

## **BUKTI SEBAGAI PENULIS KORESPONDENSI**

**Judul Artikel** : Women's Membership in Health Insurance and Correlation with Contraception Use in Indonesia  
**Nama Penulis** : Misnaniarti  
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misnaniarti misnaniarti

To: Global Journal of Health Science



Fri 29/04/2016 09:13

Dear Editor,

If you are pleasure, I want to know the process of submission from my article.  
Thanks you

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Reply

Forward

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From: Global Journal of Health Science <gjhs@ccsenet.org>

Sent: 17 March 2016 10:09:38

To: misnaniarti misnaniarti

Subject: Re: RE:[GJHS]\_Women's\_membership\_in\_health\_insurance\_and\_correlation\_with\_contraception\_use\_in\_Indonesia

Re:

RE: [GJHS] Women's membership in health insurance and correlation with contraception use in Indonesia

misnaniarti@hotmail.com

Fri 29/04/2016 09:13

To: Global Journal of Health Science <gjhs@ccsenet.org>

Dear Editor,

If you are pleasure, I want to know the process of submission from my article.

Thanks you

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From: Global Journal of Health Science <gjhs@ccsenet.org>

Sent: 17 March 2016 10:09:38

To: misnaniarti misnaniarti

Subject: Re:

RE: [GJHS] Women's membership in health insurance and correlation with contraception use in Indonesia

Dear Misnaniarti,

Your paper has been assigned to the peer review process, which may take 2-3 weeks.

Warm Regards,

Erica

Editorial Assistant

Global Journal of Health Science

2016-03-17

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>Dear Erica,

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>

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>  
> \_\_\_\_\_  
> From: Erica Grey [gjhs@ccsenet.org]  
> Sent: 16 March 2016 12:29  
> To: Misnaniarti Misnaniarti  
> Subject: [GJHS] Women's membership in health insurance and correlation with contraception use in Indonesia

>  
> Dear Misnaniarti,  
>  
> I understand your situation. However, I regret that we cannot waive or  
> reduce the publication fee for anyone. Thank you for understanding.  
>  
> Please let me know if you will be paying the publication fee, and if so, I  
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>  
> Thank you.

>  
> Erica  
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> Global Journal of Health Science  
> 2016-03-16  
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## Result of Review

**Title:** Women's membership in health insurance and correlation with contraception use in Indonesia

**Author(s):** Misnaniarti

### Decision of Paper Selection

- Accept submission, no revisions required
- Accept submission, revisions required; please revise the paper according to comments**
- Revise and resubmit for review
- Decline submission

### What should you do? (For accepted papers)

- ✓ Revise the paper according to the comments (if applicable)
- ✓ All authors must agree on the publication; please inform us of agreement by e-mail.
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- ✓ **Vol. 9, No. 2, February 2017 (e-Version First)**, if you meet above requirements within 2 weeks.
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## Comments from Internal Editor

| Evaluation   | Grade  |
|--|--|
|  | Please fill a grade of 5, 4, 3, 2, 1 (high to low) |
| <b>Overall evaluation on the paper</b>   | 3  |
| Contribution to existing knowledge   | 3  |
| Organization and Readability   | 2  |
| Soundness of methodology   | 4  |
| Evidence supports conclusion   | 3  |
| Adequacy of literature review  | 3  |
| <b>Comments and Suggestions</b>  |  |
| <p>(1) Please add/revise the author information in the revised version. The names of the authors should appear in the order of their contributions, centered between the side margins.</p> <p><i>Example:</i></p> <p style="text-align: center;">Anne Smith<sup>1</sup>, Mary A. Meade<sup>1,2</sup>, David Wolf II<sup>1</sup> &amp; Charles Rockefeller Jr.<sup>2</sup></p> <p><sup>1</sup>School of Management, Northern Canada University, Toronto, Canada<br/> <sup>2</sup>School of Economics, Peking University, Beijing, China</p> <p>Correspondence: David Wolf II, School of Management, Northern Canada University, Toronto, Ontario, M3A 2K7, Canada. Tel: 1-613-947-3592. E-mail: davidwolf@gc.ca</p> <p>(2) Some typos and grammar errors need to be corrected, perhaps a native speaker should read the manuscript to fine tune it before publication.</p> <p>(3) References should not be numbered, so citations in the text with numbers should be modified as with author's name and publication year. For example, (Smith, 1999)</p> <p>(4) Revise the paper body and references list according to <i>Paper Submission Guide</i>:<br/> <a href="http://www.ccsenet.org/submission">www.ccsenet.org/submission</a></p> <p>(5) Revise table(s) into three-line table(s).</p> <p>(6) Insert table(s) and figure(s) into the text.</p> <p>(7) Add DOI persistent links to those references that have DOIs, please retrieve Digital Object Identifiers (DOIs) at <a href="http://www.crossref.org/SimpleTextQuery/">http://www.crossref.org/SimpleTextQuery/</a></p> <p>(8) Perhaps a bit more literature searching on the subject will provide more comparative data<br/>           More references should be found and they should cover the last 5 years.</p> |  |

## Comments from External Reviewer A

|   |              |
|---|--------------|
| ❖ <b>Evaluation</b> (Please evaluate the manuscript by grade 1-5)   |              |
| 5=Excellent    4=Good    3=Average    2=Below Average    1=Poor   |              |
| <b>Items</b>  | <b>Grade</b> |
| Contribution to existing knowledge  | 3            |
| Organization and Readability  | 1            |
| Soundness of methodology  | 4            |
| Evidence supports conclusion  | 4            |
| Adequacy of literature review   | 3            |
| ❖ <b>Strengths</b>  |              |
| <p>I haven't seen or heard of this data set before, and I think it allows you to study an important question of how health insurance can affect contraceptive use. Since the data set is fairly uncommon, I would recommend highlighting the benefits of using this source. The methodology seems reasonable for studying this correlation.</p>   |              |
| ❖ <b>Weaknesses</b>   |              |
| <p>This paper was very difficult to read through. I had a hard time understanding the details of the program you were studying, what hypothesis you were testing, and the importance of the results. The statistical analysis section could give a better idea of the equations you are using and you could extend this analysis to look at other subgroups or control variables.</p>   |              |
| ❖ <b>Suggestions to Author/s</b>  |              |
| <p>The paper could greatly benefit from a more broad explanation of the Jampersal program. I also highly recommend getting a professional copyeditor to read through the paper and make changes, as there were several grammatical errors that made it difficult to read. Additionally, I think that the paper needs a more involved explanation of the importance of getting more women to use long-acting reversible contraceptives. You start with a discussion of MMR and IMR, but I do not see why having more women using LARCs could combat these high rates. You take a stance in the paper that this is a good thing, but do not explicitly state why. It would be helpful to give a brief calculation of the costs and benefits of the program to justify why the government should expand this program. Moreover, in Table 2 (sidenote: for Tables 1 and 2, the table titles are misspelled) it seems that the percentages of non-use, nonMKJP and MKJP are nearly identical for women that have insurance and those that don't. It makes it unclear why we should study or expect to see differences in contraception type in Table 3. Finally, in the first paragraph there is no introduction to the environment of contraceptive use</p> |              |

in Indonesia; you just immediately start talking about the program there. It would add to the paper if you started with some background of the current policies and take-up rates in that country and compared them to the U.S. I also think that the literature review could be put in the introduction as to not distract from the discussion in section 4.

## Comments from External Reviewer B

|   |              |
|---|--------------|
| ❖ <b>Evaluation</b> (Please evaluate the manuscript by grade 1-5)   |              |
| 5=Excellent    4=Good    3=Average    2=Below Average    1=Poor   |              |
| <b>Items</b>  | <b>Grade</b> |
| Contribution to existing knowledge  | 3            |
| Organization and Readability  | 2            |
| Soundness of methodology  | 4            |
| Evidence supports conclusion  | 4            |
| Adequacy of literature review   | 2            |
| ❖ <b>Strengths</b> The study identified and simplified a question that needed an answer for policy implications.            |              |
| <b>Weaknesses</b> A lot of editorializing will have to be conducted to improve readability and avoid confusion for readers. |              |
| <b>Suggestions to Author/s</b> An editorial assistant can be called in for grammatical and format concerns                  |              |



# Women's membership in health insurance and correlation with contraception use in Indonesia

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## ABSTRACT

### Background and purpose

One the important effort in reducing the Maternal Mortality Rate isare integrationed of Family Planning Services into Health Insurance policy. This is giving affordability in health service financing through providing contraceptive accordance with established policy. The purpose of this study is to examine the women's participation in health insurance and correlations to contraception use.

### Material and methods

The study used the 2012 Indonesian Demographic and Health Survey data-set. Samples were women aged 15 to 49 years, of married status or living together (n=33,465). The dependent variable was contraception used for three categories: such as using Long Term Contraceptive, using non-Long Term Contraceptive, and not using any kind of contraception. Data analysis used Chi-square and multinomial logistic regression with complex sample.

### Results

10.6% of women were found to have used a Long Term Contraception method was 10.6%. Health insurance membership hasve correlations to contraceptive use (OR=1.241 and 0.964,  $p < 0.05$ , CI 95%), with confounder variables of age ( $p < 0.05$ , OR=1.428 and 0.648), education ( $p < 0.05$ , OR=1.402 and 1.064), work status ( $p < 0.05$ , OR=1.151 and 0.966), parity ( $p < 0.05$ , OR=3.114 and 1.685), perception of ideal number of children ( $p < 0.05$ , OR=2.057 and 1.682), husband's education ( $p < 0.05$ , OR=0.166 and 0.920), husband's work ( $p < 0.05$ , OR=1.247 and 2.469), and role of media ( $p < 0.05$ , OR=1.255 and 1.084).

### Conclusion and recommendations

This study was empirical evidence in Indonesia that health insurance factors have a significant correlation to Long Term Contraceptive use in women. It is recommended for government to maintain and improve the policies that integrated Family Planning Services into National Health Insurance.

### Keywords

Health insurance, Contraception, Family Planning, Long Term Contraceptive, Multinomial logistic regression

## 1. Introduction

National health ~~as a~~ ~~problem~~ ~~until nowadays~~ is still high according to population health indicators such as Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR); (359 per 100,000 live births and 32 per 1,000 live births ~~respectively~~). According to data from ~~the~~ World Health Organization (WHO, 2013), these rates are still considered high compared to other ASEAN countries. The rates ~~are~~ also still far from the target of 2015 Millennium Development Goals (MDGs).

The efforts to decrease ~~of~~ MMR and IMR are harder challenges to conquer, compared to other MDGs targets, and can ~~not be~~ longer ~~be~~ done by general intervention. Breakthroughs and improvements of cross-sector collaboration are required to chase the ~~reduction backwardness~~ of MMR ~~decrease~~ to reach MDGs targets. One of the important efforts is to improve public access by giving affordability in health service financing. Government's policy ~~is~~ are Family Planning (FP) ~~S~~ services integrated ~~with~~ Health Insurance ~~policy~~ through providing equipment and materials of contraception, ~~and~~ ~~so~~ ~~providing~~ ~~receive~~ treatment ~~for~~ side effects and complications by *Badan Kependudukan dan Keluarga Berencana Nasional (BKKBN)* –National Population and Family Planning Board- ~~are~~ appropriate with established policy.

In order to support the decrease of MMR and IMR to accelerate the achievement Goals 4 and 5 of MDGs, ~~the~~ Ministry of Health ~~has~~ run several programs integrated to ~~the~~ FP service, such as *Jaminan Persalinan (Jampersal)* –a program that provides free antenatal, delivery, and postnatal services to pregnant women without health insurance and free childcare for the newborn baby– in 2011. The implementation concept was by demand side so that the participants who used the health insurance can ~~both~~ receive FP service ~~both~~ postpartum and after miscarriage. Through *Jampersal*, contraception such as ~~the~~ Long Term Contraceptive (LTC) Method, Intra Uterine Devices (IUD), implants and injectables are provided free of charge. Contraception and supporting facilities of FP services ~~are~~ provided by BKKBN (Ministry ~~of~~ Health, 2011, 2013)

In the beginning of 2014, *Jaminan Kesehatan Nasional (JKN)* –National Health Insurance– ~~was~~ started to ~~be~~ implemented. This policy ~~was~~ also strengthened FP service where in JKN, it was stated clearly that one of the benefits of promotive and preventive services was the allocation of FP services includ~~ing~~ counselling, basic contraception, vasectomy and tubectomy (Ministry ~~of~~ Health, 2013).

People participation could be seen from the ability in accessing FP services. ~~The~~ Contraceptive Prevalence Rate (CPR) was one of FP program indicators; which was expected to increase 65% in 2015 (for ~~the~~ modern method). The modern method ~~has~~ ~~id~~ not show~~n~~ improvement in the last ten years. The 2007 Indonesian Demographic and Health Survey (IDHS) showed CPR ~~was~~ 57.4% while in the 2012 IDHS, CPR was 57.9%. This could be suspected to contribute ~~to~~ the high amount of MMR. Thus, ~~there~~ ~~is~~ ~~was~~ ~~a~~ ~~needed~~ to study factors contributing ~~to~~ contraception use (BKKBN, 2014a; Mujiati, 2013).

There was not much enough information related to the association of health insurance policy implementation with the selection of contraception used by women in Indonesia. Thus, this study ~~has~~ tried to know the information by using data ~~from~~ the 2012 IDHS. The purpose of this study was to analysis participation of health insurance and its association with the use of contraceptive methods of women in Indonesia. Information about factors contributing ~~to~~ the use of contraception is very ~~much~~ needed for FP program administrators. The result of this study is expected to be useful as ~~an~~ information resource in running and integrating health insurance policy and FP services so that it can be expected to improve ~~the~~ FP program in the future.

## 2. Materials and methods

### Research Subject

The research design was cross sectional using secondary data from the results of ~~the~~ 2012 IDHS. Research locations were in all provinces in Indonesia. The population ~~was~~ are women of childbearing age, aged 15 to 49 years, ~~which~~ ~~had~~ been successfully interviewed in ~~the~~ 2012 IDHS, ~~a~~ total 45,607 women. The sample was women of childbearing age, aged 15 to 49 years, currently married or living together, n=33,465 women (weighted), 32,706 women (unweighted). ~~The~~ ~~s~~ sample was chosen based on the criteria of ~~fn~~ variable recent marital status (V501), ~~which~~ ~~are~~ married or living together.

Contraception use behaviour is one example of health behaviour. Based on theory from Lawrence W. Green (Green & Kreuter, 1991) and information from other researches, it was known that factors influencing one's health behavior are predisposing factors, enabling factors, and reinforcing factors.

### Measurements

The dependent variable was contraception used for three categories: using LTC (Code 0), using non-LTC (Code 1), and not using any kind of contraception (Code 2). The Long Term Contraceptive consisted of female sterilization, male sterilization, IUD and implants, while non-LTC consisted of pills, injectables, condoms, periodic abstinence, withdrawal (coitus interruptus), lactational amenorrhea (LAM), and other traditional and modern methods.

The primary independent variable is covered by health insurance. Since the purpose of this research is to compare women who have health insurance to women who does not, the code given in the multinomial regression analysis is 0 for women with health insurance, and 1 for women without health insurance (because it is risky to not use contraception).

### Statistical Analysis

Processing and analysis of data were conducted using SPSS version 21, including univariate, bivariate (Chi-Square) and multivariate (multinomial logistic regression) analysis. Multinomial logistic regression analysis is a multivariate analysis in which the dependent variable is nominal polychotomous categorical scale variable (Dahlan, 2014; Hosmer & Lemeshow, 2000; Kleinbaum & Klein, 2010).

Data analysis conducted interaction tests to the complete model (Hierarchically Well Formulated Model). The variables have a significant association with contraception use if p value < 0.05 (Hastono & Sabri, 2013). The selection was conducted step by step through the backward elimination system. After that, the confounding test was conducted by looking at the difference of Odds Ratio (OR) value for the main variable if the candidate's confounding variable was expelled. If the change of OR > 10% then the variable was considered as confounding.

### 3. Results

Based on this study it was found that the majority of women used non-LTC (51.3%), while women using LTC was as much as 10.6%. The number of women who did not use any kind of contraception was still high, about 38.1% (see Table 1).

Based on further analysis, it was found that the use of contraception of the majority of respondents was injectables (31.9%), pills (13.6%), IUDs (3.9%), implants (3.3%) and women sterilization (3.2%).

From Bivariate analysis showed that all of independent variables had  $p < 0.05$  which means if it was analyzed on each variables, there would be an correlation with contraception use of women (aged 15-49 with status of married or living together), see Table 2.

Based on Table 2 it was shown that of women without health insurance, there was 9.3% who used LTC, while of women with health insurance, there was 12.8% who used LTC. From this data it is shown that p value = 0.0001 ( $p < 0.05$ ) so it can be concluded that there is an association between those covered by health insurance and with contraceptive used.

It is shown that in the higher age group are more likely to be using LTC (1.5% for in women aged 15 to 19 years of 1.5%, and 14.9% while on for women aged more than 35 years of 14.9%. As well as in women highly educated women prefer using LTC (16.1%) compared to the less educated (8.3%). Women with the richest status were more likely using LTC (16.0%) than women with the poorest status (7.9%).

Next on the final model (Table 3), showed that the variable of 'covered by health insurance' had a significant correlation with the use of contraceptive method, both on the group of women using LTC and non-LTC ( $p = 0.0001$ , OR=1.241 and 0.964), controlled by variables: age (OR=1.428 and 0.648), education (OR=1.402 and 1.064), job (OR=1.151 and 0.966), number of children born (OR=3.114 and 1.685), perception about ideal number of children (OR=2.057 and 1.682), husband's education (OR=0.166 and 0.920), husband's job (OR=1.247 and 2.469), and role of media OR=1.255 and 1.084).

The contribution of the 'covered by health insurance' variable to the use of contraception on women aged 15-49 was 7.0% (rated by using pseudo-R seen from Nagelkerke). This means that health insurance covered can explain its association with the use of contraception as much as 7.0%.

From this model, it can be interpreted that ~~on~~-women having any health insurance were more likely to use LTC (1.241 times more than women without health insurance). Also ~~on~~-women who had any health insurance were 0.964 times more likely to use the non LTC method ~~0.964 times more~~ than women without health insurance, after controlled by variables of age, education, parity, perception about ideal number of children, job status, husband's education, husband's job, and the role of media.

#### 4. Discussion

In this research, a trend is seen that older women are more likely to use LTC. This is consistent with further analysis of the IDHS data (BKKBN, 2014b) that LTC (except implants) was most used by women aged 45 to 48 years, while implants were most used by women aged 35 to 39 years (4.1%). It is shown that there is an association of health insurance covered with contraception used. This is consistent with research at Cirebon Regency (Chotimah, 2011) that health insurance covered is significantly associated with FP participation.

From the number of parity, it can be seen that on women having three or more children, more majority used non-LTC than LTC (49.7% to 16.2% respectively). ~~It~~ This needs to get attention because on that condition it should be suggested to use LTC. ~~C~~Contrary to research in Eastern Cape, South Africa (Stephenson, Beke, & Tshibangu, 2008), that women with five or more children are prefer LTC over more than injectables. But it was still better than in the rural area of North Malawi (Dasgupta, Zaba, & Crampin, 2015), where there are still many women with parity five or more children not using contraception at all (41.6%). At least women in this group can use the IUD method which has potential to improve women's health and has the ability to in spacing and limiting birth to with costs that are affordable (Townsend & Jacobstein, 2007).

At Ile Ife hospital, Nigeria, with grand multipara incidents (having many children) of 9.04% it is only about 77% of women who wants to use contraception in the future. This data explains that there are still many women who need better contraception for better life quality starting from the first pregnancy until the time before grand multipara. This can be solved by conducting education about permanent methods of contraception. Education becomes the catalyst for of positive change, and cuts off the chain of poverty (Adebanjo, Adeyemi, Loto, Ijadunola, & Asa, 2011).

On unemployed women group, a majority has used non-LTC (53.4%), and there was a trend that employed woman prefer to use LTC (11.5%) to unemployed (9.3%). It was different based on all methods, based on the research in Bangladesh (Sultana, Nahar, Marions, & Oliveras, 2013) that of women using contraception (all methods) the majority are not workers (62%). ~~So were~~ In Iran (Motlaq, Eslami, Yazdanpanah, & Nakhaee, 2013), the use of all methods of contraception are used more by women who work at home (81.8%).

~~Nationally from~~ This research has shown, it is known that the use of LTC the likelihood of LTC use to be higher with women in urban than rural areas (11.6% to 9.6% respectively). While non-LTC was higher in rural than urban (52% to 50.5% respectively). This can be compared with research in Iran (Motlaq et al., 2013), that contraception use, if assessed for seen from all methods, tends to be higher in rural (84.5%) than urban (82.1%) areas.

Women with a highest wealth index use LTC the most (16%) compared to other wealth groups, compared to women in (middle group (9.6%), poor (group 9.6%). Similarly with research in the Eastern Cape where that more wealthier women prefer to use permanent contraception than women with poorer status (Stephenson et al., 2008).

Similarly with this research, shows known that the socio-demographic factors which significantly associated with contraception use are age, education, wealth index, parity, ethnicity, age at first pregnancy, source of information, and covered by health insurance as health service factors which take effect (Chotimah, 2011; Ivanty, 2014; Paskaria, 2012). Based on one the study (Ivanty, 2014), many of the sources accepted by participants related to family planning methods was by family or peer discussion (53.8%), but it was only 25% from health workers, while mass media (pamphlets and posters) was only 8.6%.

Factors known to have an association with the use of contraception such as were: age, area of residence, education, parity, and wealth index (BKKBN, 2014b). While based on the study in Uganda, it is known that the key factors associated with the use of modern contraception of early married women aged 15 to 24 were area of residence and the decision of having a child; meanwhile on women aged 25 to 34, significant factors associated with the use of contraception are level of education, household spending and the decision of having child (J. Asimwe, Ndugga, Mushomi, & Manyenye Ntozi, 2014; J. B. Asimwe, Ndugga, & Mushomi, 2013). Therefore, women's

health improvement strategies must be comprehensively based on its health determinants, which specifically addressed to the socio-economic and cultural obstacles (AbouZahr, 2014).

#### Implication of Policy based on the Results of Research

Since when this survey was conducted (the 2012 IDHS), health financing policy covering contraception services which has been implemented including *Jampersal*, and several other health insurance, although limited.

The *Jampersal* policy gave limited FP service which was more directed to service for postpartum and miscarriage. Furthermore it was remained to be continued and developed in *JKN* at 2014, which showed programme improvement. Participants can utilize the FP service as all the first of health provider and advanced provider (hospital) which have agreement with *JKN*.

The Government's attempt has been appropriate, where participants of *Jampersal* were all of the targets who had not health insurance. A limitation in its implementation was that the service provided was only postpartum (its means women giving birth until 42 days postpartum). The purpose was to push participants to use postpartum FP services.

Many challenges in the implementation becomes tasks which had to be solved by policy makers and programme planners to strengthen the policy system and make the service accessible by everyone. Lack of funds became the biggest obstacle into reaching the health goal (Singh, Darroch, Ashford, & Vlassoff, 2009). Research results in North East Province, Kenya and Northern Uganda stated that the higher proportion was of women using modern contraception if the method was available or existed around the service area (Wang, Wang, Pullum, & Ametapi, 2012).

By the information from this research, government can compile interventions addressed to improve the number of women's participation rate in family planning by compiling programmes related to those factors, such as socializing FP services through medias of which many of them are accessed by women nowadays. It can be mass media like newspapers and women's magazines or electronic media like television and the internet by utilizing social networks, for example *Facebook*.

The socializations can be conducted more aggressively to the age group with slight use of contraception like women in the group aged 35 and older. There are still many women who have not graduated from elementary school who does not use contraception, 684 persons (56.6%). Thus, intervention can be composed through cross-programmes by improving mothers' education through informal education programmes, like "Kejar Paket A" programme or others.

The reduction of fertility and population growth becomes an important part in the economic-developing countries nowadays. Evidence in Asia and Africa suggest that family planning access can affect fertility. Family planning programmes can reduce fertility as like in Bangladesh and Ghana. The reduction of fertility is associated with improvements in women's health, income, and work participation. Parents can invest more funds and time to each health, nutrition, and education when they have less children (Canning & Schultz, 2012). Family planning promotion in countries with high birth rates potentially reduce poverty and hunger, and prevent 32% of all maternal mortality and almost 10% of infant mortality (Cleland et al., 2006).

#### 5. Conclusion and recommendations

The results of this research becomes empirical evidence that nationally, the 'having health insurance' variable has a significant association with the use of contraception methods by women aged 15 to 49, both in LTC and non-LTC methods ( $p=0.0001$ ,  $OR=1.241$  and  $0.964$ ), controlled by variables of age, education, job, number of children gave birth (parity), perception about ideal number of children, husband's education, husband's job, and role of media. Thus, the policy of integrated FP service in health insurance programmes has been appropriately run by the government, by providing tools/ methods of contraception for free of charge.

Based on this study, it is recommended for government to maintain and improve this policy, especially in the -LTC method so that the number of women's participation in FP is expected to improve every year. The Ministry of Health, BKKBN, and the Public Health Office, together with their staff, must improve the cooperation and socialization so FP and reproduction health programs can be implemented continuously. Supports from health

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workers can be a booster so that women would use appropriate contraception for their needs. By socialization, it is expected to improve public awareness in FP and finally ~~can~~ reduce ~~the~~ MMR and IMR.

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**Re: [GJHS] Result of Review-58193**

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Mon 23/05/2016 05:43

To: Joseph Walker <gjhs3@ccsenet.org>

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