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RESEARCH ARTICLE OPEN ACCESS

# Women's Health Decision-Making: Evidence From 2017 Demographic and Health Surveys Data

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***Abstract.*** *Women's decision-making is an important element in preventing treatment delays. Indonesian women traditionally always depend on their family to decide on treatment. Therefore, this study aims to find out who makes decisions about health problems and analyze the factors associated with the characteristics of women who act as decision-makers in their families when facing health problems. This study used the individual subset data on married women from the 2017 Indonesia Demographic and Health Survey, which included women of reproductive age (15-49 years). Descriptive statistical analysis will be used in this study. Results: Women's health decision-making had a significant relationship with all demographic variables. Factors that have influenced women to decide about their health issues were higher educational level (p-value=0.000), have been exposed to the media (p-value=0.047), used the internet (p-value=0.000), had a bank account (p-value=0.000), employed (p-value=0.000), and lived in urban areas (p-value=0.000). Based on this result highly educated women are 2.5 times more likely to be health-related decision-makers. Conclusion: Highly educated women increased the authority of women to be decision-makers in their families, especially in health issues. By having a high education, women can determine the actions taken for manage health of themselves and their families.*

***Keywords:*** *decision-making; health; married-woman*

## BACKGROUND

Making decision is a sign of women's empowerment, and women's empowerment has a significant impact on a nations's socioeconomic progress. The ability of woman to make decision in their families, workplaces, and other social, economic, and political domains is referred to as empowerment. Women's participation in making decision is crucial for creating more egalitarian and harmonious families. Research from developing countries revealed that the two biggest factors influencing women's decision-making authority were their age and the makeup of their families. Compared to other women, older women and women living in nuclear homes were more likely to be involved in family decision- making. But more and more women are standing up for their right to participate in decision-making these days(Chowdhury, 2023). Today's women's roles in Dinodnesia are influenced by a variety of factors, including more modernization, better education, and work. Higher levels of education appear to influence women's involvement in the economic sector and elevate their status within the family, despite the fact that traditional patriarchal culture still influences many Indonesia women's decisions and behaviors in specific ways. The results of this study showed that most women with greater house-hold socio-economic position and educational attainment tended to be more self-aware, empowered, and able to communicate their health (Acharya et al., 2010; Murugesu et al., 2021; Rizkianti et al., 2020).

A decision on medical treatment should be made in a short period of time. Culturally, family often plays an important role during the decision-making process that might suspend medical treatment. Yet understanding its cultural belief is a crucial element required to design effective strategies to shorten delays (Chowdhury, 2023). Delay in start treatment causes patients to have more advanced disease, more complications, higher mortality and more people being infected from each cases. Delays are divided into patient delay, health care system delay and total delay. Some reasons that might explain the longer patient delays are stigma, fear, lack of knowledge, language problems and cultural differences in the interpretation of signs and symptoms (Farah et al., 2006). Therefore, the objective of this study is to provide a

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contribution in describing and analyzing who makes decisions about health problems and analyze the factors associated with the characteristics of women who act as decision-makers in their families when facing health problems.

## METHOD

Women's contributions to the family, industry, and society are now widely acknowledged. With the changing demographics and more women engaging in economic activities, the role of women in family decisions is growing. Her opinion of family decisions is growing as her education, jobs, and contribution to family income shift. Decision making is the outcome or performance of a mental or cognitive process that leads to the selection of a course of action from among the numerous options available. The decision-making process often results in a single final decision and choices are taken in order to accomplish objectives by implementation or intervention.

Decision making definition including method of assessing many alternatives and choosing the most likely alternative to accomplish one or more goals; process by which an individual, group of individuals or an organization reaches conclusions about future actions that must be taken in light of a set of goals and limitations on the available resources; individuals should learn to improve this mental capacity; learning process in which the person can be taught how to make rational decisions by training him in critical thinking, problem sensitivity, goal planning and drawing, and improving analysis, discovery, and investigative skills; process that involves both assessment and judgement; that is, evaluating various options and deciding which one to pursue. There must be two or three options to choose from for these procedures to take place and selection to take place (Alkaby, 2022).

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## RESULT

**Tabel 1.** Descriptive analysis of variables

| Variables | N (%) |
|---|---|
| Highest level of schooling | |
| No education | 657 (1,8%) |
| Incomplete Primary | 3.217 (9%) |
| Complete Primary | 8.857 (24,8%) |
| Incomplete Secondary | 9.247 (25,9%) |
| Complete Secondary | 9.300 (26,1%) |
| Higher | 4.369 (12,3%) |
| Media Exposure | |
| No media exposure | 19.298 (54,1%) |
| Media exposure | 16,350 (45,9%) |
| Use of Internet | |
| Never use the Internet | 22.136 (62,1%) |
| Ever used the Internet | 13.500 (37.9%) |
| Owns mobile phone | |
| No | 9.098 (25,6%) |
| Yes | 26.500 (74,4%) |
| Has Financial Account | |

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| | |
|---|---|
| No | 22.667 (63,6%) |
| Yes | 12.981 (36,4%) |
| Working Status | |
| Not currently employed | 15.776 (44,3%) |
| Work status | 19,869 (55,7%) |
| Residential | |
| Urban | 17.251 (48,4%) |
| Rural | 18.397 (51,6%) |
| Who decide issues on women's health | |
| Other | 4.153 (11,7%) |
| Respondent | 31.495 (88,3%) |

Women's characteristic were provided in Table 1. The majority of respondents had the highest level of education ever attended, which was complete secondary education (26,1%). The majority of respondent were not exposed to any media (54,1%) including tv, radio, or reading newspaper. In addition more than fifths (74,4%) was own mobile phone but never used the internet (62,1%). The majority of respondents did not have a financial account (63,6%) although the majority of respondents have worked (53,3%). The majority of the respondents have a residence in the rural area. The majority of respondents decide about health issues by respondent (88,3%).

**Table 2.** Bivariate analysis between decide issues on women's health variabels and characteristics

| Variables | Who decide issues on Women's health | | | p-value |
|---|---|---|---|---|
| | Other % | Respondent % | Total N (%) | |
| Highest level of schooling | | | | 0,000 |
| No education | 20,5 | 79,5 | 657 (1,8%) | |
| Incomplete Primary | 16,6 | 83,4 | 3.217 (9%) | |
| Complete Primary | 13,4 | 86,6 | 8.857 (24,8%) | |
| Incomplete Secondary | 11,7 | 88,3 | 9.247 (25,9%) | |
| Complete Secondary | 9,8 | 90,2 | 9.300 (26,1%) | |
| Higher | 7,1 | 92,9 | 4.369 (12,3%) | |
| Media Exposure | | | | 0,046 |
| No media exposure | 12,1 | 87,9 | 19.298 (54,1%) | |
| Media exposure | 11,1 | 88,9 | 16,350 (45,9%) | |
| Use of Internet | | | | 0,000 |
| Never use the Internet | 12,9 | 87,1 | 22.136 (62,1%) | |
| Ever used the Internet | 9,6 | 90,4 | 13.500 (37.9%) | |
| Owns mobile phone | | | | 0,000 |
| No | 14,9 | 85,1 | 9.098 (25,6%) | |
| Yes | 10,5 | 89,5 | 26.500 (74,4%) | |
| Has Financial Account | | | | 0,000 |
| No | 13,4 | 86,6 | 22.667 (63,6%) | |
| Yes | 8,7 | 91,3 | 12.981 (36,4%) | |
| Working Status | | | | 0,000 |
| Not currently employed | 50,6 | 43,4 | 15.776 (44,3%) | |
| Work status | 49,4 | 56,6 | 19,869 (55,7%) | |
| Residential | | | | 0,000 |
| Urban | 10 | 90 | 17.251 (48,4%) | |
| Rural | 13,2 | 86,8 | 18.397 (51,6%) | |

Result of bivariate analysis are provided in table 2. Based on the results there is an association between the highest level of education and who makes decisions related to health problems in women, with the result of p-value = 0.000. A total of 20.5% of decisions related to women's health were decided by others in women who did not have an educational background. A total of 92.9% of decisions related to women's health were decided by respondents themselves, namely respondents who had a higher education background.

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Based on the results, there is no relationship between exposure to media and who makes decisions related to health problems in women (p-value=0.046). There were 12.1% of respondents without exposure to any media and their health-related decision-making was done by others. Meanwhile, 88.9% of respondents who were exposed to media made health-related decisions independently.

Based on the results there is an association between internet use and who makes decisions related to health problems in women, with p-value = 0.000. A total of 12.9% of respondents never access the internet, and health-related decision-making is done by others. Whereas 90.4% of respondents used the internet and health-related decision-making was carried out by respondents.

The results show that there is a relationship between cell phone ownership and who makes decisions related to health problems. 14.9% of respondents did not have a mobile phone and health-related decision-making was done by others. As many as 89.5% of respondents have mobile phones, and health-related decision-making is done by respondents.

Based on the results there is a relationship between ownership of bank accounts and who makes health-related decisions, namely with p-value = 0.000. A total of 13.4% of respondents did not have a bank account and decision-making on the respondent's health was decided by others. While 91.3% of respondents have bank accounts and health-related decision-making is done by respondents.

Based on the results there is a relationship between having a work status and who makes health-related decisions for respondents (p-value = 0.000). 50.6% of respondents did not work and their health-related decision-making was carried out by others. While 56.6% of respondents were workers and health-related decision-making was carried out by respondents.

Based on the results there is a relationship between place of residence and the person who makes health-related decisions for respondents. 13.2% of respondents live in rural areas and health-related decision-making is done by others. Whereas 90% of respondents lived in urban areas and health-related decision-making was carried out by respondents.

**Table 3**. Multivariate analysis between women's decision-making and characteristics

| Variabel | Women decision-making about health | |
|---|---|---|
| | OR | 95% CI |
| Highest level of schooling | | |
| Incomplete Primary | 1,30 | 0-98-1,73 |
| Complete Primary | 1,68*** | 1,28-2,20 |
| Incomplete Secondary | 1,95*** | 1,48- 2,57 |
| Complete Secondary | 2,15*** | 1,62- 2,86 |
| Higher | 2,56*** | 1,85-3,54 |
| Media Exposure | | |
| No | 1,00 | 0,88-1,06 |
| Yes | 1,97** | |
| Ever Used Internet | | |
| No | 1,00 | 0,89-1,16 |
| Yes | 1,02*** | |
| Mobile Phone | | |
| No | 1,00 | 1,06-1,32 |
| Yes | 1,18*** | |
| Bank Account | | |
| No | 1,00 | 1,10-1,38 |
| Yes | 1,24*** | |
| Residential | | |
| Urban | 1,00 | 0,73-0,94 |
| Rural | 0,83*** | |
| Work status | | |
| Not currently employed | 1,00 | 1,13-1,36 |
| Work status | 1,24*** | |

***p<0,01, **p<0,05

Based on the results shown in Table 3, respondents who make decisions related to health issues have a higher education level (p-value=0.000), exposed to the media (p-value=0.047), use the internet (p-

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value=0.000), have a bank account (p-value=0.000), employed (p-value=0.000), and live in urban areas (p-value=0.000).

## DISCUSSION

This study identified factors associated with women being the decision-makers in the family regarding health issues. The results showed that there is a significant relationship between the highest level of education and the person who makes health-related decisions. In this study, it can be seen that most of the respondents who act as decision makers in the family related to health are women who have an educational background. The higher a woman's education level, the more likely she is to be a family decision-maker related to health. The level of education increases women's autonomy to make decisions about their health. The continuous advancement of education and the latest technology in education can empower women to access more information. With this information, women's ability to manage resources increases and their decision-making skills begin to grow. Education can also instill confidence and self-esteem and this has an impact on women's health-related behaviors. Women with education make different decisions than women who are only exposed to information from the media. (Alkaby, 2022).

In this study, women who had a tertiary education background were 2.5 times more likely to have autonomy in making decisions. Another study found the same thing, where women with higher education were 5.5 times more likely to have autonomy in decision-making (Sougou et al., 2020). Women with lower levels of education tend to have low autonomy over decision making, so that the decision maker is someone else, namely the husband. In this study, 20.5% of women did not have an educational background and decision-making for their health was entirely up to their husbands. Women who have unmet needs are women who do not have autonomy in making decisions for their own health. Another study found a larger percentage of 80% of primary decision makers were husbands (Sougou et al., 2020). Idris in his research explained that the factors associated with women's autonomy in deciding about health issues are age, education, occupation, as well as region of residence (Idris et al., 2023).

## CONCLUSION

This study revealed that factors associated women's decision-making power were higher education level, media exposured, ever used internet, have a bank account, employed, and live in urban areas. Highly educated women increased the authority of women to be decision-makers in their families, especially in health issues. By having a high education, women can determine the actions taken for manage health, especially for themselves.

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