



Factors that lead to stagnation of total fertility rate (TFR) decline in Jakarta Province based on 2017 Indonesian demographic and health survey (IDHS) data

Faktor-faktor yang berhubungan dengan stagnasi penurunan total fertility rate (TFR) di Provinsi DKI Jakarta berdasarkan data SDKI tahun 2017

Erina Windiany^{1*}, Tiarlin Lavidia Rahel², Anah Sugihanawati³
^{1,2,3}STIK Budi Kemuliaan, Jl. Budi Kemuliaan no. 25 Jakarta 10110, Indonesia, email: aisairiany@gmail.com

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Erina Windiany,
aisairiany@gmail.com

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ABSTRACT

Background: : The Total Fertility Rate (TFR) of 2017 IDHS data in Jakarta stagnated at 2.2, which has not yet reached the TFR target of 2.1.

Objective: To investigate the variables associated with the stagnation of TFR decline in Jakarta based on the 2017 Jakarta IDHS data.

Methods: Cross-sectional design, source of secondary data came from the 2017 IDHS fertility data of DKI Jakarta Province. Sample data of women of childbearing age, 883 samples. Independent variables: characteristics (age, education, occupation, decision maker), reproductive services (source of family planning services, media about family planning) and reproductive behavior (age at first active sexual intercourse, family planning method, use of health insurance, opinion about number of children). Data analysis was conducted up to the multivariate.

Results: There was an association between age ($p=0.000$), education ($p=0.028$), decision maker ($p=0.000$), source of family planning services ($p=0.000$), age of sexual activity ($p=0.008$), contraceptive method ($p=0.000$) and opinion on number of children ($p=0.000$) with stagnation of TFR decline. Multivariate analysis: The OR value (2.331) was highest for the variable opinion about having more than two children.

Conclusion: Factors that lead to stagnation of TFR decline in Jakarta were most at risk in the variable women of child bearing age opinion about having more than two children. Education is needed to raise awareness about the perception of ideal child value.

Keywords: Age, education, family planning, fertility, opinion on the ideal number of children.

ABSTRAK

Latar Belakang: Angka kelahiran hidup (*Total Fertility Rate*) data SDKI 2017 di Jakarta stagnan pada angka 2,2, belum mencapai target TFR 2,1.

Tujuan: untuk mengetahui faktor yang berhubungan dengan stagnasi penurunan TFR di Jakarta berdasarkan data SDKI Jakarta tahun 2017.

Metode: *Cross sectional design*, sumber data sekunder berasal dari data fertilitas SDKI Propinsi DKI Jakarta tahun 2017. Sampel data wanita usia subur (WUS), sebanyak 883 sampel. Variabel independen: karakteristik (usia, pendidikan, pekerjaan, pembuat keputusan), layanan reproduksi (sumber pelayanan KB, media tentang KB) dan perilaku reproduksi (umur seksual aktif pertama, metode KB, penggunaan jaminan kesehatan, opini jumlah anak ideal). Analisis data dilakukan sampai dengan tahap multivariat.

Hasil: Analisis bivariat: terdapat hubungan umur ($p=0,000$), pendidikan ($p=0,028$), pembuat keputusan ($p=0,000$), sumber pelayanan KB ($p=0,000$), umur seksual aktif ($p=0,008$), metode KB ($p=0,000$) dan opini jumlah anak ($p=0,000$) dengan stagnasi penurunan TFR. Analisa multivariat: nilai OR (2,331) paling tinggi pada variabel opini memiliki jumlah anak lebih dari dua.

Kesimpulan: Faktor yang berhubungan dengan stagnasi penurunan TFR di Jakarta dominan pada variabel opini WUS tentang memiliki anak lebih dari dua. Perlunya edukasi untuk menumbuhkan kesadaran tentang persepsi nilai anak yang ideal.

Kata kunci: Fertilitas, keluarga berencana, opini jumlah anak ideal, pendidikan, umur.

INTRODUCTION

Rapid population growth is one of the most important issues in Indonesia. With 270.20 million people living in Indonesia in 2020, Indonesia is the fourth-biggest nation on earth.¹ In the BKKBN Strategic Plan 2015-2019, the BKKBN has set the goal of "Achieving a Balanced Population Growth through efforts to reduce the Population Growth Rate and the Realization of Quality Families". To achieve this goal, BKKBN sets five strategic objectives that are in accordance with the objectives of population and family planning development, namely: (1). Reduction of TFR; (2). Increase modern contraceptive prevalence rate (mCPR); (3). Reduce the percentage of contraceptive dropouts; (4) Increase the number of active family planning participants using a long-acting contraceptive method; and (5) Reduce the unmet need for family planning.²

To achieve this balanced population growth condition, it is expected that TFR for Indonesian population is predicted to reach 2.1 per woman by 2020. However, after seeing the TFR in Indonesia based on the Indonesian Demographic and Health Survey (IDHS) has stagnated since 1991 to 2017. In 2017 the TFR was 2.4 per woman, which means that a woman in Indonesia gave birth to 2.4 children on average during her lifetime, it is feared that it is not in accordance with the population projection assumptions that were built when the TFR in 2020 was 2.1.³ The unachievement of TFR decline in accordance with the target

can be caused by: the perception of ideal child value, the decline in modern contraceptive utilisation, the prevalence of dropouts or unmet need for family planning services, the disparity of TFR achievements with the tendency of TFR which is still relatively high in several provinces, especially in eastern Indonesia.² The higher the TFR in a region, the higher the population density. One of the most populous regions in Indonesia is Jakarta. As the capital of Indonesia, Jakarta is the center of government, the center of the economy and national administration. It is this attraction that makes people interested in coming, settling, working and increasing their income in Jakarta, which results in a rapid increase in population growth and development. In line with the most recent data from 2019, Jakarta has 11,063,324 residents total.¹

The TFR in Jakarta Province has dropped from 2.4 to 2.2, but it has not yet achieved the goal of 2.1, according to the 2017 IDHS. Stagnation TFR decline has implications for various aspects of community life and national development. Birth control that is not matched by economic growth and infrastructure development can result in population imbalances that impact the age structure and the size of the labor force. The density of the population in Jakarta causes various impacts, including problems of employment opportunities, education, health, security, waste management, green open space, space or parks for a healthy and comfortable public.⁴

Faktor-faktor yang berhubungan dengan stagnasi penurunan total fertility rate (TFR) di Provinsi DKI Jakarta berdasarkan data SDKI tahun 2017
Erina Windiany¹, Tiarlin Lavidia Rahel², Anah Sugihanawati³

Fertility can be influenced by various factors including education, employment, income, age at first marriage, perceived value of children, infant or under-five mortality, unmet need.^{5,6} In an effort to reduce TFR, the government is implementing family planning program.² There are several factors that can influence a person or couple in the use of contraception, namely the characteristics of family planning acceptors, knowledge about contraceptive, the number of kids they have, husband's support.⁷ support from health workers⁸, and various other factors. Therefore, there is a need for a deeper study of the factors that lead to stagnation of TFR decline in Jakarta. The purpose of this study was to investigate the factors that most strongly associated with stagnation of TFR decline in Jakarta. This study's findings may be used to design policies and programs that can overcome the challenges that arise and support the TFR decline target.

METHOD

This research was grant-funded study to analyze the 2017 Jakarta IDHS data, which was conducted from October to December 2020. This study used a cross-sectional design to analyze the factors that lead to stagnation of TFR decline in Jakarta with a sample size of 883 women of childbearing age in the 2017 IDHS data of Jakarta Province. This study used consecutive sampling with inclusion criteria, which is the completeness of data in accordance with the variables to be studied, namely the characteristics of the

respondents, reproductive services, and reproductive behavior. The operational definition of stagnation in TFR decline in this study was when the respondent had more than two children. Three phases of analysis were conducted on the data: descriptive, bivariate, and multivariate. Chi square test was used in bivariate analysis, whereas Wald test for logistic regression was used in the multivariate analysis because the variables of this study were categorical scales and to find the most dominant variable associated with the stagnation of TFR decline in Jakarta.

RESULT AND DISCUSSION

This study conducted an analysis based on variables of respondents' characteristics, reproductive services, reproductive behavior towards stagnation of TFR decline in Jakarta based on IDHS data in 2017.

Table 1. The Correlation Between Respondent Characteristics and Stagnation of TFR Decline

Variables	Stagnation of TFR Decline		P valuee
	No (Had ≤2 children) (n=563)	Yes (Had >2 children) (n=320)	
Age			
≤20 & ≥35 years old	321 (57%)	274 (85,6%)	0,000*
20-34 y.o	242 (43%)	46 (14,4%)	
Education			
≤High School	421 (74,8%)	260 (81,3%)	0,028*
≥College	142(25,2%)	60 (18,7%)	
Work			
Working	312(55,4%)	179(55,9%)	0,881*
Does not Working	251(44,6%)	141(44,1%)	
Decision makers			
Women	94(16,7%)	74(23,1%)	0,000*
Women's spouse	25(4,4%)	19(5,9%)	

Variables	Stagnation of TFR Decline		P valuee
	No (Had ≤2 children) (n=563)	Yes (Had >2 children) (n=320)	
Women with spouse	184(32,7%)	132(41,3%)	
Others	260(46,2%)	95(29,7%)	

*Chi square test

Based on the data on the characteristics of respondents in table 1, that the age, education, and family planning decision-makers were found to have a strong correlation with stagnation of TFR decline ($p=0.000$).

Table 2 The Correlation Between Reproductive Services and Stagnation of TFR Decline

Variables	Stagnation of TFR Decline		P Value
	No (Had ≤2 children) (n=563) f (%)	Yes (Had >2 children) (n=320) f (%)	
Sources of Family planning services			
Government clinic /pharmacy/Government home/community delivery	49 (8,7%)	46 (14,4%)	0,000*
Privat clinic/delivery	136 (24,2%)	120 (37,5%)	
Pharmacy/Shop, friends/others	67 (11,9%)	38 (11,9%)	
Forgot/Don't Know	311 (55,2%)	116 (36,3%)	
Media			
Radio			
Exposed	51 (9,1%)	39 (12,2%)	0,140*
Not Exposed	512 (90,9%)	281 (87,8%)	
TV			
Exposed	380 (67,5%)	217 (67,8%)	0,923*
Not Exposed	183 (32,5%)	103 (32,2%)	
Newspaper			
Exposed	105 (18,7%)	72 (22,5%)	0,170*
Not Exposed	458 (81,3%)	248 (77,5%)	

*Chi Square test

Based on the data in table 2, places/sources of family planning services showed significant relationship with stagnation of TFR decline ($p=0.000$).

Table 3 The Correlation Between Reproductive Behavior and Stagnation of TFR Decline

Variables	Stagnation of TFR Decline		P Value
	No (Had ≤2 children) (n=563) f (%)	Yes (Had >2 children) (n=320) f (%)	
Age of first active sexual intercourse			
≤ 20 years old	190 (33,7%)	137 (42,8%)	0.008*
20-34 years old	349 (62%)	164 (51,2%)	
35-49 years old	24(4,3%)	19(5,9%)	
Contraceptive Method			
Long term contraception	69 (12,3%)	85 (26,6%)	0.000*
Short term contraception	113 (20,1%)	50 (15,6%)	
Specific Method	80 (14,2%)	54 (16,9%)	
No Contraception	301(53,5%)	131(40,9%)	
Use of Health Insurance in contraception			
Yes	37 (6,6%)	20 (6,3%)	0.825*
No	526 (93,4%)	300 (93,8%)	
Opinion of the ideal number of children			
≤ 2 kids	343 (60,9%)	130 (40,6%)	0.000*
>2 kids	220 (39,1%)	190 (59,4%)	

*Chi Square test

Based on the reproductive behavior data in table 3, the variables of age of onset of sexual activity, birth control method used, and opinion of ideal number of children showed a significant relationship with stagnation of TFR decline ($p=0.000$).

Multivariate Analysis

Table 4 Wald Test Logistic Regression Results Based on The Correlation Between Respondent Characteristics and Stagnation of TFR Decline

Variables	P Value *	OR	CI 95%	
			Min	Max
Age	0,000	0,193	0,134	0,278
Education	0,013	0,636	0,445	0,911
Decision maker of contraception	0,000	0,806	0,747	0,871

*Analysis with Wald Test logistic regression

Statistical analysis of table 4 revealed a significant correlation between characteristics, (age, education and decision maker of contraception) with stagnation of TFR decline ($p<0.05$); The OR (odds ratio) on age was 0.193 times (95% CI 0.134-0.278). This means than women in the group who are under 20 and over 35 years old are statistically more likely to have more than two children (0.193 times). The OR on education was 0.636, statistically this means that woman of

child bearing age with the latest education is less than or equal to high school graduation were likely to have more than two children by 0.636 times. The OR for decision maker in contraception was 0.806, this means that decision makers in using contraception by women and couples had 0.806 times chance of having more than 2 children.

Table 5 Wald Test Logistic Regression Results Based on The Correlation Between Reproductive Services and Stagnation of TFR Decline

Variables	P Value*	OR	CI 95%	
			Min	Max
Sources for family planning services	0,000	0,694	0,612	0,788
Radio	0,294	1,286	0,804	2,058
Newspapers	0,246	1,237	0,864	1,771

*Analysis with Wald Test logistic regression

The statistical analysis of table 5 revealed a significant relationship between the source of family planning services and stagnation of TFR decline ($p=0.000$). The OR of the source of family planning services was 0.694 times (95% CI 0.612-0.788), which means that fertile woman who accessed family planning services at private clinics had the possibility of having more than two children by 0.694 times compared to fertile woman who accessed appropriate family planning services (hospitals, health centers, village clinic, pharmacy, etc.)

Table 6 Wald Test Logistic Regression Results Based on The Correlation Between Reproductive Behavior and Stagnation of TFR Decline

Variables	P Value*	OR	CI 95%	
			Min	Max
Age of first active sexual intercourse	0.036	0.762	0.592	0.983
Contraceptive method	0.086	1.114	0.985	1.260
Opinion of the ideal number of children	0.000	2.331	1.758	3.091

*Analysis with Wald Test logistic regression

The statistical analysis conducted on Table 6 revealed a significant correlation ($p<0.05$) between the age at which a person engages in their first sexual activity and their opinion of the ideal number of children with stagnation of TFR decline.

The OR of age of first active sexual intercourse was 0.762 times (CI 95% 0.656-0.709), this means that woman of child bearing age with age of first active sexual intercourse at the age of 20-34 years were likely to have more than 2 children by 0.762 times compared to age < 20 years and > 35 years. The OR of the ideal number of children opinion was 2.331 (95% CI 1.758-3.091), according to the statistics result, that woman of child bearing age who think they have more than two ideal children are likely to have more than two children by 2.331 times compared to the ideal child opinion less than or equal to two children. Two variables of reproductive health behavior that has the greatest chance of stagnation of TFR decline is the opinion of woman of child bearing age about the ideal number of children owned by a family more than two children (OR. 2.331).

Respondent Characteristics

Based on the research result with Chi Square test obtained $p=0.000$ on age variable and stagnation of TFR decline, it is accordance with research which states that age and length of marriage have a positive relationship with the tendency to have more than two children.⁹ This could be because age and length of marriage are closely related to

the length of a woman's fertile period. The older the age of a woman and the longer the time a woman lives in a marriage bond, the greater the fertile period of the woman who is at risk of being exposed to pregnancy, thus causing the possibility of the woman to have more children to be greater. Older women tend to have greater fertility⁹. The average number of children born to women with younger age at first marriage also tends to be larger. This is because women of older age and women who have a younger age of first marriage have a longer fertile period, so the chances of having larger number of children will also be greater. Age has a significant positive influence on the fertility of women of childbearing age who have given birth. Every additional year of age of a woman of child bearing age who has given birth will increase the number of children born alive by more than two by 1.178 times.¹⁰

Test results of Chi square test obtained ($p=0.028$) on education variable with stagnation of TFR decline. Women who spend more time in education will shorten the risk of pregnancy because they spend a long period of years in school. In addition, highly educated women tend to choose to work before getting married, education also provides wider opportunities to participate in economic activities.⁶ Education can also increase women's knowledge in the process of information about fertility choices and pregnancy behavior.^{11,5} The better the level of education of women, the more potential they have to make a greater contribution to the

family income so that the time they devote to raising children is more limited, which in itself will affect the number of children desired.⁵

Test results of Chi square test obtained ($p=0.881$) on work variable and stagnation of TFR decline, this is in accordance with Endru Setia Adi's research that the bulk of working hours of women in the village area of Lumajang Regency does not have a significant effect on fertility, this is because the bulk of working hours of women is only considered to fill leisure time and aims to increase the income of their family income, so it does not affect fertility rates⁶. In contrast to other studies that the more hours of work devoted by women of childbearing age, the less fertility, and otherwise if the working hours of women of childbearing age are less, the more fertility.^{12,13} Women with working status have a tendency to have more than two smaller children.¹⁰

Decision makers in contraceptive use in the two groups were dominated by women of childbearing age and couples (32.7% vs 41.3%) with $p= 0.000$. The desire of women of childbearing age in determining the use of contraceptives will be influenced by the support of husbands, families, contraceptive service providers. Husband's support will affect the desire of family planning acceptors to use contraceptives. This is because many Indonesian people still adhere to a patrilineal culture where the man or husband is the head of the family who is responsible for the family and is in control of decision making. Therefore,

husband's support regarding the selection and use of family planning by wives is very influential from husband's support^{14,15,16}

In making decisions about the use of contraceptives, it cannot be separated from the role of husband to provide support and approval in the use of contraceptives. The better the support given by the husband, the decision making is in accordance with the wishes of the husband and wife, otherwise if the husband's support is lacking, there will be dissatisfaction of the wife in the use of contraceptives.¹⁷ In this study with the characteristics of decision makers, husband and wife have full involvement in decision making, the use of contraceptives is also influenced by support from contraception service providers / health workers, for example in choosing to use long-term contraception.^{18,19,20}

Reproductive Services

Reproductive services in family planning in the respondent who had <2 fertility children were dominated by the answer not knowing (55.2%), the second largest answer was contraceptive services obtained at a private clinic. In the respondent who had >2 children, contraceptive services were obtained at a private clinic (37.5%). This is in line with the 2012 IDHS data which states that the highest contraceptive services are in the private sector with the dominance of contraceptive services such as pills, injections, IUDs, condoms.²¹ Another study stated that the majority of respondents chose contraceptive services in private midwives.^{22,23}

Test results of Chi square test obtained $p=0.000$ and OR 0.694 times on the source of family planning services variable and stagnation of TFR decline, this means that women of childbearing age who are not fixed / do not know the place of family planning services are likely to have more than two children by 0.694 times compared to woman of child bearing age who access the right place of family planning services (hospital, public health centre, midwife clinic, pharmacy, etc.). Based on Nilawati's research, with $p=0.014$ and OR= 4.000, so it can be stated that respondents who get family planning services in the private sector will be likely to use contraception as much as 4.000 times greater than women who are in the government sector.²⁴ To increase contraceptive coverage, family planning services should be available and accessible to all couples of childbearing age anywhere, whether public or private. The need to evaluate the family planning program, contraceptive evaluation includes an assessment of specific contraceptive methods, side effects, and convenience of use.²⁵

The variable of media exposure to family planning information showed that the majority of both groups were exposed to family planning-related information through TV (67.5% vs. 67.8%). The study results there is no correlation ($p>0.05$) among media exposure to family planning information and stagnation of TFR decline. This is in accordance with other studies on the data analysis of the 2019 Program Performance

and Accountability Survey (SKAP).²⁶ Yunita's research states that the source of information on contraceptive methods through print/electronic media was found to be OR 12.1, meaning that women who get information about contraceptive through print / electronic media are 12.1 times more likely not to use contraceptive methods. This may be due to the message conveyed through print/electronic media not being understood and not understood by women.²⁷

In contrast to previous research, there is a significant relationship between exposure to information about family planning through print and electronic media with the use of family planning, especially long-term methods.^{22,28}

Women who gain knowledge/information about family planning through television are 1.6 times more likely to become family planning acceptors, while radio media as a source of information about family planning media is less powerful in influencing contraceptive use among the community.²⁹

Syahmida's research states that the percentage of women who have one to two children is higher in women who have access to media that informs about family planning compared to women who do not have access to media. Conversely, women who had more than two children tended to be many in those who did not access information about family planning from the media.³⁰

Reproductive behavior

Test results of Chi square test obtained $p=0.000$ on the reproductive behavior variables (age at first active sexual intercourse, birth control method, and opinion of ideal number of children) and stagnation of TFR decline (table 3). There is no significant correlation between the use of health insurance (BPJS) and stagnation of TFR decline ($p>0.05$). The age of first marriage is one that can affect the level of productivity in Fertile Age Couples. The age of first marriage will contribute to the birth rate. The average age of the population when married for the first time and the length of time a person is in marital status will affect the high and low fertility.

The percentage of women who had one to two children tended to rise with the age of first sexual intercourse. In contrast, the proportion of women who have more than two children tends to be more in women who have sexual intercourse at a younger age with a value of $p=0.01$ indicating that there is a significant relationship between the age of first sexual intercourse and the number of children born.³⁰ The younger age of woman of first marriage, the longer the reproductive period, the longer the risk of a woman to become pregnant and give birth, the more children she has^{5,9}. The low age of first marriage of women is thought to be due to the low level of education and economic capacity, as well as the influence of socio-cultural factors that will encourage parents to immediately marry off

their female children even though they are still young.⁵

The results of this study analysis show that the method of birth control with stagnation of TFR decline shows $p=0.000$. In Syahmida's study, among women who had one to two children, there was no difference in the proportion of husbands/partners who agreed or disagreed with the use of family planning methods. Women with five or more children were more likely to be found among those whose husbands disagreed with the use of family planning methods. With a $p=0.001$, there was a significant association between husband/partner opinion and the use of family planning methods.³⁰

Respondents' opinions about the perception of how many children are ideal to have in the family that obtained from the 2017 IDHS data are statistically significant for stagnation of TFR decline. The results of Sri Yuniarti's research show that the factor of perceived value of children is significantly related to fertility rates. Perception is the variable most closely related to fertility rates. Most woman of child bearing age have a positive perception of the value of children, namely providing emotional, economic, self-development benefits, recognizing children, harmony and family successors.⁵ This is in line with Syahbudin's research which states that women who have one to two children are more common among those who want two children or less. Conversely, those who have more than two children born alive tend to want to have more than two children. The $p=0.001$

indicates that the number of children desired (ideal children) has a significant relationship with the number of live born children.³⁰

Parents' views on the value of children and the number of children in the family can be an obstacle to the success of family planning programs.³¹

The high fertility rate in Bengkulu in 2010 was also influenced by the ideal number of children in the family, as suggested by Freedman (1962) in relation to the economic value of children. The data shows that the ideal number of children in Bengkulu Province is three (rounding up from 2.8) for both rural and urban residents.³² Changing the paradigm towards the opinion how many children are ideal to have in the family is certainly not easy, although it is also not impossible to do. Modernization and increased education of the Indonesian people are expected to will be able to change views that are more oriented towards small family norms.

There is no relationship between the utilisation of health insurance in family planning and stagnation of TFR decline. This contradicts Sri Yuniarti's research that the childbirth insurance factor is significantly related to fertility rates. The reality is that many women of child bearing age use birth insurance and the fertility rate is still high. Using birth insurance means that the cost of pregnancy and maternity care is free, so that it can trigger the desire of fertile woman to have more than two children, without imposing restrictions.⁵

Multivariate analysis in table 6 obtained an OR value of opinion on the ideal number of children is 2.331, this means that the respondents who think the ideal children to have in the family is more than two are likely to have children more than two by 2.331 times, compared to the ideal child opinion less or equal to two children. The two variables of reproductive health behavior that has the greatest correlation is the opinion/perception about the ideal number of children owned by a family is more than two children (OR. 2.331).

CONCLUSION

According to the analysis of the 2017 Jakarta IDHS data, indicates that the factor that leads to stagnation of TFR decline is the opinion of the ideal number of children owned by the family more than 2 children (multivariate analysis).

To achieve the TFR in accordance with the expected target, it requires cooperation from various parties, ranging from families, communities to the government. The success of fertility control is strongly influenced by public awareness of the importance of family planning. The efforts to raise public awareness must be maximally pursued through various extension activities, socialization, education, guidance, monitoring and more optimal family planning services by utilizing technology. The government should strive to provide family planning services that are affordable, easily

accessible to the community, improve counseling services, socialization of reproductive rights, and most importantly increase public understanding of fertility regulation and the perception of how many children are ideal to have in the family.

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