge in developing countries, including in Indonesia [11].

Indonesia is a country with strong religious and cultural values, so the use of contraception is interpreted as a form of opposition to these values. The values are so strongly related to the concept that a child is a fortune from God that having many children is perceived as the amount of sustenance a family will receive, and the belief that a child is an opening door for sustenance for a family makes a barrier to contraceptive use [12,13]. A study in Pakistan also explained that economic levels and strong religious and cultural norms were also barriers to the use of contraceptive methods [14]. In addition, several studies explained the barrier factors of family planning programs, including individual, household, and community level factors. Urbanization and poverty are also conditions related to lack of access to family planning programs [5,14,15].

Based on the Indonesian Health Demographic Survey (IDHS) in 2002 - 2003, around 4 % of women of childbearing age use traditional family planning (KB) tools/methods, which increased to 5 % in the 2007 IDHS. In the 2012 IDHS, there was a decline in the trend of using traditional contraceptives, to 4 %, but there was an increase again, reaching 6 %, in the 2017 IDHS [10]. In the Special Region of Yogyakarta Province, the proportion of traditional contraceptive users, based on the 2017 IDHS, reached 18 % of the total users of contraception of all methods, indicating an increasing trend when compared to the 2012 IDHS results, which were around 10 %. Based on the 2017 IDHS, it is known that the use of traditional contraceptives is higher in urban areas than in rural areas. The impact of the use of traditional contraceptives contributes significantly to the occurrence of unwanted pregnancies, especially in developing countries [10,16]. The Central Bureau of Statistics (BPS) also reported that the use of traditional contraceptives contributed to nearly 30 % to cases of unwanted pregnancy [2].

This study aims to describe the correlation between predisposing, enabling, and reinforcing factors in family planning access among the urban poor in the City of Yogyakarta. This theory is then elaborated on using the precede-proceed model [18]. According to the previous explanation of Green theory, the behavior of individuals or groups in accessing health services is determined by 3 factors: Predisposing, enabling and reinforcing factors [19].

Materials and methods

Data sources

This study uses probability sampling to draw conclusions (inference). The sampling technique used was the cluster sampling technique. The number of samples for each region is described in **Figure 1**, below:

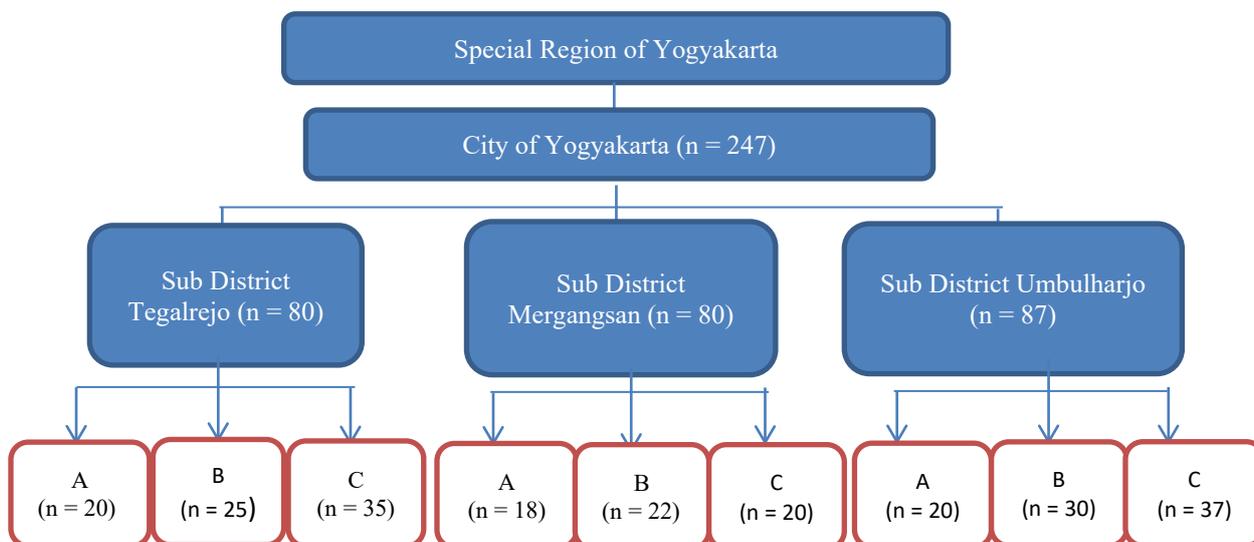


Figure 1 Sample frame.

The sample of this study was of married women of childbearing age, aged 15 - 49 years. The research sample met the inclusion criteria, namely, living in the Tegalrejo, Mergangsang, or Umbulharjo areas for at least 6 months, being poor, and being willing to be the respondents of this study. This research was voluntary, so that if a respondent refused to be interviewed, the researcher would replace them with another respondent. None of the respondents who were invited refused to be interviewed. All of the respondents were given a souvenir after the interview session, to express our thanks for their time and information in this study. This research instrument used a questionnaire, which was an improvement from the 2017 Indonesian Demographic and Health Survey questionnaire, which consisted of 6 parts, namely the socio-demography of respondents, knowledge of family planning, contraceptive use behavior, and access to family planning services, family support, friends and health workers. In order to maintain the confidentiality of informant data, informed consent was conducted prior to conducting interviews.

Data analysis

Access to family planning services meant health facilities accessed by poor women in an effort to obtain contraceptive services. In this study, access to family planning services was categorized as midwives, health centers, clinics, government hospitals, private hospitals, mobile family planning services and pharmacies.

Independent variables of this study were age, education level, employment status, family income, knowledge of family planning, number of children, family support, support from friends, support from health workers, family planning visits, and national health insurance or Jaminan Kesehatan Nasional (JKN) membership. All variables involved in the analysis of this study were dichotomous; therefore, the chi square test was used to determine whether there was a meaningful correlation in choosing family planning services among poor child-bearing aged women in the city of Yogyakarta.

Frequency distribution was done to identify all responses. In addition, this was followed by bivariate statistical analysis (cross tabulation) to identify the relationship between the dependent and independent variables to obtain candidate variables ($p < 0.25$) which would be used as predictors in multivariate analysis (multiple logistic regression). All statistical analyses of quantitative results were carried out with the help of STATA version 13.0.

Ethical statement

The Ahmad Dahlan University ethics committee approved the ethical clearance of this study. The respondents' identities have all been deleted from the dataset. Respondents provided written approval for their involvement in the study. Researchers obtained data collection permits and dissemination of research results on ethics certificate number 011801013.

Abbreviation

Bappenas: The Ministry of National Development Planning (National Development Planning Agency); BKKBN: National Population and Family Planning Agency; JKN: Jaminan Kesehatan Nasional (National Health Insurance); MoW: Metode Operasi Wanita (Tubectomy); PHC: Public Health Centre (pusat kesehatan masyarakat or puskesmas).

Results and discussion

Socio-demographics of respondents

Table 1 explains that the largest age group of respondents was aged 40 - 44 years, comprising 64 people (25.01 %). The majority of respondents had completed high school education, at a number of 114 people (46.15 %). More than half of respondents are unemployed, at 144 people (58.29 %). The majority of respondents had a family income of < 1,700,000 IDR (USD 110.6), at 173 people (70.04 %). The majority of respondents had good contraception knowledge, namely 192 people (77.73 %). The number of children owned, by 189 (76.51 %) respondents, was ≤ 2 children. The majority of respondents, totaling 209 people (84.61 %), received family support to use contraception. The majority of respondents, totaling 206 people (83.40 %), received the support of friends to use contraception. 232 people (93.92 %) stated that they received support from health workers to use contraception. The majority of respondents, 230 people (93.12 %), said they had never been visited by family planning officers. A total of 232 respondents (93.93 %) had health insurance.

Table 1 Socio-demographics of the respondents (n = 247).

Variables	Responses	Freq.	Percent
Age	< 25 years	7	2.83
	25 - 29 years	22	8.90
	30 - 34 years	57	23.07
	35 - 39 years	57	23.07
	40 - 44 years	64	25.91
	45 - 49 years	40	16.19
Level of education	No Education	7	2.83
	Primary	39	15.79
	Junior high school	68	27.53
	Senior high school	114	46.15
	Undergraduate	19	7.69
Job status	Unemployment	144	58.29
	Employment	103	41.70
Family income	< 1,700,000 IDR	173	70.04
	≥ 1,700,000 IDR	74	29.95
Knowledge of FP	Less	5	2.02
	Average	50	20.24
	Good	192	77.73
Number of children	≤ 2	189	76.51
	> 2	58	23.48
Family support	Unsupported	34	13.76
	Supported	209	84.61
	Neutral	4	1.62
Peer support	Unsupported	19	7.69
	Support	206	83.40
	Neutral	22	8.91
Health providers support	Unsupported	10	4.04
	Supported	232	93.92
	Neutral	5	2.02
Visited by FP officer	No	230	93.12
	Yes	17	6.88
Health insurance Membership	Not membership	15	6.07
	Membership	232	93.93

Bivariate analysis

Table 2 is a bivariate statistic between predisposing factors (age, level of education, job status and number of children), enabling factors (family income and knowledge of FP), and reinforcing factors (family support, peer support, health provider support, FP officer having visited, and health insurance membership). **Table 2** explains that women aged 25 - 29 years had a tendency to access family planning services in public health centers (PHC) or *puskesmas*, with a proportion of 0.688 (p -value 0.648, 95 % CI: 0.434 - 0.864). Women with the level of education of having graduated from college chose to access family planning services at PHCs with a proportion of 0.809 (p -value 0.015, 95 % CI 0.564 - 0.933). Women who did not work chose to access family planning services in clinics with a proportion of 0.704 (p -value 0.162, 95 % CI 0.616 - 0.780). Women with an income of ≥ 1,700,000 IDR chose to access family planning services in clinics with a proportion of 0.702. Women who had knowledge about family planning chose to access family planning services in PHCs with a proportion of 0.700.

Table 2 shows that women who had a number of children ≤ 2 chose to access family planning services at PHCs with a proportion of 0.684. Women with families who were not supported chose access to family planning services in PHCs with a proportion of 0.754 (p -value 0.148, 95 % CI 0.565 - 0.887).

Women with peers who supported them preferred to choose the place of family planning services in PHCs with a proportion of 0.713 (p -value 0.028, 95 % CI 0.639 - 0.777). Women who received support from health workers chose access to family planning services in health clinics with a proportion of 0.689 and with statistical significance (p -value 0.325, 95 % CI 0.617 - 0.752). Women who were not visited by family planning officers chose to access family planning services in midwives with a proportion of 0.154 (p -value 0.508, 95 % CI 0.109 - 0.214).

Table 2 shows that women visited by family planning officers chose to access family planning services in clinics with a proportion of 0.778 (p -value 0.508, 95 % CI 0.419 - 0.927). Women who had national health insurance or Jaminan Kesehatan Nasional (JKN) cards chose to access family planning services from midwives with a proportion of 150 and with statistical significance (p -value 0.909, 95 % CI 0.106 - 0.209). Women who did not have a JKN card chose to access family planning services in clinics with a proportion of 0.805 and were statistically significant (p -value 0.909, 95 % CI 0.473 - 0.950). **Table 2** explains that the factors related to the selection of places to gain access to family planning services for the urban poor in Yogyakarta City was peer support with a p -value = 0.028.

The results showed that the places to access family planning services in the city of Yogyakarta for the urban poor group consisted of midwives, public health centers, health clinics, government hospitals, private hospitals and family planning on mobile services. Based on age, preference for places to obtain family planning services for the urban poor in the city of Yogyakarta was as follows: Age < 25 years preferred to access family planning services in PHCs and Health Clinics, 25 - 29 years of age preferred visiting private hospitals to access family planning services, 30 - 34 years preferred accessing mobile services, 40 - 44 years preferred accessing midwives, and 45 - 49 years preferred accessing government hospitals and dispensaries, even though age categories were not significantly associated with accessing family planning services.

Women who had graduated tertiary education level chose to access family planning services at PHCs with a proportion of 0.809 (p -value 0.015, 95 % CI 0.564 - 0.933). However, the results of this study indicate that the level of education did not correlate with the choice of family planning services among the urban poor in Yogyakarta. This finding is different from the results of previous studies, which stated that the level of education was related to the experience of a person or group in choosing health [20,21]. Women with an income of \geq 1,700,000 IDR chose to access family planning services in clinics with a proportion of 0.702. The results of this study are in line with research that explained that a person's financial ability determines the choosing of the type of health service. The lack of a person's financial ability then has a tendency to not access health services or to choose unpaid health services [22,23].

Women with friends who supported them preferred to access family planning services in PHCs with a proportion of 0.713 (p -value 0.028, 95 % CI 0.639 - 0.777). Peer support had a strong correlation in influencing a person's attitudes and behaviors to make decisions in choosing contraceptive services. Friends are individuals and groups that influence very strongly someone's decision-making behavior to act. In general, friends have the same experience, so this strengthens individuals to make decisions [18,21].

Based on the results of the research that has been done, it is shown that friends are a factor influencing someone to choose a contraceptive method in the urban poor group. Thus, it is very important to educate couples of childbearing age by initiating the formation of family planning care groups as peer educators, as well as strengthening family planning cadres in each region as family planning facilitators. This research becomes richer if it is deepened by conducting a qualitative study exploring the reasons for using traditional contraceptives from social and religious perspectives.

Table 2 Correlation between predisposing, enabling, and reinforcing factors and access of family planning services among urban poor in Yogyakarta.

Variable	Access of family planning services														
	Midwives		PHC		Health clinic		Gov. hosp		Private hosp		Mobile service		Drug store		Total
	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop
Age															
< 25 years (n = 7)	0.000		0.794	[0.308 - 0.971]	0.206	[0.029 - 0.692]	0.000		0.000		0.000		0.000		1.000
25 - 29 years (n = 22)	0.156	[0.041 - 0.443]	0.688	[0.434 - 0.864]	0.015	[0.002 - 0.107]	0.047	[0.006 - 0.275]	0.070	[0.010 - 0.366]	0.000		0.024	[0.003 - 0.156]	1.000
30 - 34 years (n = 57)	0.175	[0.091 - 0.309]	0.630	[0.484 - 0.756]	0.077	[0.027 - 0.205]	0.014	[0.002 - 0.097]	0.000		0.029	[0.004 - 0.180]	0.074	[0.026 - 0.195]	1.000
35 - 39 years (n = 57)	0.119	[0.057 - 0.234]	0.791	[0.656 - 0.883]	0.024	[0.003 - 0.154]	0.021	[0.003 - 0.139]	0.028	[0.004 - 0.175]	0.011	[0.001 - 0.073]	0.005	[0.001 - 0.038]	1.000
40 - 44 years (n = 64)	0.189	[0.103 - 0.322]	0.629	[0.487 - 0.752]	0.068	[0.023 - 0.183]	0.031	[0.007 - 0.123]	0.050	[0.012 - 0.181]	0.000		0.033	[0.007 - 0.136]	1.000
45 - 49 years (n = 40)	0.101	[0.034 - 0.263]	0.654	[0.468 - 0.802]	0.039	[0.005 - 0.234]	0.094	[0.027 - 0.278]	0.000		0.014	[0.002 - 0.096]	0.098	[0.030 - 0.278]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(30) = 30.424 Design-based F(27.10, 6667.47) = 0.877 p-value = 0.648															
Level of education															
Uneducated SD (n = 7)	0.188	[0.026 - 0.665]	0.321	[0.086 - 0.703]	0.000		0.308	[0.075 - 0.708]	0.000		0.000		0.183	[0.025 - 0.659]	1.000
Primary (n = 39)	0.155	[0.063 - 0.333]	0.660	[0.474 - 0.807]	0.089	[0.025 - 0.273]	0.059	[0.014 - 0.213]	0.000		0.000		0.038	[0.005 - 0.226]	1.000
Junior high school (n = 68)	0.184	[0.100 - 0.312]	0.685	[0.550 - 0.795]	0.033	[0.008 - 0.127]	0.017	[0.004 - 0.066]	0.000		0.018	[0.004 - 0.071]	0.063	[0.021 - 0.175]	1.000
Senior high school (n = 114)	0.131	[0.077 - 0.212]	0.693	[0.590 - 0.780]	0.063	[0.026 - 0.142]	0.018	[0.004 - 0.072]	0.053	[0.020 - 0.133]	0.015	[0.002 - 0.101]	0.027	[0.009 - 0.079]	1.000
Undergraduate (n = 19)	0.103	[0.023 - 0.357]	0.809	[0.564 - 0.933]	0.055	[0.008 - 0.311]	0.000		0.000		0.000		0.033	[0.004 - 0.208]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(24) = 42.465 Design-based F(20.54, 5052.09) = 1.562 p-value = 0.051															
Job status															
Unemployed (n = 144)	0.156	[0.102 - 0.231]	0.704	[0.616 - 0.780]	0.054	[0.025 - 0.116]	0.007	[0.001 - 0.040]	0.029	[0.009 - 0.086]	0.004	[0.001 - 0.028]	0.046	[0.019 - 0.106]	1.000
Employed (n = 103)	0.135	[0.075 - 0.231]	0.644	[0.530 - 0.744]	0.059	[0.022 - 0.150]	0.077	[0.035 - 0.161]	0.019	[0.003 - 0.125]	0.024	[0.005 - 0.111]	0.042	[0.016 - 0.106]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(6) = 11.147 Design-based F(5.63, 1385.51) = 1.552 p-value = 0.162															
Family income															
< 1.700.000 IDR (n = 173)	0.162	[0.110 - 0.232]	0.673	[0.590 - 0.746]	0.033	[0.013 - 0.078]	0.038	[0.017 - 0.086]	0.035	[0.013 - 0.091]	0.006	[0.002 - 0.026]	0.052	[0.025 - 0.107]	1.000
≥ 1.700.000 IDR (n = 74)	0.112	[0.052 - 0.223]	0.702	[0.568 - 0.808]	0.114	[0.050 - 0.240]	0.023	[0.005 - 0.101]	0.000		0.025	[0.003 - 0.158]	0.025	[0.007 - 0.082]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(6) = 12.104 Design-based F(5.78, 1423.02) = 1.737 p-value = 0.112															
Knowledge of FP															
Less (n = 5)	0.516	[0.146 - 0.869]	0.484	[0.131 - 0.854]	0.000		0.000		0.000		0.000		0.000		1.000
Average (n = 50)	0.228	[0.122 - 0.387]	0.633	[0.473 - 0.769]	0.060	[0.017 - 0.191]	0.051	[0.013 - 0.184]	0.027	[0.004 - 0.171]	0.000		0.000		1.000
Good (n = 192)	0.115	[0.075 - 0.173]	0.700	[0.621 - 0.768]	0.057	[0.028 - 0.112]	0.030	[0.013 - 0.071]	0.025	[0.008 - 0.076]	0.015	[0.004 - 0.056]	0.057	[0.030 - 0.107]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(12) = 14.915 Design-based F(10.83, 2663.08) = 1.045 p-value = 0.403															
Number of children															
≤ 2 Children (n = 189)	0.147	[0.100 - 0.213]	0.684	[0.605 - 0.755]	0.062	[0.031 - 0.118]	0.024	[0.009 - 0.062]	0.026	[0.008 - 0.079]	0.006	[0.001 - 0.024]	0.051	[0.025 - 0.100]	1.000
> 2 Children (n = 58)	0.148	[0.071 - 0.283]	0.671	[0.524 - 0.791]	0.041	[0.010 - 0.151]	0.065	[0.022 - 0.179]	0.022	[0.003 - 0.142]	0.029	[0.004 - 0.181]	0.024	[0.003 - 0.152]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000

Variable	Access of family planning services														
	Midwives		PHC		Health clinic		Gov. hosp		Private hosp		Mobile service		Drug store		Total
	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop	95 % CI	Prop
		0.204]		0.743]		0.102]		0.069]		0.066]		0.043]		0.084]	
Pearson: Uncorrected chi2(6) = 5.640 Design-based F(5.94, 1460.09) = 0.737 P-value= 0,619															
Family support															
Unsupported (n = 34)	0.064	[0.016 - 0.223]	0.754	[0.565 - 0.878]	0.086	[0.024 - 0.264]	0.056	[0.013 - 0.211]	0.041	[0.006 - 0.241]	0.000		0.000		1.000
Supported (n = 209)	0.163	[0.115 - 0.227]	0.672	[0.596 - 0.740]	0.052	[0.026 - 0.103]	0.031	[0.013 - 0.070]	0.023	[0.007 - 0.069]	0.014	[0.004 - 0.051]	0.045	[0.022 - 0.089]	1.000
Neutral (n = 4)	0.000		0.482	[0.082 - 0.907]	0.000		0.000		0.000		0.000		0.518	[0.093 - 0.918]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(12) = 21.040 Design-based F(11.52, 2832.96) = 1.430 p-value = 0.148															
Peer support															
Unsupported (n = 19)	0.222	[0.082 - 0.477]	0.545	[0.309 - 0.763]	0.163	[0.051 - 0.415]	0.000		0.070	[0.010 - 0.366]	0.000		0.000		1.000
Supported (n = 206)	0.147	[0.101 - 0.210]	0.713	[0.639 - 0.778]	0.031	[0.012 - 0.077]	0.034	[0.016 - 0.074]	0.023	[0.007 - 0.070]	0.014	[0.004 - 0.052]	0.037	[0.018 - 0.075]	1.000
Neutral (n = 22)	0.080	[0.018 - 0.293]	0.486	[0.262 - 0.715]	0.212	[0.071 - 0.487]	0.061	[0.008 - 0.333]	0.000		0.000		0.161	[0.041 - 0.462]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(12) = 29.632 Design-based F(11.72, 2884.06) = 1.929 p-value = 0.028															
Health provider Support															
Unsupported (n = 10)	0.090	[0.012 - 0.447]	0.638	[0.297 - 0.880]	0.142	[0.020 - 0.575]	0.000		0.130	[0.018 - 0.550]	0.000		0.000		1.000
Supported (n = 232)	0.147	[0.103 - 0.206]	0.689	[0.617 - 0.752]	0.054	[0.028 - 0.100]	0.036	[0.017 - 0.074]	0.021	[0.007 - 0.063]	0.013	[0.003 - 0.046]	0.041	[0.020 - 0.081]	1.000
Neutral (n = 5)	0.278	[0.038 - 0.790]	0.427	[0.096 - 0.840]	0.000		0.000		0.000		0.000		0.295	[0.041 - 0.803]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(12) = 16.396 Design-based F(10.78, 2652.27) = 1.141 p-value = 0.325															
FP officer visited															
No (n = 230)	0.154	[0.109 - 0.214]	0.673	[0.601 - 0.738]	0.061	[0.033 - 0.110]	0.030	[0.014 - 0.063]	0.021	[0.007 - 0.064]	0.013	[0.003 - 0.047]	0.048	[0.025 - 0.090]	1.000
Yes (n = 17)	0.062	[0.009 - 0.340]	0.778	[0.491 - 0.927]	0.000		0.087	[0.012 - 0.424]	0.073	[0.010 - 0.377]	0.000		0.000		1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(6) = 6.997 Design-based F(5.96, 1465.20) = 0.881 p-value = 0.508															
Health insurance Membership															
Not membership (n = 15)	0.103	[0.015 - 0.474]	0.805	[0.473 - 0.950]	0.092	[0.013 - 0.442]	0.000		0.000		0.000		0.000		1.000
Membership (n = 232)	0.150	[0.106 - 0.209]	0.673	[0.601 - 0.737]	0.054	[0.028 - 0.101]	0.036	[0.017 - 0.074]	0.027	[0.010 - 0.070]	0.013	[0.003 - 0.046]	0.047	[0.024 - 0.089]	1.000
Total (n = 247)	0.148	[0.105 - 0.204]	0.681	[0.612 - 0.743]	0.056	[0.031 - 0.102]	0.034	[0.016 - 0.069]	0.025	[0.009 - 0.066]	0.012	[0.003 - 0.043]	0.044	[0.023 - 0.084]	1.000
Pearson: Uncorrected chi2(6) = 2.855 Design-based F(5.93, 1458.25) = 0.349 p-value = 0.909															
Source: Primary data, 2018															

Conclusions

Based on the results of the data analysis, it can be concluded that the factor affecting family planning program access among poor couples in the city of Yogyakarta is peer support.

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