

Realizing Gender Equity through Reproductive Health Programs in Indonesia: Reality or Utopia?

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Gender equity as an integral element of reproductive health

In September 1994, the United Nations International Conference on Population and Development (ICPD) at Cairo, addressed the complex relationship between women's reproductive and sexual health needs at the micro level, and population policies determined by demographic and environmental goals at the macro level. Departing from conventional demographic theories, a new reproductive health framework was launched, which addresses the multi-faceted nature of women's subordination and acknowledges gender as a precondition for health and development. More broadly, in this unprecedented approach the improvement of women's political, economic, cultural, social, legal and health status is seen as a highly important end in itself and as essential to the achievement of sustainable development. Only by tackling the underlying barriers to gender equity in all social spheres can women exert more control over their reproductive and sexual lives, effectively act upon their needs, and attain a high standard of health and development (ICPD 1994, §4.1).

Based upon these principles, the implementation of reproductive health policy and programs needs to ensure the protection and exercise of basic women's rights, and to approach gender issues within the context of sustainable development. To enable women to deal with complex social institutions that limit their access to necessary reproductive health knowledge and services, the ICPD Program of Action strongly recommends governments to support policy and programs that: 'will improve women's access to secure livelihoods and economic resources, alleviate their extreme responsibilities with regard to housework, remove legal impediments to their participation in public life, and raise social awareness through effective programs of education and mass communication' (Ibid).

However, the practical feasibility of such recommendations is questionable in view of the lack of clear cut, comprehensive strategies. A series of broad goals concerning reproductive health and the status of women have been set, but those responsible for implementing them, from service providers to national planners and international donors, require further guidance on how to pursue the expanded reproductive health agenda (McGinn et al, 1996; see also Hardee & Yount 1995) In the words of Faundes, Hardy and Pinotti (1989, 117): 'An important and necessary step forward in the process of improving reproductive health is the consensus on concepts. Such agreement, however, will not help women...if clearer directions on how to transform the conceptual framework into practice are not available.'

Next, to translate these broad and ambitious goals into effective programs, a multi-sectoral approach is needed which goes beyond the provision of medical and family planning services. By recognizing the link between gender, reproductive health,

and development, the reproductive health framework has the potential to 'strengthen national-level responses by calling on a wider array of participants'. (Hempel 1996, 80). As a premise, it is assumed that all sectors of society will cooperate with each other in a common effort to reform the social role of men and women in society, which will eventually lead to the improvement of their reproductive health status. However, in reality: within the government, ministries do not always get along; communities, NGOs and government often have conflicting interests; and even reproductive health advocates may hold very different interpretations of gender and reproductive health.

Some critics have also argued that a broadened approach may dilute what existing programs already do well. In their view, available facilities and human resources would be insufficient to respond to an increased demand for comprehensive reproductive health care (Ibid 79; Faundes 1996). Directly related to this argument is the fear that funds initially allocated to population would be diverted to foster other improvements in the life of women and increase access to education, economic resources, and social status. What is more, these rising demands to expand the reproductive health agenda as to include all aspects of women's development will collide with falling international resources for family planning programs (Potts, 1996).

In this paper, I will not attempt to enter into the debate on whether a comprehensive, multi-sectoral approach to the fundamental determinants of gender inequalities is complementary or contradictory to high quality reproductive health services, although I should state from the onset that of all the main approaches to the issue, I support those which link enhancement of women's reproductive health with improvements in their social status. Based on these principles, reproductive health policies and programmes are needed that ensure and protect the exercise of women's basic rights. Starting from the belief that only by addressing gender inequity will reproductive health programmes have the potential to improve women's health, I focus on the ways in which these programmes view the multi-faceted nature of women's subordination and are trying to change it. By using examples from Indonesia, I question the capacity of existing paradigms in the reproductive health field to counter gender disparities, and call for alternative approaches.

An exclusive focus on women

The ICPD Programme of Action implies that changes in gender relationships can be brought about through women-centred interventions to improve women's status. As the new Director General of the World Health Organization, then Prime Minister of Norway, Gro Harlem Brundtland, said in her opening statement to ICPD: 'When we adopt the Program of Action... We promise to make men and women equal before the law, but also to rectify disparities, and to promote women's needs more actively than men's until we can safely say that equality has been reached' (Germaine & Kyte 1995, ii).

Recognising that women are in an underprivileged position, a women-centred approach 'seeks to bolster the power of women' (Klugman 1996, 227) and set in motion a process by which women can strengthen their will and capacity to identify, understand and overcome gender discrimination, thus taking action on their own behalf (Arrows 1995, 11; IWHC 1989, 10). Current programmes are focused on women and directed at empowering them to assert their reproductive needs and rights, in order to compensate for existing gender imbalances in sexual and reproductive relationships. Systematic efforts are being made to increase women's knowledge about reproductive health and provide the skills women need to control their reproductive lives and gain greater access to reproductive health services and decision-making processes.

Whether such interventions paradoxically fail to foster empowerment while successfully promoting learning, by subscribing to the illusory assumption that 'knowledge is power', is an issue that deserves serious scrutiny. I raise it here only in passing, as I wish to examine an equally important assumption –whether an exclusive focus on women in reproductive health programmes does indeed lead to women's empowerment. Experience in Indonesia indicates that it may not be feasible for women to assert their reproductive and sexual rights in the private (household) sphere when they are powerless in the wider society, such as in the patriarchal Batak society in North Sumatra, where women are very much subordinate to men.¹

In 1995, the non-governmental organization Bina Insani started a participatory program that aimed at providing reproductive health education and gender training to village women in the area of Pematang Siantar, North Sumatra. After more than one year, the women felt comfortable about discussing reproductive health issues and had become aware of their unequal position vis-a-vis their husbands in the field of reproductive health. They also felt empowered in manifesting their needs in the health setting and did no longer hesitate to confront the health workers in demand of better services. This empowering process in the public sphere had however not reached the private sphere. One of Bina Insani's staff admitted that she was disappointed because women were not willing to address reproductive health issues at home in the belief that it was simply not possible to confront their husbands. She also seemed to agree with them: 'You know, here women still walk behind their husband when they go to church or some other public events. Are we not foolish in trying to empower them to be equal in the bedroom?' The same skepticism was visible on the faces of a group of women participating in one of Bina Insani's regular meeting on sexual health. Sitting in a circle on the floor, the women were listening and incredulously looking at the facilitator who was explaining the need of inter-spousal communication to effectively prevent STDs and AIDS transmission. Finally, one of them took the courage to speak up and said: 'When my husband asks me to bring a glass of water, I bring him the glass of water. I do not discuss it with him, I do just as I am told. I know, it is not fair but this is what wives are expected to do. We never talk much. We do not really discuss things between us. We are not used to it. It is not part of our culture. How can I now start to address very sensitive and intimate issues with him? I would never ask him whether he is having an affair. I know that sometimes he drinks and comes back late at night, as men usually do. But I never ask where he has been. Nor do we discuss whether we want to have sex or not. It would only cause trouble, because he could get very upset at my improper behaviour.' The facilitator did not have to ask other participants about their opinion since their nodding clearly indicated that they all agreed.

A women's health activist in Eastern Indonesia had a similar experience during an AIDS prevention project:²

Many men from one of the islands of Flores migrate to Malaysia to work illegally in plantations, and often bring home an illness known as 'migrant's disease'. It is common practice for a man returning home to get a penicillin injection before he has sex with his wife again. When I discussed with a group of migrants' wives the risk of HIV and other STDs that penicillin does not cure, and the possibility of using condoms, one woman asked: 'And what if he thinks that I don't love him any more?'

¹ From notes taken during a project-monitoring visit, Pematang Siantar, 1996.

² Personal communication with Galuh Wandita, field consultant, Indonesia Programme, Oxfam Australia.

While degrees of gender power vary enormously across places, classes, ethnic groups and individuals, the question remains whether it is realistic to expect women to achieve their reproductive rights when they are unable to assert their economic, social and political rights. It seems as if we are caught in a vicious circle. If sexual and reproductive relationships are not based in gender equity, reproductive health programmes may fail to help women to overcome what puts them at risk. At the same time, to postpone such programmes until women have attained an equal place in the family as well as in society could be to postpone them indefinitely, to the continuing detriment of women's health.

Furthermore, it is questionable whether, from the point of view of reproductive health programmes, it is effective to focus exclusively on women. A classic example are STD/AIDS prevention programmes that aim to empower sex workers to negotiate with their clients for safer sex, by providing them with information and skills (Alexander 1990; de Zalduondo 1991). There is by now abundant evidence that even if sex workers are aware of the risks and willing to use condoms, they often cannot because their clients refuse to do so (Rojanapithayakorn & Hanenberg 1996; Shephard 1996, 11). In one AIDS education programme for sex workers in a large brothel in Purwakarta, Central Java (Suyanto et al 1997) the sex workers' knowledge of STDs and how to prevent them six months after the intervention was remarkably improved. Yet nearly all the sex workers said that they were unable to apply their new knowledge and skills, due to their weak negotiating position vis-à-vis their clients. The authors note that the exclusion of male clients from the programme undermined its effectiveness; the women were often not protected from STDs and HIV. These findings suggest that focusing exclusively on women may not be effective in enhancing their reproductive health status.

Even if programmes targeting sex workers are dismissed as unrepresentative because of the financial nature of the sexual transactions, similar examples exist among programmes that target wives as the following two examples show:³

The Rural Development Foundation has been carrying out a participatory programme for women farmers, integrating community development with reproductive health education for the past two years. Its aims are to teach women how they can better care for their health and raise their awareness of reproductive rights. Through their newly acquired knowledge, the women in this programme realised that their husbands, who frequently emigrated for long periods of time, might be having relationships with other women and risking their health. Their new awareness was not empowering, however. On the contrary, they felt frustrated by the impossibility of sharing their fears with their husbands, as it was widely believed that a man would get upset at the 'mistrust' and might use violence against them. They also felt that the prevention messages were not appropriate to them, since condoms ought to be used by men (compare with Giffin 1998). Further, they considered condoms inappropriate for long-term relationships, especially if a couple were planning to have children. As a result, the women became very anxious, which improved neither their situation nor their well-being.

The Indonesian Society for Pesantren and Community Development started an innovative awareness-raising programme in 1994 for women preachers in Islamic boarding schools in rural Java and Madura, offering women-centred interpretations of reproductive rights within the teachings of Islam (Sciortino, Marcoes Natsir & Mas'udi 1996). During an evaluation of the programme, the women said they had become aware of new theological interpretations of women's position in the family and the Moslem community, that they believed would lead to improved health for women. They felt they had learned skills in how to present an argument and that religion was

³ The description of the two projects that follows is from their activities in 1996.

more on their side. Yet they did not know how to apply their new awareness in their private life, since their husbands were not equally convinced that Islam respected women's reproductive rights. When challenged by their wives, the men countered that in Islam decisions on contraceptive use, number of children, timing and modalities of sex were entrusted to men. In their view, women merely had to comply with what men decided. As a result, the women experienced considerable unease. They no longer fully believed in the old religious paradigms, which neglected women's reproductive needs, but they felt unable to assert the more supportive paradigms they had become aware of. Furthermore, they were convinced that efforts to change their husbands' attitudes towards sexual and reproductive matters would mean disruption of their family life, something they were not willing to risk. They opted for poor reproductive health and unsatisfactory sexual relationships rather than an insecure future.

The women participating in both these programmes made a plea to the NGOs involved to direct their efforts towards their husbands rather than themselves, in view of the men's dominant role in the areas of reproduction and sexuality.⁴ Without negating the many positive successes of women-centred programmes and experiences in other countries and the validity of their values, which I share, I conclude from these examples and others like them that reproductive health programmes focusing exclusively on women in Indonesia have not been able, at least in the short run, to challenge existing gender imbalances in sexual and reproductive relationships. This may be related to the pervasiveness of paternalism, that is fundamental to the overall structure of social stratification in Indonesia, with the *bapak* (father/husband) as the source of power and benign leadership, and the *ibu* (mother/wife) as his subordinate companion (Suryakusuma 1991; 1991a). As Hull and Hull (1995, 20) stated: '...calls for the institutions of health and family planning to be more under the control of women give rise to confusion in a patrimonial system where all power is regarded as rightfully and benignly being the province of a leadership which is "naturally" male.'

More generally it could be argued that to change gender relations in the private sphere, particularly in the sexual domain, is much more difficult than to improve gender roles in the public sphere.⁵ Or, it may be that the perceived 'failure' of women-centred reproductive health programmes is short-term since, in a process of social transformation, personal crises can trigger a transformation in gender relations. However accurate these perceptions possibly are, they do not alter the fact that Indonesian women are not alone in their call for greater attention to men in reproductive health programmes.

'We can't leave men out of the equation'⁶

Men are an increasingly 'popular' focus of reproductive health interventions. In the past, men's participation was sought by family planning programmes to increase the use of condoms and vasectomy. In Indonesia, efforts to increase the number of male contraceptive acceptors started in the early 1970s, and in 1974 the Indonesian Association for Permanent Contraception (Perkumpulan Kontrasepsi Mantap Indonesia) was established to provide vasectomy services (Azrul Azwar 1993). Later, men's involvement was considered necessary to support women's contraceptive use, when studies in both rural and urban areas

⁴ As a result, both projects have begun including men in their programmes. With regards the Rural Development Foundation's activities, see: Hadipranoto et al, 1996.

⁵ View put forward by members of Indonesian Women's Health Forum on 12 February 1998.

⁶ Berer 1996.

showed that husband's approval was the most important determinant of contraceptive use by women (Mantra et al 1994; Habsjah et al 1996; Hidayana 1996).

The influence of men has been deemed so great that some authors have gone so far as to claim that changes in fertility behaviour can occur even 'in the absence of inter-spousal communication or of the involvement of women in reproductive decision-making'. Consequently, programmes should focus on men and motivate them in order to become a 'positive force in a broad family planning effort' (Karra et al 1997, 33-34).

More recently, largely as a result of AIDS prevention efforts (Edwards in Karra et al, 24), the concept of male involvement has been recast to focus on men's sexual and reproductive responsibilities more broadly. The ICPD Programme of Action encourages men to participate in all areas related to human reproduction and family formation, including responsible parenthood, sexual and reproductive behaviour, prevention of sexually transmitted diseases, and shared control of and contribution to family income and children's welfare (ICPD 1994, §4.27). This renewed interest in men is once more grounded in the recognition of their preponderant power in nearly every sphere of human life:

In many cases [men] make decisions about women's contraceptive use and impose the conditions in which women exercise their sexuality, sometimes through violent means. Even in supposedly modern societies, women still find it difficult to make decisions about their own lives, restrained by customs and laws that give men the power to authorise or prevent women from seeking sterilisation or using contraceptives, for example (Gomez 1997, 31).

An alternative intervention paradigm has therefore emerged:

Conventional population programmes, for more than four decades, have largely been designed and implemented with a gender bias –towards women.... This bias should be shaken off. A revolution of sorts has quietly been taking place: men and their influence on women's contraceptive use and continuation; men and their role in the prevention of sexually transmitted diseases (STDs) including HIV/AIDS; men and their attitudes towards family planning and male contraceptive methods; and so on. This recognition points the way towards a population/reproductive health programme agenda that must include men to be effective and sustainable over the long run (Moi-Lee 1996, 1).

Yet there is an apparent contradiction when complaints about the neglect of men by programmes and the plea for men's greater involvement, are justified by pointing to the powerful role of men in reproduction. This circular reasoning raises some doubts about claims that 'men have been left out of the picture' and 'reduced to silent partners'. If this is indeed the case, how is it that the majority of reproductive health programme and policy managers in Asia are men and in most countries it is men who have responsibility for advising on matters concerning sexuality and family planning to a clientele that consists primarily of women? (Piet-Pelon 1996) Should this type of men's involvement be enhanced even further or rather reduced in favour of greater gender balance?

With regard to Indonesia, what about the fact that Indonesian women must formally have their husbands' permission to use a contraceptive method or have an abortion? An Indonesian housewife whom I interviewed, for example, went to a private clinic where abortions were performed for medical reasons and in cases of contraceptive failure.⁷ She

⁷ Indonesia's law on abortion is conservative; although a new law was passed in 1992, it has not yet been implemented (Djohan E et al, 1993) Some private hospitals, however, like the NGO

had been using an IUD for more than five years, but when it failed she was not prepared to continue the pregnancy. The practitioner showed understanding of her problem and asked her to show her marriage certificate and call in her husband. She became confused and made a number of excuses before admitting that her husband did not approve of her decision. The practitioner immediately refused to carry out an abortion and showed her the door.

Another example is among migrant women who, before going abroad for work, mostly in the Middle East and Hong Kong, are compelled by their husbands to stop using their contraceptive methods. The men do not see a need for their wives to protect themselves from pregnancy while they are separated. The women do as they are told since any other behaviour would be interpreted as an intention to betray them. However, the women do not always agree. They have heard of too many cases of sexual abuse and subsequent unwanted pregnancy among migrant women, for whom it is not rare to be sent home with a child they or their relatives do not really want (Prihatini et al 1996).

Although in such cases men believe they have a responsibility and are willing to be held accountable for it, this does not seem to entail respect for women's autonomy. Instead, if their decisions do not match those of their partners the men take advantage of their dominant position to impose their will. If the underlying rationale for involving men is that they have power and can 'motivate' women, there is considerable danger that women will have even less control over their bodies than before.⁸ Assuming that dominating women is not the goal most advocates of 'men's involvement' would envision, the challenge becomes to involve men in a way that supports women's emancipation and does not reinforce unequal gender relationships.

In a framework of women's emancipation, men's involvement in reproductive health is not only important for attaining responsible and shared decision-making in sexuality and reproduction, but also for promoting gender equity.⁹ Men are expected to become more sympathetic to women's needs, revise all forms of behaviour that negatively affect women's physical and mental well-being, and support women in the exercise of their rights.

This paradigm implicitly assumes that inequities between men and women can be overcome by inviting men to renounce their control over women and share their power, rather than women taking action on their own behalf to gain power and autonomy from men. This represents a strategic shift from enabling women to protect their own health and assert their own reproductive rights, to encouraging men to protect women's health and respect the rights of their partners –as if women need no longer strive for their own well-being because it will be granted to them by those who wield the power, i.e. men.

Some critics view this faith in men's willingness to accept the loss of dominance and privileges as naïve or unrealistic. Considering the slow pace at which the number of male contraceptive method users has increased in Asia, including in Indonesia (Meliata 1995), any envisioned participation of men beyond contraceptive use seems optimistic. Furthermore, the archetype of the 'generous and responsible man', as constructed by

described here, do provide abortion services within strict guidelines to married women who are accompanied by their husbands (Habsjah et al 1996).

⁸ Comment by Nicole Haberland, 1997.

⁹ For more on the advantages of expanding men's role in reproduction for men themselves and whether emphasising men's reproductive health needs would result in decreasing resources and services for women, see Mundigo A, 1995 and all features in RHM, No. 7, 1996.

reproductive health programmes, not only is far from people's lives, but also represents an ideological, and often, an elitist ideal.

An example in Indonesia is the 'Mother Friendly Man', a role model proposed by the Mother Friendly Movement (Gerakan Sayang Ibu), launched by the Ministry for the Role of Women in 1996 to curb the extremely high maternal mortality rate¹⁰ (MUPW 1996). This model adopts Javanese aristocratic (*priyayi*) ideals, stressing harmonious husband-wife relationships. Based on the assumption that pregnant women die because 'they are not loved by their husbands', men are invited to love their wives, devote their full attention to them and fulfil their every desire until they give birth, without thought for time or money (MUPW 1996a, 23).

Stressing their position as heads of families, men are urged to contribute to the reduction of maternal mortality by motivating their pregnant wives to attend a modern midwife and be vaccinated against tetanus, eat nutritious food and to run their households in such a way that their wives' physical workload is reduced (Woodhouse 1996, 13). In other words, husbands are expected to act as 'benevolent leaders'. Their superior position is kept intact, and the existing *status quo* is not affected by efforts to foster gender equity.

Thus, even programmes promoting men's involvement in a way that is consonant with women's health needs may not lead to more egalitarian or shared responsibilities. Without clear definitions of men's responsibility and accountability, even these programmes could have the effect of rendering women more dependent on the goodwill of their partners. To urge men to be benevolent and not to harm their wives and children may convey the message that women are in men's power and unwittingly contribute to male dominance.

Programme examples support these fears. In a recent pilot project to involve men in women's reproductive health which has just started in Jakarta, a video was shown in which a husband accompanied his wife to the doctor. Several women in the audience commented: 'In our culture, normally men do not accompany their wives to the doctor, and if they do they wait outside. In this video, the man is very active, always takes the initiative... and asks all the questions to the doctor. It is good that the video shows how men can play a role. But why is the woman so passive?' (Murniati 1997).

Another programme in South Sulawesi, to increase spousal communication on matters of family planning, had the unforeseen effect that the men who participated stopped relying on their wives to decide which contraceptive method to use and began to take the decision themselves, often in terms of their own pleasure and convenience. In a similar programme, men's support for their wives' use of contraception increased but their own use of male-controlled methods decreased, not always to their wives' satisfaction.¹¹

Women may also not always wish a more active role for men. For example, among 50 women family planning users, 25 per cent did not approve of vasectomy for their husbands as they were afraid their husbands could more easily betray them (Widyantoro et al 1995).

The concerns raised by these examples need to be followed up; research on men's roles in women's reproductive health has barely begun and programme interventions are still rare (for a review see UNFPA 1995). Caution may be called for to avoid the possibility that 'the involvement of men... ends up empowering men even more -that is to say, disempowering women even further' (Berer 1996, 8).

¹⁰ Maternal deaths are currently estimated at 450 per 100,000 live births, the highest in Southeast Asia.

¹¹ Information from the Sulawesi chapter of the Indonesian Consumer Association.

The reification of the family

If focusing on either men or women to the exclusion of the other fosters, maintains or even reinforces gender inequality, then it would seem that reproductive health programmes need to transcend their preoccupation with individuals in order to redress this inequality. Recent attempts to intervene at the level of the family, as the smallest social unit, may seem at first sight a way out of this impasse, since such an approach does not separate women, men and their children, but treats them as a whole. Its proponents argue that a focus on the family: '...offers a much more holistic and, at the same time, synthesising approach, since the family represents the fullest reflection, at the grass-root level, of the strengths and weaknesses of the social and developmental welfare environment' (Sokalski 1993, 8).

One of the countries that has taken up the 'family approach' as a strategy is Indonesia. In the early 1990s the National Family Planning Coordinating Board (BKKBN) launched the Prosperous Family (*Keluarga Sejahtera*) Policy to broaden its mandate beyond family planning. The concept came of age with Law No. 10 in 1992 on 'Population Development and the Development of Prosperous Families', which outlines the official definition and functions of the family¹² and the overall objectives of the family welfare movement (Hull & Hull 1995). Since then, the focus of population-related programmes has gradually shifted towards improving the socio-economic status of the family rather than the demographic and health status of the individual (Haryono Suyono 1996). Indonesia is proud to have done this long before Cairo and to have 'moved beyond' the ICPD Programme of Action and 'gender dualism'. The Minister of Population and BKKBN Head, Haryono Suyono, stated: 'Indonesia's goal is not to empower women or men. It is to empower the family. Beginning with legal marriage and a harmonious relationship between husband and wife, empowerment increases with a family's ability to fulfil certain defined functions and to contribute to the promotion of development.'¹³

Government efforts are directed at helping each Indonesian family, especially the most vulnerable, to perform what are called its eight basic functions, namely 'religion, socio-culture, love and caring, protection, reproduction, socialisation and education, economy, and environmental preservation' (Haryono Suyono 1995, 2). The relevant programmes and policy on reproduction are intended to strengthen the capability of each family to develop responsible and appropriate reproductive behaviour, which is defined by health and moral indicators. Families considered 'responsible' are those that believe in God, have sufficient knowledge of family planning and basic reproductive health, have only two children, live a healthy life, and do not practice 'immoral' behaviour. Premarital abstinence, marital fidelity and family life education of youth by parents is considered vital to the survival of the family as a unit. Families that do not meet all of these criteria are labelled 'vulnerable' and in need of special attention.

Specific interventions have more refined criteria. In its AIDS programme, BKKBN has categorised families according to their risk of exposure to HIV. In this complex typology, 'families with a member infected with HIV/AIDS', 'families that do not properly practice religion', 'families wherein some of the members are employed in the entertainment sector' and 'families that live in disagreement' are ranked as highest risk and designated as requiring maximum social control and medical care (BKKBN 1995a; 1995b).

¹² In this policy, only a married couple with children and a divorced or widowed single parent with children are recognised as a 'family'.

¹³ BKKBN statement.

Leaving aside considerations about the discriminatory implications and moralistic undertones of such an approach, it is important to note that individual characteristics are being attributed to entire families, and the family as a unit, rather than its members, is held responsible for sexual or reproductive behaviours. Along the same lines, it is the reproductive health of the family and not that of its individual members which is at stake. Thus, the government's Family Health Programme promotes 'healthy family life' and 'family use of modern health services'. Men and women and their individual health needs and rights have disappeared, superseded by collective needs and rights.

While this reification process may be intellectually appealing for its potential to transcend the male-female dichotomy, operationalising its concepts is difficult since 'the family' as such does not behave as a unit or as the sum of its parts. Although terms such as 'Family Health Education Campaign' or 'Family Health Clinic' are increasingly being used by some in the reproductive health field, it is usually not the case that all the members of a family are involved at the same time or to the same degree. If individual members are *de facto* the focus of interventions, what then is different from previous approaches?

Furthermore, a family-centred approach does not provide an effective paradigm to recognise or support gender equity. On the contrary, by treating the family as a cohesive unit this paradigm actually obscures internal gender and other power dynamics. How men interact with women –or for that matter, parents with children– is simply not questioned nor taken into consideration.

In conclusion: a focus on relationships¹⁴

This review of concepts and programme examples suggests that a focus on the family is inadequate to address gender issues, and that other ways are needed to transcend the limitations of an exclusive focus on women's empowerment or men's involvement and responsibility. If the goal is not to change men or women on their own, but to change the power relationship between them into a more equal one, then: '...instead of talking about the increase in the involvement of one sex or the other, it would be helpful to talk about increases and decreases in inequality' (Helzner 1996, 152).

Adopting a more dialectical view of structure and agency, a new generation of programmes is drawing attention to the mutually-constituted relationships between men and women (see Giffin 1998). The main emerging approach seeks to involve different actors at different stages. Two of the Indonesian NGOs mentioned above no longer work exclusively with women: the Indonesian Society for Pesantren and Community Development (P3M) still runs workshops for Moslem women teachers, but now also runs discussions (*halqah*) for Moslem leaders of both sexes. These promote awareness of gender and reproductive rights from a theological perspective, as part of a broader effort to create a just Moslem society. Similarly, the Rural Development Foundation now include the husbands of the women they train in their field school classes and meetings.

Over time, both of these organisations have come to believe that 'empowering women' before 'involving men' is the most appropriate intervention strategy, at least in the Indonesian context. Only if women are equipped with the necessary information and skills, will they feel able to communicate openly with men and if necessary dare to confront them:

One of the themes of the first three-day halqah undertaken by P3M early in 1997 focused on the religious norm precluding women from daily prayer during menstruation. For women who

¹⁴ From Nichter 1997, 14.

experience intermittent bleeding as a side effect of contraception, this issue is particularly pressing. According to fiqh (Islamic jurisprudence) women can pray when bleeding only if it is caused by disease. The male religious leaders claimed that Islam prescribes that only after eight days of bleeding can a woman be considered sick and therefore allowed to pray, and that to differentiate menstruation from disease-related bleeding, the colour of the blood and whether it lasts more than 12 hours must be taken into account. The women participants, all alumni of P3M, disapproved. One of them finally took courage and protested that 'reality is different from doctrine'. With enthusiasm, the other women teachers followed her and said the men did not understand women's bodies. 'How can a woman differentiate the colour of blood?' 'When is she supposed to start to count the 12-hour period?' An animated discussion followed on the validity of studying religious texts from a gender perspective. Both men and women agreed on the need to find new, women-friendly interpretations and committed themselves to work in this direction. They now meet regularly to study and discuss relevant religious texts.¹⁵

In this paradigm, the women first acquire relevant knowledge and become able to give each other solidarity and make their voices heard. As a result, men cannot as easily dominate decision-making or insist on maintaining the status quo. To work the other way round and start with men's involvement before attempting to foster women's empowerment, does not seem strategically sound.

The challenges involved should not be underestimated. When a certain programme is already perceived by the community as being for women, it may be difficult to convince men to participate at a later stage.¹⁶ The group Bina Insani found this recently when they started to expand their reproductive health programme to include joint workshops for men and women and there was a poor turnout of men (ICOMP 1998).

Hence, good timing is needed and strategies to explain to the community that a programme aims to involve men as well as women at different phases. The members of the Indonesian Women's Health Forum believe that the choice of programme name should reflect the focus on gender and avoid wording such as 'women's reproductive health' or 'health from a women's perspective'. They suggest using terms such as 'reproductive health for men and women' or 'health from a gender perspective'. They also argue that programmes should be designed so that they do not appear to be in the interest of women only, but as equally important for the health of men (Faisel & Ahmed 1996). Besides encouraging men to use condoms in order 'to protect the wife and children' (Outlook 1997:5) it is also important to stress that men need condoms to protect themselves.

A more holistic –but at the same time more complex– approach is to start reproductive health activities with different groups contemporaneously. Small, rural communities could be divided into peer groups, eg. by sex, age, marital status or socio-economic class. Each of these groups could carry out relevant activities in an atmosphere of privacy and confidence. Periodically, the groups could meet together to exchange views and undertake collective activities (Welbourn 1995). For example, the Indonesian Planned Parenthood Association (IPPA) in Jambi, South Sumatra, has developed a reproductive health programme which divides villagers in four peer groups: married men, married women, adolescent men and adolescent women. Although these peer groups address different themes, they have two in common, reproductive rights and gender equity, and

¹⁵ Personal communication with Lies Marcoes, coordinator, P3M programme on reproductive rights in Islam on 5 February 1998.

¹⁶ View put forward by members of Indonesian Women's Health Forum on 12 February 1998.

exchange views on these in joint meetings. Growing out of their newly acquired awareness, each group has drawn up an action plan with follow-up activities.¹⁷

Using a similar, simultaneous approach, Bina Insani, is now encouraging couples in the area where they work, to discuss sexuality and reproductive health and become aware of gender inequalities. Many cultural taboos have been challenged and some significant behaviour changes in relationships between men and women have occurred. A first-year evaluation, based on interviews with both men and women, clearly showed that men have reduced their violent behaviour against women, and no longer compel their wives to have sexual intercourse against their wishes (ICOMP 1998).

Although it is too early to assess the long-term impact of this new orientation in reproductive health programmes, initial results are promising and emphasise the value of exploring new strategies; these will need to be refined and implemented in different socio-cultural contexts, a challenge for both health professionals and activists. Only by remaining creative and avoiding set trends will gender finally be recognised and addressed within the social relationships it circumscribes.

¹⁷ Project correspondence between IPPA Jambi and Ford Foundation Jakarta Office.

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