Sciortino, Rosalia.: The Challenge of Addressing Gender in Reproductive Health Programs: Examples From Indonesia. Reproductive Health matters. May 1998.6(11). P.33-43.

The Challenge of Addressing Gender in Reproductive Health Programs: examples from Indonesia

Rosalia Sciortino

In 1994, ICPD stressed gender equity as a precondition for health and development while affirming the need to address women's subordination in reproductive health programs. However, those responsible for implementing these broad goals still struggle with how to operationalise gender-aware approaches. Starting from the assumption that gender equity and women's empowerment are necessary to achieving women's reproductive health and using examples from Indonesia, this paper focuses on the ways in which reproductive health programs view gender inequity. It questions the capacity of existing intervention paradigms to counter gender disparities and promote women's emancipation. It discusses the problems of a women-centered approach, of focusing on men in order to support women, and of reifying the family to the detriment of its individual members. Finally, it suggests that new, alternative approaches for interventions should be sought which transcend individual actors and uphold a focus on relationships.

In 1994, the UN international Conference on Population and Development (ICPD) addressed the complex relationship between women's individual reproductive and sexual health needs and global population and development policies. Departing from conventional demographic theories, a new reproductive health framework was devised which addressed women's subordination and made the improvement of women's status an important end in itself, essential to sustainable development. Only by tackling the underlying barriers to gender equity in all social spheres, it said, will women be able to exercise more control over their reproductive and sexual lives, act effectively to fulfil their needs, and attain a high standard of health and development A. To enable women to deal with complex social institutions that limit their access to reproductive health information and services, the Program of Action recommended policies and programs that:

"... 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."

Based on these principles, reproductive health policies and programs are needed that ensure and protect the exercise of women's basic rights. In this paper, I start from the belief that only by addressing gender inequity will reproductive health programs have the potential to improve women's health. My focus is therefore on the ways in which these programs view the multi-faceted nature of women's subordination and are trying to change it. 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 Program of Action implies that changes in gender relationships can be brought about through women-centered intervention 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:

"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" B.

Recognizing that women are in an underprivileged position, a women-centered approach seeks to bolster the power of women C 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 D. Current programs are focused on women and directed at empowering women 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 paradoxical 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 programs 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.

In 1995, the non-governmental organization Bina Insani set up a participatory program of reproductive health education and gender training for 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 that regard. They also felt able to articulate their needs to health workers and no longer hesitated to demand better services. This process of empowerment had not, however, reached their private lives. One of the staff of Bina Insani expressed disappointment that women were not willing to address reproductive health issues at home because they believed it was simply not possible to confront their husbands. She also seemed to agree with them:

"You knows, women still walk behind their husbands here when they go to church or other public events. Are we not foolish trying to empower them to be equal in the bedroom?" E

The same skepticism was apparent in one of Bina Insani's regular meetings on sexual health. Sitting in a circle on the floor, a group of women were looking incredulously at the facilitator, who was explaining the need for inter-spousal communication if STD and HIV transmission were to be prevented effectively. Finally, one of them found the courage to speak up and all the other women were nodding that they agreed:

"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 behavior." E

A women health activist in Eastern Indonesia had a similar experience during an AIDS prevention project. F

"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 "migrate 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?"

While degrees of gender power vary enormously across places, classes, ethnic groups and individuals, the question remains whether it is realistic for 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 programs may fail to help women to overcome what puts them at risk. At the same time, to postpone such programs 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 reproducing health programs, it is effective to focus exclusively on women. A classic example are STD/AIDS prevention programs that aim to empower sex workers to negotiate with their clients for safer sex, by providing them with information and skills G. 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 H. In one AIDS education program for sex workers in a large brothel in Purwakarta, Central Java, I 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-a-vis their clients. The authors note that the exclusion of mate clients from the program 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 programs targeting sex workers are dismissed as unrepresentative because of the financial nature of the sexual transactions, similar examples exist among programs that target wives J. The Rural Development Foundation, for example, has been carrying out a participatory program 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 program realized 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 K. 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.

Similarly, the Indonesian Society for Pesantren and Community Development started an, innovative awareness-raising program in 1994 for women preachers in Islamic boarding schools in rural Java and Madura, offering women-centered interpretations of reproductive rights within the teachings of Islam L. During an evaluation of the program, the women said they had become aware of new theological interpretations of women's position in the family and the Moslem community that they felt would lead to improved health for women. They felt they had learned skills in how to present an argument and that religion was more on their side. Yet they did not know how to apply their new awareness in their private lives, 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 lives, 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 programs 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 M. Without negating the many positive successes of women-centered programs 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 programs 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 companions N.

'...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' O.

It has been 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 P. Or, it may be that the perceived 'failure' of women-centered reproductive health programs is short-term since, in a process of social transformation, personal crises can trigger a change 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 programs.

'We Can't Leave Men Out Of The Equation' Q

Men are an increasingly 'popular' focus of reproductive health interventions. In the past, men's participation was sought by family planning programs 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 R. Later, men's involvement was considered necessary to support women's contraceptive use, when studies in both rural and urban areas showed that the husband's approval was the most important determinant of contraceptive use by women S.

The influence of men has been deemed so great that some authors have gone so far as to claim that changes in fertility behavior can occur even 'in the absence of inter-spousal communication or of the involvement of women in reproductive decision-making'. Consequently, programs should focus on men and motivate them in order to become a 'positive force in a broad family planning effort T.

More recently, largely as a result of AIDS prevention efforts the concept of male involvement has been recast to focus on men's sexual and reproductive responsibilities more broadly. The ICPD Program of Action encourages men to participate in all areas related to human reproduction and family formation, including responsible parenthood, sexual and reproductive behavior, prevention of sexually transmitted diseases, and shared control of and contribution to family income and children's welfare U. 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 authorize or prevent women from seeking sterilization or using contraceptives, for example V.

An alternative intervention paradigm has therefore emerged:

'Conventional population programs, 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 program agenda that must include men to be effective and sustainable over the long run W.

Yet there is an apparent contradiction when complaints about the neglect of men by programs 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 program 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? X Should this type of men's involvement be enhanced even further or rather reduced in favor 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 Y. She 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 behavior 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 Z.

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 AA. 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 AB. Men are expected to become more sympathetic to women's needs, revise all forms of behavior 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 the 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.

Some critics view this faith in men's willingness to accept the loss of dominance and privileges as naive or unrealistic. Considering the slow pace at which the number of male contraceptive method users has increased in Asia, including in Indonesia, AC any envisioned participation of men beyond contraceptive use seems optimistic. Furthermore, the archetype of this 'generous and responsible man', as constructed by reproductive health programs, is often far from people's lives but 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 rate AD AE. 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 AF. Men are urged as heads of families 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 AG. In other words, husbands are expected to act as 'benevolent leaders'. Their superior position is kept intact, not affected by efforts to foster gender equity.

Thus, even programs 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 programs 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.

Program 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?' AH

Another program 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 program, 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 AI.

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 AJ.

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 program interventions are still rare AK. Caution may be called for to avoid the possibility that 'the involvement of men ... ends up empowering men even more - that is to say, dis-empowering women even further Q.

The Reification on 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 programs, 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, synthesizing 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' AL.

One of the countries that have 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 family AM and the overall objectives of the family welfare movements. Since then, the focus of population-related programs has, gradually shifted, towards improving the socio-economic status of the family rather than the demographic and health status of the individual AN. Indonesia is proud to have done this long before Cairo and to have 'moved beyond' the ICPD Program 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' AO.

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, socialization and education, economy, and environmental preservation AP. The relevant programs and policy on reproduction are intended to strengthen the capability of each family to develop responsible and appropriate reproductive behavior, 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' behavior. 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 labeled 'vulnerable' and in need of special attention.

Specific interventions have more refined criteria. In its AIDS program, BKKBN has categorized 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 AQ.

Leaving aside considerations about the discriminatory implications and moralistic overtones 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 behaviors. 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 Program 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 approach?

Furthermore, a family-centered approach does not provide an effective paradigm to, recognize 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 Relationships AR

This review of concepts and program 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' AS.

Adopting a more dialectical view of structure and agency, a new generation of programs is drawing attention to the mutually constituted relationships between men and women. The main emerging approach seeks to involve different actors at different stages. Two of the Indonesian NG0s 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 includes the husbands of the women they train in their field school classes and meetings.

Over time, both of these organizations have come to believe that 'empowering women' before 'involving men' is the most appropriate intervention strategy, at least in the Indonesian contexts. 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 experience intermittent bleeding as a side effect of contraception, this issue is particularly pressing. According to fiqu (Islamic jurisprudence) women can pray when bleeding only if it is caused by disease. The male religious leader 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 color 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 color 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' AT.

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 program is already perceived by the community as being for women, it may be difficult to convince men to participate at a later stage. The group Bina Insani recently when they started to expand their reproductive health program to include joint workshop for men and women and there was a poor turnout of men AU.

Hence, good timing is needed, along strategies to explain to the community that a program aims to involve men as wen as women at different phases. The members of the Indonesian Women's Health Forum believe that the choice of program 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 programs 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 AV. Besides encouraging men to use condoms in order 'to protect the wife and children AW. 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 socioeconomic 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 AX. For example, the Indonesian Planned Parenthood Association (IPPA) in Jambi. South Sumatra, has developed a reproductive health program 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 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 AY.

Using a similar, simultaneous approach, Bina Insani is now encouraging couples in a village where they recently begun working, to discuss sex and reproductive health and become aware of gender inequalities. Many cultural taboos have been challenged and some significant behavior 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 behavior against women, and no longer compel their wives to have sexual intercourse against their wishes.

Although it is too early to assess the long-term impact of this new orientation in reproductive health programs, initial results are promising and emphasize 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 recognized and addressed within the social relationships it circumscribes.

Acknowledgments

A previous version of this paper was presented at the IUSSP Conference, Beijing, October 1997. Thanks to the members of the Indonesian Women's Health Forum, in particular Kamala Chandrakirana Soetjakmoko, Nathalie Kollman, Endah Nurdiana, Ninuk Widyantoro. Lies Marcoes and Atashendartini Habsjah, for advice and help on this paper. The opinions expressed are those of the author, and not necessarily those of the Ford Foundation.

Correspondence

Rosalia Sciortino, Ford Foundation, S. Widjojo, llth floor, JI. Jend. Sudirman 71, Jakarta 12190, Indonesia. Fax: 62-21-252-4078. E-mail: r.sciortino@fordfound.org

References and Notes

A__ ICPD $4.1.1994.

B__ Germaine A. Kyte R. 1995. The Cairo Consensus. The Right Agenda for the Right Time. International Women's Health Coalition, New York.

C__ Klugman B. 1996. ICPD Plan of Action: its ideological effects. Health Transition Review. 6(2):225-29.

D__ Challenges after Cairo. Arrows for Change 1995; 1(l):11. Resources for Women's Reproductive Health in the Third World. International Women's Health Coalition, New York, 1989.

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

F__ Galuh Wandita, field consultant, Indonesia Program, Oxfam Australia, personal communication.

G__ Alexander P, 1990. Provisional guidelines for sex work related AIDS prevention interventions. (Unpublished) -de Zalduondo B, 1991. Prostitution viewed cross-culturally: toward recontextualizing sex work in AIDS intervention research. Journal of Sex Research. 28(2):223-48.

H__ Dyer C, 1996. Rape ruling sets legal precedent. Guardian. 20 March.- Rojanapithayakorn W, Hanenberg R, 1996. The 100% condom program in Thailand. AIDS. 10(1):1-7.

-Shephard B, 1996. Masculinity and the male role in sexual health. Planned Parenthood Challenges. 2:11-14.

I__ Suyanto, Kuncoro B, Setiawan D et al, 1997. Pelembagaan Penggunaan Kondom di Kalangan Pramunikrnat. Pusat Penelitian Kependudtkan UGm, Yogyakarta.

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

K__ Compare with: Giffin K, 1998. Beyond empowerment: heterosexuality's and the prevention of AIDS. Social Science & Medicine. 46(2):151-56.

L__ Sciortino R, Marcoes Natsir L, Mas'udi M, 1996. Learning from Islam: advocacy of reproductive rights in Indonesian pesantren. Reproductive Health Matters. 8(November):86-96.

M__ As a result, both projects have begun including men in their programs. Re the Rural Development Foundation's activities, see: Sri Hadipranoto S, Wijaya H, Santoso H et al, 1996. Empowering women farmers through men. Innovations. 4:15-28.

N__ Suryakusuma J. 1991. State ibuism: the social construction of womanhood in the Indonesian new order. Asian Vision. 2:46-71. Suryakusuma J. 1991. The state and sexuality in the Indonesian new order. Paper presented at Perspectives on Gender in Indonesia: Women in Society, History and Media, University of Washigton, Seattle, 15-16 June.

O__ Hull T, Hull VJ, 1995. Politics, culture and fertility: transitions in Indonesia. Paper presented at John Caldwell Seminar 'The Continuing Demographic Transition'. Canberra, 14-17 August.

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

Q__ Berer M, 1996. Men (Introduction). Reproductive Health Matters. 7(May):7-18.

R__ Azrul Azwar, 1993. Some notes on male participation in the Indonesian family planning program. Majalah Keschatan Masyarakat Indonesia. 2:124-27.

S__ Mantra IB et al, 1994. Tingkat Penerimaan Keluarga Berencana Pada Suami Di Daerah Kota Dan Desa Di Propins-iJaiva Tengah, Jawa Timur Dan Nusa Tenggara Timur. Badan Koordinasi Keluarga Berencana Nasional, Jakarta.

- Habsjah A, Diao Ai Lien, Favoriati D, 1996. Men and Reproductive Health: Understanding Their Potential Roles, Population Council, Jakarta.

- Hidayana I, 1996. Men's roles, sexuality and reproductive health. (Unpublished)

T__ Karra MV, Stark NN,- Wolf J, 1997. Male involvement in family Planning: a case study spanning five generations of a South Indian family. Studies in Family Planning. 28(1).24-34.

U__ ICPD §4.27. 1994.

V__ Gomez A, 1997. The challenges of gender. Women's Health Journal. 1:29-34.

W__ Moi-Lee L, 1996. Putting men on the agenda. Innovations, 4:1-13.

X__ Piet-Pelon NJ, Ahmed-Al-Kabir, 1996. Highlights of regional male involvement family planning program; and Alauddin M, Rafiquz Zaman AK, 1996. Males as FP-MCH-RH service providers. In: Male Involvement in Family Planning: A Challenge for the National Program. Workshop Proceedings. NIPORT/GTZ/Population council/AVSC International.

Y__ Indonesia's law on abortion is conservative; although a new law was passed in 1992, it has not yet been implemented. See Djohan E et al, 1993. The attitude of health providers towards abortion in Indonesia. Reproductive Health Matters. 2(November):32-40. Some private hospitals, however, like the NGO described here, do provide abortion services, within strict guidelines, to married women who are accompanied by their husbands. See [S] above.

Z__ Prihatini Ambaretnani, Riawati S, Mustary C et al, 1996. Pelatihan mengenai wanita dan kesehatan bagi tenaga kerja Indonesia wanita. Project report.

AA__ Haberland N, personal communication, 1997.

AB__ For more on the advantages of expanding men's role in reproduction for men themselves and whether emphasizing men's reproductive health needs would result in decreasing resources and services for women, see Mundigo A, 1995. Men's Roles, Sexuality, and Reproductive Health. International Lecture Series on Population is-sues; and all features in Reproductive Health Matters No 7, 1996.

AC__ Meliala N, 1995. Men's participation in family planning: how far does it go? Conveying Concerns: Women Write on Male Participation in the Family. Population Reference Bureau, Washington DC.

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

AE__ Gerakan Sayang Ibu. Kantor Menteri Negara Urusan Peranan Wanita, Jakarta, 1996.

AF__ Rumusan Lokakarya Percepatan Penurunan Angka Kematian Ibu. Kantor Meriteri Negara Urusan Peranan Wanita, Jakarta, 1996.

AG__ Woodhouse SJ, 1996. Sambutan Kepala Penvakilan UNICEF pada Lokakarya Evaluasi Gerakan Sayang Ibu. UNICEF, Yogyakarta.

AH__ Murniati A, 1997. Ayah dan kesehatan reproduksi keluarga. Report prepared for Population Council.

AI__ Information from Sulawesi chapter, Indonesian Consumer Organization.

AJ__ Widyantoro N, Habsjah A, Fajar Aviatri M et al. 1995. Laporan akhir memperbaiki sistim informasi dan pemilihan metoda kontrasepsi oleh klien. Research report, POGI and Pusat Kajian Wanita UI.

AK__ For a review, see: Male Involvement in Reproductive Health, Including Family Planning and Sexual Health. Technical Report 28. UN Population Fund, New York, 1995.

AL__ Sokalski H, 1993. Aims of the International Year of the Family. Development 4:6-16.

AM__ In this only a married couple with children and a divorced or widowed single parent with children are recognized as a 'family'.

AN__ Haryono Suyono, 1996. Prosperous family development. Integration. Fall:27-33.

AO__ BKKBN statement, 1996.

AP__ Haryono Suyono, 1995. Policy on increasing the role of women in the development of family welfare. Address of the State Minister for Population/Chairman of NFPCB at first meeting of In-Country Advisory Committee for Women's Studies. Bogor, 9 January.

AQ__ Pedoman Pencegahan Dan Penanggulangan Penyakit HIV/AIDS Melalui Peningkatan Ketahanan Keluarga. BKKBN/Kantor Menteri Negara Kependudukan. Jakarta. 1995.

-Buku Pegangan Tentang Pembangunan Keluarga Sejah tera Sadar HIV/AIDS Bagi Petugas Lapangan KeIuaraa Berencana. BKKBN/Kantor Menteri Negara Kependudukan, Jakarta, 1995.

AR__ Nichter M, 1997. Male responsibility and women's sexual health: considering women and men together. Community-based Programs for adolescent Sexual Health and Domestic Violence against Women. Pimpawun Boonmongkon, Anjana Suvarnananda (eds). Mahidol University, Bangkok.

AS__ Helzner J, 1996. Men's involvement in family planning. Reproductive Health Matters. 7(May):146-54.

AT__ Lies Marcoes, coordinator, P3M program on reproductive rights in Islam, personal communication, 5 February 1998.

AU__ Enhancing reproductive health status in the rural area: a community approach. ICOMP, 1998. (Unpublished)

AV__ See also Faisel A, Jahiruddin Ahmed, 1996. Role of men as the users of contraceptive methods. Male Involvement in Family Planning: A Challenge for the National Program. Workshop Proceedings. NIPORT/GTZ/Population Council/AVSC International.

AW__ Messages for men. Outlook. 1997: 14(3):5.

AX__ Welbourn A, 1995. Stepping Stones' Action Aid, London.

AY__ Project correspondence between IPPA Jambi and Ford Foundation Jakarta office.