WHO BEARS THE BURDEN? GENDER, CONTRACEPTIVE RESPONSIBILITY, AND THE LEGAL REGULATION OF REPRODUCTIVE CHOICE IN INDONESIA

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Abstract

This study examines how gender relations, cultural norms, religious beliefs, and state intervention shape contraceptive responsibility and reproductive choice in Indonesia. It focuses on gender imbalance in family planning, in which women bear the social and moral burden of contraception, while men remain marginally involved. Drawing on socio-legal analysis, feminist theory, and Michel Foucault's concept of biopower, the study analyses legislation, policy debates, historical developments, and scholarship, with particular attention to Government Regulation No. 28 of 2024 and recent controversies concerning contraceptive access and vasectomy. The findings show that contraception in Indonesia is not merely a matter of medical choice, but a contested field structured by patriarchy, religious interpretation, cultural expectations, healthcare systems, and population policy. Women's reproductive decisions are frequently influenced by husbands, medical authorities, and state programmes, while male contraceptive participation remains limited by narrow method availability and dominant ideals of masculinity. The regulation of adolescent access to contraception further reveals tensions between reproductive health, moral governance, abstinence, and cultural values. Through a biopolitical lens, family planning emerges as both a public health instrument and a mechanism for managing population, productivity, and social order. The study argues that reproductive autonomy cannot be realised through expanded contraceptive availability alone. Effective reform requires gender-responsive policies that promote meaningful male participation, safeguard informed and voluntary choice, address coercive and patriarchal decision-making, and recognise Indonesia's diverse social, religious, and cultural contexts. Responsibility for contraception must therefore be understood as shared, negotiated, and grounded in individual rights rather than assigned predominantly to women.

***Keywords**: Contraception; Family Planning; Gender; Reproductive Health; State Policy.*

A. Introduction

"My body, my choice!" slogan reflects a central pillar of reproductive rights and bodily autonomy.[1] Rooted in feminist theory and gender politics, bodily autonomy asserts that individuals

[1] Seda Saluk, '"My Body, My Decision!": Abortion, Bodily Autonomy, and Reproductive Rights Activism in Turkey', *Journal of Middle East Women's Studies* 19, no. 3 (2023): 379–400, https://doi.org/10.1215/15525864-10815525; Miri Trauner, 'My Body, Whose Choice? A Case for a Fundamental Right to Bodily Autonomy', *Brooklyn Law Review* 89, no. 2 (2024): 643–79, https://brooklynworks.brooklaw.edu/blr/vol89/iss2/6/; Zachary D. Palmer and Elle Rochford, 'Bodily Autonomy and the Limits of Gender-Based Activism in Organizing Beyond

have control over one's own body and make decisions regarding it.[2] This concept is deeply rooted in gender politics, holding that individuals should have the authority to make decisions about their own bodies, free from external interference or coercion. Feminist scholars have long argued that restrictions of bodily autonomy lead to broader societal oppression.[3] This principle is enshrined in the Universal Declaration of Human Rights, a document adopted by the United Nations General Assembly decades ago – which continues to serve as critical benchmark for dignity, freedom, and equality for all people, regardless of gender or any other status. [4]

However, the question arises: to what extent should the state be concerned with the morality or other factors surrounding reproductive choices, beyond issues of harm and consent? Some forms of reproduction – such as human cloning and human-animal hybrids – are often not regarded as matters of individual privacy and decision-making. Instead, these practices are subject to public debate, often serving as conduit for moral constraints on reproductive decisions. The widespread prohibition of human cloning, even under legal framework that mandate evidence of a direct harm, demonstrates that the state authority frequently overrides individual choice in reproduction matters. While public morality – as a justification for state regulation of reproduction – should be rejected, the concept of human dignity may justify state intervention in certain cases. Specifically, decisions that seem to objectify, dehumanize, or shame the human species may present risks to human dignity, making them potential grounds for regulation. The potential impact of some reproductive choices on human dignity could justify state intervention. This brings forward a delicate balance between individual rights and the state's responsibility to safeguard ethical

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the Binary', in *Handbook of Gender and Activism* (Edward Elgar Publishing, 2025), https://doi.org/10.4337/9781803929583.00014; Aga Natalis and Ani Purwanti, *Ilmu Hukum Feminis* (Rajawali Pers, 2026).

2 Priscilla Alderson, 'Bodily Integrity and Autonomy of the Youngest Children and Consent to Their Healthcare', *Clinical Ethics* 19, no. 4 (2024): 291–96, https://doi.org/10.1177/14777509231188006.

3 Robin Stevenson, *My Body, My Choice: The Fight for Abortion Rights*, vol. 2 (Orca Book Publishers, 2019); Katharina Wolf and Petra Theunissen, '"My Body, My Choice": Discursive Brandjacking and the Strategic Reframing of Protest Language', *Public Relations Review* 52, no. 1 (2026): 102652, https://doi.org/10.1016/j.pubrev.2025.102652; Tashina Blom, 'My Body My Choice: The Hostile Appropriation of Feminist Cultural Memory in American Anti-Vaccine Movements', *Memory Studies* 17, no. 5 (2024): 1089–104, https://doi.org/10.1177/17506980241262391.

4 David J. Scheffer and Mark S. Ellis, 'Protect Human Rights and Fundamental Freedoms', in *The UN Charter: Five Pillars for Humankind*, ed. David J. Scheffer and Mark S. Ellis (Springer Nature Switzerland, 2025), https://doi.org/10.1007/978-3-031-94866-4_2; Tameshnie Deane, 'Gender-Based Violence in International Human Rights Law – The Efficacy of the United Nations Human Rights Legal Framework and CEDAW in Addressing the Issue', *The Age of Human Rights Journal* 23 (2024): e8662, https://doi.org/10.17561/tahrj.v23.8662; Aoife M. O'Connor et al., 'Transcending the Gender Binary Under International Law: Advancing Health-Related Human Rights for Trans* Populations', *Journal of Law, Medicine & Ethics* 50, no. 3 (2022): 409–24, Cambridge Core, https://doi.org/10.1017/jme.2022.84.

standards – prompting further investigation into how far the state should go in regulating reproductive choices.[5]

Despite international human rights, bodily autonomy – particularly women's and girls' rights, remain severely compromised under threat in many parts of the world. Although the Universal Declaration of Human Rights asserts universal rights for all, structural barriers leave millions unable to exercise control over their reproductive lives.[6] Statistics show that nearly half of all pregnancies are unintended, and maternal mortality claims a life every two minutes – primarily from preventable complications. Gender-based violence also affects one in three women over their lifetimes, an insecurity acutely compounded in humanitarian crises and conflict settings. These circumstances highlight the urgent need for the universal recognition and protection of bodily autonomy. It demands universal access to comprehensive quality sexual and reproductive health information and services, including reliable contraception and respectful maternal care.[7]

Contraception, commonly referred to as birth control, encompasses various methods, devices, or medications employed to prevent pregnancy.[8] Given that these options vary significantly in clinical efficacy, side-effect profiles, and accessibility, a comprehensive understanding of these trade-offs is essential for facilitating informed, autonomous reproductive choices – particularly for women, who carry the primary physiological burden of family planning.[9]

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5 Elizabeth Wicks, *The State and the Body: Legal Regulation of Bodily Autonomy* (Bloomsbury Publishing, 2016).

6 Each year in developing regions, more than 30 million women do not give birth in a health facility, more than 45 million have inadequate or no antenatal care, and more than 200 million women want to avoid pregnancy but are not using modern contraception. Each year worldwide, 25 million unsafe abortions take place, more than 350 million men and women need treatment for one of the four curable sexually transmitted infections (STIs), and nearly 2 million people become newly infected with HIV. Additionally, at some point in their lives nearly one in three women experience intimate partner violence or non-partner sexual violence. Ultimately, almost all 4·3 billion people of reproductive age worldwide will have inadequate sexual and reproductive health services over the course of their lives. see Ann M. Starrs et al., 'Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission', *The Lancet* 391, no. 10140 (2018): 2642–92, https://doi.org/10.1016/S0140-6736(18)30293-9.

7 UNFPA Executive Director, *Human Rights Require Bodily Autonomy for All – at All Times*, 9 December 2023, https://www.unfpa.org/press/human-rights-require-bodily-autonomy-all-%E2%80%93-all-times; German Federal Ministry for Economic Cooperation and Development (BMZ), 'Bodily Autonomy and Reproductive Health', BMZ, 2023, https://www.bmz.de/en/issues/bodily-autonomy-and-reproductive-health.

8 Jean-Jacques Amy and Vrijesh Tripathi, 'Contraception for Women: An Evidence Based Overview', *BMJ* 339 (2009), https://doi.org/10.1136/bmj.b2895; Regine Sitruk-Ware et al., 'Contraception Technology: Past, Present and Future', *Contraception* 87, no. 3 (2013): 319–30, https://doi.org/10.1016/j.contraception.2012.08.002; Stephanie Teal and Alison Edelman, 'Contraception Selection, Effectiveness, and Adverse Effects: A Review', *JAMA* 326, no. 24 (2021): 2507–18, https://doi.org/10.1001/jama.2021.21392.

9 Alison Scott and Anna Glasier, 'Evidence Based Contraceptive Choices', *Towards Evidence-Based Gynaecology* 20, no. 5 (2006): 665–80, https://doi.org/10.1016/j.bpobgyn.2006.03.002; Helen H. Kim and Sabrina Holmquist, 'Contraception', in *Pediatric Endocrinology: A Practical Clinical Guide*, ed. Sally Radovick and Madhusmita Misra (Springer International Publishing, 2018), https://doi.org/10.1007/978-3-319-73782-9_29; Rakhi Jain and Sumathi Muralidhar, 'Contraceptive Methods: Needs, Options and Utilization', *The Journal of Obstetrics and Gynecology of India* 61, no. 6 (2011): 626–34, https://doi.org/10.1007/s13224-011-0107-7.

Discussions surrounding such programs frequently revolve around the various contraceptive methods employed. As characterized by its unique cultural traits, Indonesia exhibits a notable degree of religious influence that significantly shapes societal perspectives on contraception.[10] Religious education is initiated at a young age, leading to the internalization of religious knowledge that shapes subjective perspectives on various issues.

A significant portion of the Indonesian population experiences restricted mobility, influenced by deep-rooted cultural and traditional connections. Within conservative and faith-based communities, modern contraception is frequently framed as fundamentally incompatible with religious teachings or cultural values.[11] Theological opposition often characterises "family planning" as an illicit interference with divine providence, while broader socio-cultural critiques allege that contemporary contraception erodes moral values or lessens the significance of family life. Religious and cultural perspectives on contraception exhibit significant variation. Most of religious teachings do not explicitly forbid the use of modern contraception, considering it is employed for justifiable reasons, such as health considerations or the family welfare.[12] The proliferation of these myths leads many individuals to feel trapped by societal norms that often diverge from actual circumstances. [13]

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[10] Erlinda Noviantika Ardila and FX. Sri Sadewo, 'Konstruksi Masyarakat Madura Tentang Pemakaian Alat Kontrasepsi Implan Di', *Paradigma* 2, no. 3 (2014): 1–7, https://ejournal.unesa.ac.id/index.php/paradigma/article/view/9080; Jessi Gustina et al., 'Influence of Sociocultural Beliefs and Practices on Contraception in Deli Serdang, Indonesia', *Malahayati International Journal of Nursing and Health Science* 8, no. 6 (2025): 788–94, https://doi.org/10.33024/minh.v8i6.887.

[11] Gustina et al., 'Influence of Sociocultural Beliefs and Practices on Contraception in Deli Serdang, Indonesia'; Abibata Barro et al., 'Knowledge, Beliefs and Perceptions of Religious Leaders on Modern Contraceptive Use in Burkina Faso: A Qualitative Study', *Pan African Medical Journal* 39, no. 1 (2021): 216, https://doi.org/10.11604/pamj.2021.39.216.27082; Sena Adugna Beyene et al., 'Prevalence and Predictors of Modern Contraceptive Method Utilization Among Married Couples in the Pastoralist Communities of Fentale District, Eastern Ethiopia', *Scientific Reports* 15, no. 1 (2025): 12395, https://doi.org/10.1038/s41598-025-92285-1; Alfian Gafar et al., 'Determinants of Contraceptive Use Among Married Women in Indonesia', *F1000Research* 9 (2020): 193, https://doi.org/10.12688/f1000research.22482.1; Dwi Wulandari and Ella Nurlaella Hadi, 'Asosiasi Budaya Patriarki Terhadap Penggunaan Kontrasepsi', *Jurnal Riset Kesehatan Poltekkes Depkes Bandung* 16, no. 2 (2024): 354–64, https://doi.org/10.34011/juriskesbdg.v16i2.2549; Amirrtha Srikanthan and Robert L. Reid, 'Religious and Cultural Influences on Contraception', *Journal of Obstetrics and Gynaecology Canada* 30, no. 2 (2008): 129–37, https://doi.org/10.1016/S1701-2163(16)32736-0.

[12] Ajeng Hijriatul Aulia et al., 'Controversial Phenomenon of The Freedom to Buy and Sell Contraceptives in Palangka Raya', Articles, *Indonesian Journal of Law and Islamic Law (IJLIL)* 7, no. 1 (2025): 54–65, https://doi.org/10.35719/ijlil.v7i1.446; Satrio Bagus Tatag Ananto and Wiwik Afifah, 'Legality of Contraceptive Use in Children and Adolescents Based on Government Regulation No. 28 of 2024', *Progressive Law Review* 6, no. 2 (2024): 139–48, https://doi.org/10.36448/plr.v6i2.224; Nicholas J. Hill et al., '"My Religion Picked My Birth Control": The Influence of Religion on Contraceptive Use', *Journal of Religion and Health* 53, no. 3 (2014): 825–33, https://doi.org/10.1007/s10943-013-9678-1.

[13] Nikodemus Niko and Jakkrit Sangkhamanee, 'Beyond Gender Norms: Unveiling Myths and Taboos of Male Rape in Indonesia', *Sexuality, Gender & Policy* 8, no. 4 (2025): e70035, https://doi.org/10.1002/sgp2.70035.

The Indonesian government's new policy on reproductive health for school-age and teenage people has caused much public discussion. Government Regulation No. 28 of 2024, enacted to implements Law No. 17 of 2023 on health affairs, establishes statutory frameworks governing contraceptive access for target populations. Specifically, Article 103 (1) discusses programs that help school-age and teenage people improve their reproductive health by providing communication, information, education, and health services. Article 103 (4) further incorporates the provision of contraceptives within the scope of these covered reproductive health services covered by the policy. Other services include early disease identification, treatment, rehabilitation, and counselling.[14]

Recently, the public strongly reacted to West Java Governor regarding Deddy Mulyadi's proposal to mandate vasectomy for individuals receiving social assistance. Subsequently, a few days later, as reported by Tempo[15], Deddy Mulyadi provided clarification that participation in the Family Planning program, particularly regarding vasectomy, would not be a prerequisite for the impoverished to access social assistance. He emphasised that the statement issued on social media was merely a suggestion and recommendation. He elaborated that the family planning program in question need not exclusively involve vasectomy; it could encompass various contraceptive methods or alternative pregnancy prevention strategies available to men. In light of the aforementioned issues, several essential questions emerge: What does contraception refer to? What factors influence the construction of gender within the framework of contraception? What are the competing narratives that shape the understanding of contraception? What is the correlation between contraception and personal reproductive autonomy? What motivates the State to involve itself in personal reproductive decisions?

Analysing contraception in the context of biopower reveals that Michel Foucault's theory offers a significant framework for comprehending the State's influence over reproductive regulation. The State's involvement in reproductive health – exemplified by surveillance and family planning framework – indicates a strategic approach to managing population dynamics aimed at ensuring social and economic stability. However, such regulatory governance routinely

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[14] Ananto and Afifah, 'Legality of Contraceptive Use in Children and Adolescents Based on Government Regulation No. 28 of 2024'; Alfian Firdaus Firdaus and Imron Mustofa, 'Kontra-Preventif Peraturan Pemerintah Nomor 28 Tahun 2024 Dalam Menangani Kesehatan Reproduksi Anak Usia Sekolah', *Majelis: Jurnal Hukum Indonesia* 2, no. 4 (2025): 1–17, https://doi.org/10.62383/majelis.v2i4.1158; Pra Setiawati Faika et al., 'Implementation of Government Regulation No. 28 of 2024 on Legal Abortion to Ensure Legal Certainty', *Indonesian Journal of Advanced Research (IJAR)* 4, no. 6 (2025): 691–700, https://doi.org/10.55927/ijar.v4i6.14719.

[15] Tempo.co, 'Dedi Mulyadi Klarifikasi Soal Vasektomi Jadi Syarat Penerima Bansos', *Tempo.Co*, 8 May 2025, https://www.tempo.co/politik/dedi-mulyadi-klarifikasi-soal-vasektomi-jadi-syarat-penerima-bansos-1374571.

infringes upon individual autonomy, especially regarding women's rights to make reproductive choices, underscoring the conflict between State authority and personal liberties.

B. Gender, Power, And Contraception: The Perspectives of Historical, Social, and Policy

Judith Butler[16] argues that gender is not an inherent identity; rather a series of socially repeated actions. In the context of family planning programs, women continue to be positioned as the primary subjects in reproduction and contraception – a construct regulated and maintained by social norms and state policies. As Butler[17] highlights, bodies are not merely biological givens; rather, they function as discursively produced sites through which power relations are enacted and normalised. Thus, the social construction of gender that defines women as more responsible for reproductive issues contradicts international commitments that demand equality in access to health, including in decisions about family planning. Existing state policies and social norms often do not align with human rights principles guaranteed by international conventions, which should provide space for women to protect and expand female bodily self-determination.[18]

Malcolm Potts and Martha Campbell[19] further detail in their article "History of Contraception" that contraception extends beyond birth control methods aimed at preventing fertilisation. It also includes several actions – such as abortion and infanticide, which can all be viewed as strategies for managing family size. Ultimately, the central objective of contraception aims to manage the preferred number of family members. Contraception refers to a concept with a long history, recognised, and utilised since approximately 1550 BCE, rather than a modern invention or limited to contemporary societies. The Egyptian Papyrus stands as one of the earliest documents addressing contraception, detailing the application of plant mixtures as tampons inserted into the female genital area to inhibit pregnancy. In Ancient Greece, various plants were recognised for their potential to lower sperm count and were subsequently used as birth control methods. During the 16th century, these natural methods gained widespread adoption globally. Gabriele Falloppio developed a device that bore similarities to the contemporary condom, which was initially intended to protect against sexually transmitted diseases such as syphilis. The birth

[16] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, vol. 3 (Routledge Press, 1990).
[17] Judith Butler, *Bodies That Matter: On the Discursive Limits of 'Sex'* (Taylor & Francis, 2014).
[18] Carolina Retmawati Putri et al., 'Negotiating the Body: Reproductive Autonomy and Gendered Power in Family Planning Program', *Jurnal Hawa: Studi Pengarus Utamaan Gender Dan Anak* 7, no. 1 (2025): 89–101, https://doi.org/10.29300/hawapsga.v7i1.8736.
[19] Malcolm Potts and Martha Campbell, 'History of Contraception', *The Global Library of Women's Medicine*, ahead of print, 2009, https://doi.org/10.3843/GLOWM.10376.

control pill represents a significant advancement in contraception, having been developed and mass-produced in the period following World War II.

The global expansion, normalisation, and promotion of artificial contraception marks a significant shift in societal norms, representing one of the most substantial social revolutions of contemporary times.[20] According to data from the WHO, among the 1.9 billion women of reproductive age (15–49 years) worldwide in 2021, 1.1 billion required family planning services. Within this cohort, 874 million utilised modern contraceptive methods, while 164 million experienced an unmet need for contraception.[21] Universal access to these technologies upholds the fundamental human right to determine the timing and size of one's family, while resulting substantial health benefits by preventing unintended pregnancies and reducing associated health risks. These interventions encompass a broad continuum of care, ranging from reversible modalities to permanent options. Condom it unique in their ability to prevent both pregnancy and the transmission of sexually transmitted infections, including HIV.[22] Contraception is often viewed it as primarily a woman's responsibility, with many men assuming limited responsibility. In numerous countries, the use of male contraceptives, such as condoms and male sterilization, remains rare.[23] Despite their pivotal role in shaping fertility outcomes, men are rarely positioned as primary targets within reproductive planning initiatives or contraception research.[24]

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[20] Andrea R. Genazzani et al., 'Contraception Today and Family Planning: A Comprehensive Review and Position Statement on the Ethical, Medical, and Social Dimensions of Modern Contraception', *Gynecological Endocrinology* 41, no. 1 (2025): 2543423, https://doi.org/10.1080/09513590.2025.2543423.

[21] World Health Organization, *Family Planning/Contraception* (World Health Organization, 2024), https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception.

[22] The Society for Adolescent Health and Medicine, 'Condom Availability in Schools: A Practical Approach to the Prevention of Sexually Transmitted Infection/HIV and Unintended Pregnancy', *Journal of Adolescent Health* 60, no. 6 (2017): 754–57, https://doi.org/10.1016/j.jadohealth.2017.03.019; Joi K. Lee et al., 'Condom, Modern Contraceptive, and Dual Method Use Are Associated with HIV Status and Relationship Concurrency in a Context of High Mobility: A Cross-Sectional Study of Women of Reproductive Age in Rural Kenya and Uganda, 2016', *Contraception* 117 (January 2023): 13–21, https://doi.org/10.1016/j.contraception.2022.09.001; Aga Natalis, 'Breaking the Silence: Gender Power Imbalances, Stealthing, and the Fight for Sexual Autonomy', *Journal of Forensic Medicine Science and Law* 33, no. 2 (2024): 68–72, https://doi.org/10.59988/jfmsl.vol.33issue2.12.

[23] John Ross and Karen Hardee, 'Use of Male Methods of Contraception Worldwide', *Journal of Biosocial Science* 49, no. 5 (2017): 648–63, Cambridge Core, https://doi.org/10.1017/S0021932016000560; Japneet Kaur et al., 'Assessment of Demand for Male Contraceptives: A Multi-Country Study', *Andrology* 12, no. 7 (2024): 1512–24, https://doi.org/10.1111/andr.13726; Johannes Bitzer, 'Male Contraception – Part of Gender Medicine and Reproductive Rights of Men', *Contraception* 145 (May 2025): 110734, https://doi.org/10.1016/j.contraception.2024.110734; Lisa Campo-Engelstein, 'Are We Ready for Men to Take the Pill?', *BBC News*, 21 October 2019, https://www.bbc.com/news/health-49879667.

[24] Jessica Davis et al., 'Male Involvement in Reproductive, Maternal and Child Health: A Qualitative Study of Policymaker and Practitioner Perspectives in the Pacific', *Reproductive Health* 13, no. 1 (2016): 81, https://doi.org/10.1186/s12978-016-0184-2; Derya Bağlan and Tuğba Yilmaz Esencan, 'Examining Men's Attitudes Toward Family Planning in Istanbul, Turkey', *BMC Public Health* 25, no. 1 (2025): 1150, https://doi.org/10.1186/s12889-025-22402-2.

Caroline Ramazanoglu and Janet Holland[25] articulate that sexuality and safer sexual practices correspond with Foucault's notion, that "the body is the point of intersection between large structures of power and the smallest – most local practices." In essence, sexual intercourse—frequently viewed as a natural and private act—is significantly shaped by societal norms and public policies. The context of contraception reveals that it is not merely a neutral and rational response to the risk of unintended pregnancy. Instead, it is an activity intricately intertwined with gender meanings, where the dynamics of power between men and women significantly influence and constrain choices and decisions. To comprehend the dynamics of power relations in the context of contraception, it is essential to analyse the disproportionate burden of contraceptive responsibility assigned to women, and the societal frameworks that shape male and female sexuality.

Historically, women relied on a range of their reproductive health management strategies, utilising herbal remedies, abortion, and abstinence. Rather than operating in isolation, they developed collaborative efforts to create, disseminate, and implement methods for managing their fertility. However, the increasing dominance of men in the healing professions led to a significant transfer of power from women, particularly in their roles in childbirth and prevention. Nonetheless, the marginalisation of women in the field of healing and the increasing male dominance over women's reproductive decisions faced significant opposition. Women have persistently sought to reclaim authority over their reproductive health and personal lives and the current health movement represents a recent development in this ongoing struggle.

Abigail Raebig's[26] article entitled "*Birth Control and First Wave Feminism*" indicates that early feminist movements in the 19th and early 20th centuries exhibited a varied perspective on contraception. Numerous early feminist activists opposed formal contraception, concerned it could encourage "promiscuity," yet they advocated for women's autonomy to refuse intercourse and utilise non-medical approaches to postpone pregnancy. In contrast, the "free love" movement adopted a more progressive stance by acknowledging women's sexual desires and advocating for birth control. Despite their ideological divergences, both movements sought to expand women's self-determination, particularly in the realm of sexual autonomy. Within the context of the suffrage struggle, prohibition of alcohol, divorce law reforms, and contraception—which encompassed

[25] Caroline Ramazanoglu and Janet Holland, 'Women's Sexuality and Men's Appropriation of Desire', in *Up Against Foucault: Explorations of Some Tensions between Foucault and Feminism*, ed. Caroline Ramazanoglu (Routledge, 1993), https://doi.org/10.4324/9780203408681-16.

[26] Abigail Raebig, *Birth Control and First Wave Feminism* (Texas Woman's University, 2020), https://twu.edu/media/documents/history-government/Birth-Control-and-First-Wave-Feminism.pdf.

methods to prevent or terminate pregnancy (such as condoms, abortifacients, abstinence, coitus interruptus, etc.)—was regarded as an essential means for women to exercise control over their bodies and lives. Crucially, access to reliable birth control permitted women to delay childbearing, facilitating their broader participation in higher education and political endeavours rather than confining them exclusively to domestic and maternal roles. The notion of contraception fundamentally questions the belief that a husband possesses the sole authority to dictate sexual relations and family size. Movements – such as "voluntary motherhood" – highlighted the importance of women's autonomy in rejecting intimacy. This is a concept considered radical at the time, as societal expectations compelled women to comply unconditionally with their husbands' desires.

In the United States, women's contraceptive choices and experiences have been profoundly shaped by the population control establishment historically dominated by medical professionals and eugenicists since the early twentieth century.[27] Following World War I, there was a notable change in political dynamics that diminished the feminist–radical focus on reproductive autonomy. Consequently, this shift prompted numerous birth control advocates to transition towards the social sphere, thereby allowing medical "experts" like Margaret Sanger to take prominence.[28] Redefined through an elitist lends, the movement adopted the slogan "more children for the fit, fewer for the unfit." By the 1950s and 1960s, the ideological narrative of the "population bomb" had taken firm root, finding broad institutional endorsement across state governments, the scientific community, and businesses sectors. This led to a global contraception revolution, framing birth control as an immediate response to the demographic expansion in developing countries – which were perceived as a national security risk and a potential conduit for the spread of communism. The Population Council was established in 1952 to address the need for an international agency focused on population planning.[29]

The options available to women concerning new contraceptive technologies have been constrained in multiple aspects. Initially, these are limited to products currently available in the market, and decisions about their use are shaped by factors such as socio-economic status,

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[27] Betsy Hartmann, 'Population Control I: Birth of an Ideology', *International Journal of Health Services* 27, no. 3 (1997): 523–40, JSTOR, http://www.jstor.org/stable/45130847; Linda Gordon, 'The Politics of Birth Control, 1920–1940: The Impact of Professionals', *International Journal of Health Services* 5, no. 2 (1975): 253–77, https://doi.org/10.2190/BFW2-C705-25TE-F99W.

[28] Maud Anne Bracke, 'Women's Rights, Family Planning, and Population Control: The Emergence of Reproductive Rights in the United Nations (1960s–70s)', *The Orang History Review* 44, orang. 4 (2022): 751–71, https://doi.org/10.1080/07075332.2021.1985585.

[29] Donald T. Critchlow, 'Birth Control, Population Control, and Family Planning: An Overview', *Journal of Policy History* 7, no. 1 (1995): 1–21, Cambridge Core, https://doi.org/10.1017/S0898030600004127.

educational attainment, and legal frameworks. Women typically follow physicians' recommendations or the instructions on packaging, which often convey only the outcome without elaborating on the underlying processes or associated risks, unless mandated by law. The majority of research conducted in the United States has predominantly concentrated on women's reproductive systems, with comparatively less emphasis on men's. However, there has been some investigation into male contraceptive pills in countries – such as China. While the primary burden of contraception continues to women, gaining institutional control over the technology remains largely out of reach. Birth control technology, along with women's autonomy over reproductive choices, presents a dual nature of advantages and obstacles. The interplay between the medical and scientific communities, the pharmaceutical sector, and governmental entities frequently serves to restrict women's freedoms, preserving institutional authority over reproductive choices.[30]

Kate Fisher[31] observes that women have historically acknowledged their dependence on their husbands, who possess the authority to determine contraceptive options. Nevertheless, they often feel pride and gratitude when their husbands show understanding. Some historians contend that such situation emerged from prolonged pressure exerted by women to persuade or compel their husbands to adopt contraception. Ultimately, decision-making autonomy regarding contraceptive practices was ultimately transferred to the husbands. That wives rarely challenge this situation indicates the extent to which women prioritise its preservation; relinquishing primary responsibility to men relieves women of a burdensome moral weight, as domestic gender roles evolve, men – particularly within younger demographics – are increasingly assuming greater responsibility for household tasks and child rearing. This shift is impacting perceptions of contraception, as men, particularly those from younger generations, are increasingly recognising it as a collective responsibility. Indeed, studies indicate that men with higher education levels, increased income, and a lesser adherence to traditional gender norms exhibit greater support for and interest in male-specific contraceptive methods.

However, the presence of male contraceptives, including male birth control pills, does not inherently guarantee elevated usage rates. The low rates of vasectomy reflect a broader global disparity in family planning, particularly given that the procedure has been available for nearly two centuries and presents lower risks and costs when compared to female sterilisation. It is noteworthy that female sterilisation remains ten times more prevalent worldwide, despite its

[30] Chwee Lye Chng, 'The Male Role In Contraception: Implications For Health Education', *Journal of School Health* 53, no. 3 (1983): 197–201, https://doi.org/10.1111/j.1746-1561.1983.tb07820.x.
[31] Kate Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960* (OUP Oxford, 2006).

greater invasiveness and risk. Contraceptive practices are influenced by the socio-cultural context in which individuals exist, rather than occurring in isolation. This framework highlights the significance of reproductive decision-making – which includes three key components: the choice to reproduce, the determination of contraceptive methods, as well as, particularly for women, the option to either continue or terminate an unwanted pregnancy. Related to the reproductive rights and behaviour, contraception encounters a significant challenge: it involves two individuals, each possessing an equal right to define their reproductive objectives. Consequently, selecting a contraceptive method must consider the biopsychosocial profile of each individual to ensure optimal reproductive health and enhance the quality of life for both parties.

A pertinent illustration arises from research conducted by Peter Sternberg, Alan White, and John H. Hubley[32] on Nicaraguan men's engagement in sexual and reproductive health matters. Their research, based on transcripts from focus group discussions, illustrates how diverse ideological discourses within society shape sexuality. By privileging the concept of "discourse" over "ideology," they effectively pinpointed five critical dimensions influencing men's perspectives on family planning. This study highlights that the term "medical discourse" does not represent an official medical consensus; rather, it reflects a subjectively lay framing constructed by men who perceive these views as "medical knowledge." In this context, the "pro-feminist discourse" refers to a segment of men who acknowledge women's rights, exemplifying a forward-thinking perspective aligned with the Western liberal feminism. These discursive dimensions can be outlined as follows: Initially, religious discourse – particularly within Catholicism – frames contraception as sinful, perceives vasectomy as a hindrance to men's obligation to procreate, and underscores the objective of maximising the number of children. Second, traditional patriarchal discourse suggests that women utilising birth control methods are perceived as unfaithful, that the responsibility of pregnancy lies with women, and that men possess the authority to determine when and if a woman can conceive. Third, medical discourse emphasises the perception that artificial contraceptives – such as the pill and IUD – may be considered as dangerous or ineffective way, while also suggesting that condoms could diminish sexual pleasure. However, it is recognised that contraception can have positive implications for women's health. Fourth, the pro-feminist discourse asserts women's autonomy in deciding on pregnancy and emphasises the pressures men can exert on women regarding childbearing. Last, contemporary Western discourse highlights that

[32] Peter Sternberg et al., 'Damned If They Do, Damned If They Don't: Tensions in Nicaraguan Masculinities as Barriers to Sexual and Reproductive Health Promotion', *Men and Masculinities* 10, no. 5 (2008): 538–56, https://doi.org/10.1177/1097184X06291920.

men bear the responsibility of having only as many children as they can financially sustain, and these decisions should be made collaboratively by the couple.

C. Contraception and Family Planning: The Perspectives of Social, Gender, and Policy in Indonesia

The basis for family planning policy originates from the recognition of significant demographic challenges since the Earth became inhabited by hundreds of millions of individuals.[33] In 1978, the WHO and UNICEF convened in Alma-Ata to address the elevated rates of maternal and perinatal mortality worldwide. This landmark conference established the Primary Health Care framework, which encompassed antenatal care, clean and safe delivery facilities – encouraging people to adopt family planning, and improving referral services. The Population Conference in Mexico in 1984 stressed the importance of high fertility rates and short birth intervals for mothers and new-borns. It was becoming increasingly worrying that Indonesia's population was growing rapidly.[34]

In the absence of interventions to stop the rapid population growth, even the most rigorous economic and social development programs being rendered ineffective. Some people argue that protecting the future of humanity necessitates the immediate enhancement of reproductive health through more aggressive family planning efforts. Failing to reinforce these programmes risks entrenching global populations in cycles of structural poverty, destitution, and ignorance—outcomes that represent the most terrible and oppressive tragedies for humans. The contemporary family planning movement was forged through the concerted efforts of key activists and reformers across the US and internationally. In the decades following its inception, these foundational initiatives catalysed the establishment of organised family planning networks on global scale. For example, the Indonesian Family Planning Association (PKBI) was formed in Indonesia.[35]

On January 1967, a contraceptive conference took place in Bandung, and the mass media played a pivotal role in disseminating information about the event to the wider public. The first PKBI *(Perkumpulan Keluarga Berencana Indonesia)* congress was held in February 1967 to

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[33] John Bongaarts et al., *Family Planning Programs for the 21st Century: Rationale and Design* (Population Council, 2012), https://doi.org/10.31899/rh11.1016; Sarah A. Johnson et al., 'How It Started, and How It's Going: Global Family Planning Programs', *Clinical Obstetrics and Gynecology* 64, no. 3 (2021): 422–34, https://doi.org/10.1097/GRF.0000000000000625; John Cleland et al., 'Family Planning: The Unfinished Agenda', *The Lancet* 368, no. 9549 (2006): 1810–27, https://doi.org/10.1016/S0140-6736(06)69480-4.

[34] Riant Nugroho, *Public Policy 7: Dinamika Kebijakan Publik, Analisis Kebijakan Publik, Manajemen Politik Kebijakan Publik, Etika Kebijakan Publik* (PT Elex Media Komputindo, 2023).

[35] *Ibid.*

conduct family planning of a government program as soon as possible. In April 1967, Ali Sadikin, the Governor of Jakarta, recognised that it was time to officially launch the family planning program in Jakarta by establishing the DKI Jakarta Family Planning Project. The family planning movement in Indonesia underwent a significant transformation on August 16, 1967. During the Old Order, the movement was led by volunteers and operated discreetly because the head of State at the time opposed the implementation of family planning. However, during the New Order, family planning was formally recognised and incorporated into the government's policy. The National Family Planning Institute (LKBN) was established as a semi-governmental organisation under the authority of the Minister of People's Welfare in October 1968. The establishment of this institution reflected the government's strong commitment to implementing its family planning strategy. Family planning initiatives were incorporated into the first Five-Year Development Plan (Repelita I) and subsequently remained an integral component of successive national development plans.[36]

Fast forward to 2007, condom usage among sex workers in Indonesia had reached 68%, with a goal of 80% for high-risk groups. However, several challenges remained, including local reluctance to embrace 100% condom usage policies due to stigma and moral concerns. The Sentani Commitment, ratified in 2004, highlighted a national effort to combat HIV/AIDS, with a strong emphasis on condom use and harm reduction strategies, alongside other preventive measures. This commitment also aligns with UNAIDS' principles, focusing on high-risk sexual activities and intravenous drug use. However, opposition from local politicians and entertainment venue operators, who feared potential economic losses, hindered full implementation of these measures. Research conducted by the USAID Health Policy Initiative further revealed the tension between promoting condom use and societal beliefs, with some fearing that such initiatives would normalise prostitution and extramarital sex.[37]

Siti Nurjanah et al.[38] indicate that the factors affecting contraceptive selection in Indonesia are varied, encompassing several elements such as age, education, employment, as well as

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[36] *Ibid.*

[37] Megan Kendall and Karina Razli, *Indonesia: Sex Work and HIV/AIDS*, HIV and AIDS Data Hub for Asia-Pacific (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010), https://www.aidsdatahub.org/resource/indonesia-sex-work-and-hiv-aids; Kai Spratt et al., *Implementing 100% Condom Use Policies in Indonesia: A Case Study of Two Districts in Jakarta* (USAID Health Policy Initiative, 2007), http://www.healthpolicyplus.com/archive/ns/pubs/hpi/Documents/398_1_Indonesia_Cup_Case_Study_FINAL_2_28_08.pdf.

[38] Siti Nurjanah et al., 'Factors Influencing the Selection of Contraceptives: A Literature Review', *Proceedings of the 2nd Lawang Sewu International Symposium on Health Sciences: Midwifery (LSISHS-M 2023)*, 16 July 2024, 181–88, https://doi.org/10.2991/978-94-6463-461-7_19.

emotional, informational, and instrumental support from partners. In this context, age has a crucial role in the selection of contraceptive methods. Research indicates that the optimal age range for choosing contraception is between 20 and 35 years, as women in this stage have fully developed reproductive systems, which minimises the likelihood of complications during pregnancy. Furthermore, education significantly influences decision-making processes. Individuals with advanced education tend to exhibit greater openness to new concepts and demonstrate a more rational approach when making decisions regarding reproductive health, including their acceptance of family planning initiatives. Employment influences contraceptive choices, as women in the workforce or couples with greater economic resources typically exhibit fertility behaviours that favour smaller family sizes, motivated by financial factors.

The provision of emotional support by husbands further significantly influences the selection of contraceptive methods. Providing comfort, empathy, and motivation as forms of support enhances women's confidence in their choices and use of contraception. This support encompasses providing consent for the selection of contraceptive methods and addressing any potential side effects that may occur. The provision of informational support by husbands, including guidance on contraceptive use and reminders about medication schedules, plays a crucial role in enabling women to make informed decisions about their reproductive health. Instrumental support, including accompanying wives to healthcare facilities or aiding with medical consultations, significantly impacts the decision regarding the choice of contraceptive method. Contraceptive choices are shaped by both intrinsic factors, such as age and education, as well as partner support, which is essential for enabling women to make informed and confident decisions.

Family planning represents a government initiative aimed at aligning population requirements with the principles of sustainable development. Contraception becomes essential in reducing health risks associated with pregnancy, thereby enhancing reproductive health services. In Indonesia, the landscape of contraceptive use is predominantly characterised by hormonal methods – including injections, pills, and implants. The government's family planning policy has redirected its emphasis towards the promotion of non-hormonal methods, including intrauterine devices (IUDs), tubectomy, and vasectomy. This shift has generated a range of perspectives, with specific individuals endorsing the change while others express dissent.

The discussion regarding the availability of contraceptives to students and adolescents underscores the contrasting viewpoints involved. Critics contend that such policies may unintentionally convey approval of premarital sexual activity among young people, thereby reinforcing undesirable social behaviours. Conversely, proponents argue that contraceptives play

a crucial role in protecting adolescents against sexually transmitted infections and unintended pregnancies, particularly in situations where unprotected sexual activity may occur. From this perspective, the policy is perceived as an essential measure for protecting reproductive health and promoting overall well-being. This debate prompts a critical examination of the broader consequences of contraception access for young individuals.

Supporters contend that the provision of contraceptives to adolescents represents a governmental measure that can mitigate reproductive health challenges – including sexually transmitted infections – and safeguard against unintended pregnancies. This is consistent with international accords, including the International Conference on Population and Development (ICPD) held in Cairo in 1994, where nations, including Indonesia among them, pledged to provide adolescents with the necessary resources and information to protect themselves against pregnancy and HIV/AIDS. They argue that restricting access to contraceptives constitutes a breach of fundamental health rights. Besides its distribution, reproductive health services should include education, enabling young individuals to comprehend their bodies and make informed choices.[39]

Opponents of the policy express concerns that may lead to the normalisation of premarital sex, potentially undermining cultural and religious values that emphasise abstinence before marriage. The ambiguous language in Government Regulation No. 28 of 2024 invites extensive interpretation, leaving the policy's actual purpose unclear. Critics contend that the emphasis ought to be on comprehensive sex education instead of solely distributing contraceptives, as these practices could potentially compromise the values cherished by Indonesian society. There is a concern that supplying contraceptives to youth may be interpreted as endorsing behaviours that are inconsistent with established traditional norms.

Additionally, a 2018 survey conducted by the BKKBN indicated a notable disparity in contraceptive usage between genders, indicating that 96.7% of women utilised contraceptives, whereas only 3.3% of men did. The observed discrepancy can be attributed to the predominance of contraceptive methods available, which are primarily designed for women, including IUDs, hormonal implants, and sterilisation procedures. In contrast, men face a restricted range of choices, primarily consisting of vasectomy or the use of condoms. The observed gender disparity underscores a more profound concern: the family planning program frequently assigns the

[39] Mindy Jane Roseman and Laura Reichenbach, 'International Conference on Population and Development at 15 Years: Achieving Sexual and Reproductive Health and Rights for All?', *American Journal of Public Health* 100, no. 3 (2010): 403–6, https://doi.org/10.2105/AJPH.2009.177873; Michael T. Mbizvo and Sharon J. Phillips, 'Family Planning: Choices and Challenges for Developing Countries', *Challenges in Fertility Regulation* 28, no. 6 (2014): 931–43, https://doi.org/10.1016/j.bpobgyn.2014.04.014.

responsibility of contraception predominantly to women. Family campaigns have often given limited attention to men's responsibility for contraception, thereby perpetuating the perception that women bear the entire burden of family planning.[40]

While family planning initiatives aim to control population growth and decrease maternal and child mortality, they frequently neglect to address the involvement of men in reproductive health. The deeply rooted patriarchal ideology within Indonesian society fosters the perception that reproductive health is predominantly a woman's obligation. This compromises women's autonomy concerning their bodies, as male partners or governmental regulations often influence choices about contraception. The issue of women's reproductive rights, established within international human rights frameworks, frequently receives insufficient attention. This has resulted in a situation in which women are expected to manage their reproductive health independently, lacking equivalent support from men.

The gender imbalance in family planning reflects broader societal issues. The patriarchal framework influences reproductive health and simultaneously reinforces conventional domestic roles for women. The State's emphasis on women's bodies for population control reinforces the idea that women's primary function is confined to the private of domestic realm. Although it tackles significant health issues; this method does not effectively confront the gendered beliefs that restrict women's autonomy and men's involvement in shared reproductive duties.

By analysing the historical context of family planning, it is possible to identify its origins in early population control initiatives, in which large populations were deemed crucial to national power, especially in times of war. Over time, concerns about resource scarcity, as outlined in Malthusian theory[41], led to an emphasis on population growth management. Contraception was regarded as a strategy to decrease maternal and child mortality, which frequently stemmed from numerous pregnancies or closely timed births. The identified health risks, including the physical strain experienced by women and the emotional neglect of children stemming from resource limitations, highlight the necessity for effective family planning policies.

Additionally, early marriage, especially in pre-Soeharto Indonesia, intensified the reproductive health risks faced by young women. Social pressures often compelled them to enter

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[40] Robiatul Adawiyah, 'Sadarkah Kita Bahwa Implementasi KB Timpang Gender Dan Diskriminatif Terhadap Perempuan', *The Conversation*, 29 June 2022, https://theconversation.com/sadarkah-kita-bahwa-implementasi-kb-timpang-gender-dan-diskriminatif-terhadap-perempuan-185751; Robiatul Adawiyah, 'Pemakaian Kontrasepsi Bukan Cuma Urusan Perempuan, Tapi Juga Laki-Laki', *Konde.Co*, 30 June 2022, https://www.konde.co/2022/06/pemakaian-kontrasepsi-bukan-cuma-urusan-perempuan-tapi-juga-laki-laki/.

[41] Thomas Robert Malthus, *An Essay on the Principle of Population: The 1803 Edition* (Yale University Press, 2018).

marriage before they were physically or emotionally prepared. Consequently, children were frequently regarded as a resource to enhance the family's financial standing rather than as individuals entitled to adequate care and education. The concept of family planning is further shaped by a range of internal and external factors, including religious beliefs, cultural norms, and educational systems. As individuals engage with their communities, they assimilate norms and values that shape their perceptions of issues such as contraception. The dynamics of socialisation and the influence of education significantly inform public perceptions and acceptance of contraceptive methods.

Therefore, contraception transcends a purely technical matter and is shaped by societal norms and cultural values. By fostering education and raising awareness, individuals and communities can transform their understanding of reproductive health. This shift allows for the transcendence of conventional boundaries and supports the adoption of a more equitable framework for family planning that encompasses both men and women.

D. Biopower, Reproductive Control, and State Intervention: A Critical Examination of Contraception and Women's Autonomy

The use of contraceptives plays a pivotal role in the management of sexually transmitted infections (STIs) and the prevention of unwanted pregnancies globally.[42] However, as Kristen Lagasse Burke and Laura Duberstein Lindberg[43] assert, the choice of contraceptive methods is influenced by more than just cost—it is also shaped by how individuals interact with the healthcare system, healthcare practitioners, and their partners. These interactions are impacted by social and structural factors that can either facilitate or hinder access to preferred contraceptive options.

In this context, the acceptance and use of contraception, particularly condoms, are deeply embedded in a web of cultural, social, and psychological factors, as well as structural determinants

[42] Karen J. Derefinko et al., 'Sexually Transmitted Infections and Contraceptive Use in Adolescents', *American Journal of Preventive Medicine* 58, no. 4 (2020): 536–46, https://doi.org/10.1016/j.amepre.2019.11.012; Jennifer Deese et al., 'Contraceptive Use and the Risk of Sexually Transmitted Infection: Systematic Review and Current Perspectives', *Open Access Journal of Contraception* 9 (November 2018): 91–112, https://doi.org/10.2147/OAJC.S135439.

[43] Kristen Lagasse Burke and Laura Duberstein Lindberg, 'Gender, Power, and Nonpreferred Contraceptive Use in the United States: Results from a National Survey', *Socius* 10 (December 2024): 23780231241282641, https://doi.org/10.1177/23780231241282641.

such as health policy and access to healthcare services.[44] Iddo Tavory and Ann Swidler[45] discuss several discourses surrounding contraceptive use, particularly focusing on condoms. In many communities, condoms are not merely considered as a tool for preventing disease but also as a symbolic act that reflects the nature of the relationship. This perspective aligns with the socio-ecological framework, which suggests that contraceptive use must be understood within a broader context, where cultural norms, healthcare policies, and interpersonal dynamics intersect.

One significant aspect of this discourse include the concept of sensuality, or the "sweetness" associated with sexual intimacy. In various cultures, sexual pleasure is often metaphorically described as "sweetness," especially when it involves the exchange of bodily fluids as central to sexual enjoyment. As a result, the use of condoms is often perceived as inhibiting this "sweetness," leading to the belief that it diminishes the pleasure of sexual experiences. This perception strongly influences the reluctance to use condoms, despite awareness of the health risks posed by STIs and HIV. In local language, condom use is often compared to eating candy wrapped in plastic—suggesting a less satisfying experience.

The second axis of discourse, closely tied to the socio-ecological perspective, centres on trust and love. In relationships where trust is regarded as essential, such as marriage or long-term partnerships, the proposal to use a condom may be perceived as a sign of mistrust or as an indication that the relationship lacks seriousness. Conversely, the decision not to use a condom may be interpreted as an expression of emotional intimacy and a symbol of a genuine connection, in which the exchange of bodily fluids without barriers is viewed as the ultimate act of love and trust. This reveals how interpersonal relationships and communication shape the perception and use of contraceptives.

The third axis concerns risk and danger, which intersect with both cultural and structural factors. Although awareness of HIV/AIDS and its potential consequences is widespread, many individuals continue to resist using contraception because of concerns often outweigh the perceived benefits of condom use, creating a complex situation in which individuals must balance the risk of HIV infection against the health risks of using condoms. Personal experiences and broader healthcare systems influence these conflicting perceptions of risk, highlighting the

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[44] Nancy Kidula et al., 'The Impact of Male Contraception on Global Sexual and Reproductive Health and Rights', *Contraception* 145 (May 2025): 110811, https://doi.org/10.1016/j.contraception.2025.110811; Idayu Badilla Idris et al., 'Influence of Sociocultural Beliefs and Practices on Contraception: A Systematic Review', *Women & Health* 62, no. 8 (2022): 688–99, https://doi.org/10.1080/03630242.2022.2117764.

[45] Iddo Tavory and Ann Swidler, 'Condom Semiotics: Meaning and Condom Use in Rural Malawi', *American Sociological Review* 74, no. 2 (2009): 171–89, https://doi.org/10.1177/000312240907400201.

importance of understanding how healthcare policies and access to reliable information shape people's decisions regarding contraception.

The interplay among sensuality, trust, and risk within the socio-ecological context, shows how contraceptive choices are not simply based on individual preferences. Social norms, cultural beliefs, healthcare access, and relationship dynamics play significant roles in shaping decisions. For instance, someone may feel comfortable using a condom with a partner whom they do not fully trust, yet hesitate to do so with a more intimate partner, interpreting this decision as an expression of love and commitment. Thus, contraceptive use is shaped by complex, interwoven factors that extend beyond personal choice alone.

Gender becomes one of the most important things that affects these choices. Hegemonic masculinity, which refers to the dominant societal standards of ideal masculine behaviour, often results in an unequal distribution of reproductive obligations. Historically, contraceptive techniques have centred on women's bodies, whereas male contraceptive options are frequently neglected or inadequately addressed in healthcare environments. As a result, responsibility for preventing pregnancy is not shared equally between men and women.

In sexual partnerships, the power dynamics between partners can also affect their choices about birth control. A widespread reluctance among men to utilise condoms or engage in dialogue about birth control often compels women to initiate these discussions or resort to convert, partner-independent methods. This means that women have to start the conversation or use techniques that do not involve their partner. This respect to men's preferences may lead women to prioritise their partner's comfort over their own birth control needs. In certain instances, more severe actions, such as contraceptive sabotage, further intensify the disparity in reproductive decision-making.

Moreover, variables such as ethnicity, age, and sexual orientation exacerbate the complexities of contraceptive availability and decision-making, particularly for vulnerable populations. Research has shown that power dynamics in relationships and healthcare settings affect how people use birth control. These dynamics often create a mismatch between what people want to use and what they actually use, influenced by social, cultural, and structural factors, as well as cost.

In Indonesia, the impact of patriarchal society on contraceptive use among women of reproductive age (WUS) is significant. Patriarchy, which puts men in charge of making decisions for the family, often includes choices about family planning and birth control. In cultures with strong patriarchal norms, husbands often determine whether contraception is used, while wives are generally expected to usually go along with what their husbands say. This situation limit's women's

autonomy in making decisions about their reproductive health, leaving many women unable to choose the birth control technique most appropriate to their health needs.[46]

Patriarchal cultural norms also reduce men's participation in family planning initiatives. In many places, contraception continues to be regarded primarily as a woman's responsibility, leading many men to perceive little obligation to participate in either contraceptive decision-making process or the usage of contraceptive techniques. This idea further reinforces gender inequality by putting the primary responsibility for family size and birth control on women. [47]

This cultural effect is correlated to societal constructions that view men using contraception as a threat to traditional ideas of what it means to be a man. To achieve gender equality in family planning programs, it is necessary to change how people and cultures think about things so that husbands and wives share more responsibility. Raising awareness and providing education, particularly for men, is essential to achieve more equitable decision-making in reproductive health to alleviate the unequal burden that women frequently endure in family planning.

The concluding point will elucidate the reasons behind the State's active involvement in reproductive issues, primarily through regulatory measures and the provision of contraception because reproduction functions as a dimension of biopower, or life power, intended to be controlled and governed to ensure the persistence of economic, political, and social structures.[48] Michel Foucault[49] further posits that power is not solely derived from authoritative sources, such as written laws, but is also a productive force.[50] It is embedded in diverse surveillance and disciplinary techniques that contribute to the formation of "docile bodies." In the realm of reproduction, the State utilises two primary mechanisms: surveillance and punishment/discipline. Contemporary surveillance encompasses epidemiological tracking via health applications, including location-monitoring systems implemented during the pandemic, as well as data collection on fertility, pregnancy, and birth rates conducted by governmental statistical agencies. Mapping citizens' reproductive patterns allows the State to collect data that informs policy

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46 Wulandari and Hadi, 'Asosiasi Budaya Patriarki Terhadap Penggunaan Kontrasepsi'.

47 Nikodemus Niko, 'Indigenous Women in the Food Chain System: The Marginalization and Alienation of Indigenous Knowledge on Environmental Management', *Asian Politics & Policy* 17, no. 2 (2025): e70014, https://doi.org/10.1111/aspp.70014.

48 Michel Foucault, *The Birth of Biopolitics: Lectures at the Collège de France, 1978–1979* (Palgrave Macmillan, 2010).

49 Michel Foucault, 'Discipline and Punish: The Birth of the Prison', in *Social Theory Re-Wired* (Routledge, 2023); Michel Foucault, *The History of Sexuality*, The History of Sexuality, v. 1 (Allen Lane, 1979); Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings 1972 - 1977*, ed. Colin Gordon (Pantheon Books, 1981).

50 Nickolas John James, 'Law and Power: Ten Lessons from Foucault', *Bond Law Review* 30, no. 1 (2018): 31–42, https://doi.org/10.53300/001c.5658.

interventions concerning birth control – including the implementation of family planning programs that may subsidise or limit access to contraception in alignment with population objectives.

The State establishes reproductive health laws that impose penalties for infractions, such as banning abortions in the absence of medical justification and limiting the promotion and distribution of specific contraceptive methods. This method of punishment involves mandatory counselling and certification for health professionals – ensuring that contraceptive methods are utilised solely within the "scientific framework" recognised by the State. Foucault[51] further highlighted that modern punishment extends beyond the physical realm, aiming to influence the inner self through medical standards and sexual education designed to cultivate the "ideal" reproductive behaviours among citizens.

Moreover, the notion of biopower elucidates the State's vested interest in overseeing reproduction. The factors of health, birth, mortality, and disease transmission are essential to national productivity and stability. The State aims to maintain demographic equilibrium, considering the proportions of younger and older populations, geographic dispersion, and specific health metrics. This approach is intended to ensure a productive workforce, manageable pension obligations, and cultural dynamics aligned with developmental objectives. This strategy positions contraception as a tool of biopolitics: family planning initiatives serve to mitigate population surges in overcrowded, impoverished regions, while simultaneously, birth incentives or natality enhancement measures can be targeted at particular demographics that the State aims to influence, such as increasing birth rates in isolated areas.

The international concern regarding the "population bomb" during the 1950s and 1960s reinforced the State's involvement in the large-scale production and distribution of contraception.[52] The fear regarding a "population explosion" served to justify government intervention in developing nations, manifesting in both international donor-funded family planning initiatives and domestic policies that regulate marriage age, family size, and access to contraceptive pills. In this context, women, who hold the primary responsibility for reproduction, are subtly positioned as subjects of biopower – situated within a framework of medical professionals, administrative bodies, and donor organisations that shape contraception policies. Foucault emphasised the resistance is essential for power to maintain its dynamic nature. Within this framework, women's bodily autonomy and the reproductive rights movement are crucial by advocating comprehensive

[51] Foucault, 'Discipline and Punish: The Birth of the Prison'.
[52] David Lam, 'How the World Survived the Population Bomb: Lessons From 50 Years of Extraordinary Demographic History', *Demography* 48, no. 4 (2011): 1231–62, https://doi.org/10.1007/s13524-011-0070-z.

access to information and contraceptive options, resisting intrusive State interventions. Such forms of resistance underscores that genuine autonomy in reproduction is attainable only when women have the authority to determine when and how contraception is used, rather than passively adhering to the biopolitical mandates imposed by the State. Through the lens of contraception as a site of contention, women confront the mechanisms of biopower that aim to control and govern their lives in the interest of national productivity and stability.

E. Conclusion

Contraception serves an essential function in family planning, enabling individuals to regulate reproduction and enhance health outcomes. In Indonesia, the practice of family planning is shaped by a complex interplay of cultural, religious, and societal factors that significantly influence public attitudes and decision-making. The influence of religious teachings in Indonesia serves as a crucial role in shaping attitudes towards modern contraceptive methods, as specific communities view contraception as misaligned with their religious or cultural values. Several concerns are identified surrounding the issue – numerous religious viewpoints do not categorically forbid contraception, mainly when it is employed for health-related purposes or to protect the welfare of families. The ongoing existence of myths and misconceptions surrounding contraception, driven by cultural and religious beliefs, has established obstacles to its broad acceptance and utilisation.

The interplay of gender dynamics becomes a crucial factor in the discussion of contraception. Throughout history, the responsibility for family planning has fallen mainly on women, with societal norms solidifying their position as the primary decision-makers in matters of reproductive health. The gendered division of responsibilities has resulted in women shouldering the predominant burden of contraception, a scenario further exacerbated by societal expectations and governmental policies. Judith Butler's theory of the social construction of gender emphasises how women's bodies are shaped by power dynamics and societal norms, as well as by governmental regulations. These gendered norms lead to a disproportionate allocation of responsibilities regarding family planning, frequently constraining women's reproductive autonomy. The unequal participation of men in reproductive decision-making continues to reinforce gender disparities in family planning.

In Indonesia, the influence of government policies is significant in determining the availability of contraception and family planning services. The state's engagement in reproductive health has evolved, characterised by policies aimed at regulating population growth and addressing

public health issues. Several initiatives such as the National Family Planning Institute (LKBN) and various family planning programs launched in the late 1960s were designed to tackle the challenges posed by rapid population growth and its effects on the country's development. These policies have faced criticism for their disproportionate emphasis on women's reproductive health, while failing to involve men in the family planning process adequately. The recent initiatives by the government to offer contraception to school-age and teenage individuals, as detailed in Government Regulation No. 28 of 2024, have ignited discussions regarding the possible social consequences of these policies. Critics contend that this approach may lead to the normalisation of premarital sex, whereas supporters highlight the necessity of protecting young individuals from unintended pregnancies and sexually transmitted infections.

The cultural and religious context in Indonesia significantly influences contraceptive choices. Societal attitudes, influenced by traditional and religious beliefs, frequently position contraception as primarily a woman's responsibility – resulting in the marginalisation of men in this discourse. The observed gender imbalance is evident in the underutilisation of male contraceptive methods, including condoms and vasectomy, even though these options are accessible. The distribution of responsibility for contraception predominantly rests with women, resulting in an imbalanced burden. The difference in contraceptive usage between men and women is illustrated by survey data indicating that a significant majority of women utilise contraceptives, whereas only a minor percentage of men do so. This imbalance reinforces gender stereotypes that continue to portray family planning as primarily a woman's responsibility.

The state's involvement in the regulation of contraception, especially via family planning initiatives, highlights the relationship between reproductive health and biopower. Michel Foucault's concept of biopower elucidates the mechanisms by which the State exercises regulation and control over populations through policies dictating reproductive practices. In such context, contraception serves as a mechanism for regulating demographic expansion and ensuring national stability. The state's engagement in reproductive health, especially in regulating family planning programs, frequently mirrors broader economic and political agendas instead of emphasising personal reproductive autonomy. These dynamic invites critical examination of how State policies centred on population control may shape or constrain women's reproductive rights, rather than prioritising personal choice.

Family planning programs have achieved notable advancements in enhancing reproductive health; however, the persistent issues of gender inequality and cultural resistance still affect the overall effectiveness of these initiatives. The insufficient participation of men in family planning,

along with the ongoing societal norms that burden women with primary contraceptive responsibility, continues to obstruct progress toward more equitable reproductive health practices. The State's involvement in contraception regulation underscores the wider biopolitical factors that shape reproductive decisions, frequently undermining personal autonomy. These existing dynamics highlight the necessity for family planning policies that are more inclusive, acknowledging the critical roles of both men and women in reproductive health decisions.

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