

MEN'S INVOLVEMENT IN FAMILY PLANNING: A GENDER PERSPECTIVE

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Intisari

Akhir-akhir ini, keterlibatan pria dalam kesehatan reproduksi secara umum mulai banyak mendapat sorotan. Tulisan ini terutama membahas apakah keterlibatan tersebut berarti mempersempit kesenjangan antara pria dan wanita secara umum. Dengan perspektif gender, keterlibatan pria dan wanita dianalisis dalam 3 tingkatan, yaitu pada tingkat kebijakan internasional, tingkat program dan tingkat individu. Hasil studi pustaka ini menunjukkan bahwa proses pembuatan keputusan yang berkaitan dengan keluarga berencana belum banyak dibahas, berbeda halnya dengan jenis keputusan dan pembuat keputusan. Untuk menyatakan bahwa keterlibatan pria berakibat positif terhadap kesetaraan gender (gender equality), diperlukan pemahaman yang lebih mendalam mengenai proses pembuatan keputusan sebagai titik kritis ke arah kesetaraan gender.

Introduction

Gender perspective has been a powerful standpoint which creates various responses across disciplines, professions, and regions. As an illustration, epidemiologists and public health experts react by initially disaggregating their data according to sex to look for sex differences; sociologists in the past two decades begin to dig even deeper by differentiating between how nature determines biological

male and female (sex) and how society or culture attaches behavioral, attitudinal, and physical expectations to each sex (gender) (Auerbach and Figert, 1995); feminists postulate that disadvantages of being a woman is the result of women oppression by men.

One of many health issues which has been given enormous attention in the international calen-

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question is why reproductive health? This question provokes many responses varied from a strong systematic discrimination against women by means of laws that obstruct part of women's basic right to have access to reproductive health services, the fact that reproductive health is indeed a sensitive issue because it is directly related to sexuality and morality (Cook, 1993), to a short cut-simplistic way of thinking that in order to apply gender perspective in health, we need to pay more attention to the obvious traditional biological difference between female and male, that is, in reproduction. This simplistic view, in other words, states that giving more emphasize on women's reproductive health is what gender perspective in health means.

The first reason of the choice of family planning as a central issue in this paper is by no means restricting reproductive health into family planning, but because discussion on family planning has been heavily centered upon women. The reason for this female orientation is, however, inevitable: the excessive threat of child bearing on women's

planning and women empowerment, fast development of female contraceptive methods, and the biological, psychological, and social expectations on the reproductive role of women and its social reproduction (Gulhati, 1986).

Second, it is certainly sensible to give more attention to gender issues for the other half (that is, men) in a women-centered area, since gender perspective demands taking into account the interaction between men and women rather than concentrating on women per se (Helzner, 1996). Therefore, differences as well as similarities between men and women should be given equal emphasize to achieve mutual relationship and mutual benefit (Busfield, 1996; Doyal, 1996; Keller, 1992). Besides, from the process point of view, do we not repeat the same history by not involving women in development activities and excluding men in family planning programs?

Aim

The central idea behind this essay is that while the conception of lack of women involvement in all areas of development has been

widely recognized and proven to create disadvantage for women, lack of men involvement in an area which is traditionally regarded as typical women concern may also have a negative impact on women. This paper will first demonstrate the difference between women-centered and gender equality approaches in reproductive health in general, followed by attempts to answer the following questions: How are men involved in family planning? What does men involvement in family planning mean? What does this mean for women?

Literature Search

In addition to book references, published articles were retrieved from two main databases, namely Popline up to June 1998 and Medline up to July 1997. The main key words used were: family planning, man or male involvement, and decision making. In the process of literature search, it is worth mentioning that when the key word family planning is combined with male, this results in about 10% for popline and 5% for medline out of the total articles in family planning. This percentage may well be a broad indicator to reflect how little attention has been devoted into research involving men in family planning.

Women-Centered and Gender Equality Approach in Reproductive Health

In thinking about gender in relation to reproductive health, it is useful to differentiate between two different approaches found in the literature (Standing, 1997): women-centered and gender equality. These two approaches are related to the concept used by experts in development, that is, Women in Development (WID) and Gender and Development (GAD) framework. The WID approach is based on the underlying rationale that the process of development would be much better if women were fully incorporated in the process. In contrast, the GAD approach believes that to focus on women in isolation is to ignore the real problem, i.e. their subordinate status to men. It emphasizes the importance of gender relations when designing measures to help women in the development process (Moser, 1992).

A women-centered approach is mainly concern with the implications or specific consequences for women as the result of differences between the sexes, or more straight forward, differences of the biology of reproduction. This approach will thus identify specific health intervention to address the imbalance

* At least two conference serve as the landmark of this agenda with particular reference to their success to incorporate gender perspective. These are the UN third International Conference on Population and Development in Cairo, 1994 and the fourth Conference in Beijing, 1995.

of women-specific intervention (Overholt *et al*, 1985). Women-centered approach gives particular importance on the practical needs as opposed to strategic needs, therefore, deals with relatively short-term result (Moser, 1992). Examples of this approach are:

- * Interventions on obstetric emergency care for pregnant women at first referral health facilities
- * Women's receptivity to family planning information at post-abortion service
- * The effectiveness of different methods of counseling for women experiencing domestic violence
- * Intervention on nutritional supplementation for pre-marriage adolescent women

To understand the standpoint of gender equality approach, one has to start with a definition of gender. First of all it is widely acceptable that gender is socially constructed. The debate is whether it includes biological difference or if it is independent of sex. Moreover, it also depends on if one defines biological difference as biological sex (i.e. reproduction) (Gulhati, 1986) or to include other organs in the body in a broader meaning. The latter implies that socially constructed differences between man and woman also include and deal with biological difference (for further explanation, see Hubbard, 1992). The definition of gender used in this ar-

Vlassoff (Vlassoff, 1994):

"Gender refers not only to biological or sex difference between men and women but also to the context of their behavior in the society, the different role that they perform, the variety of social and cultural expectations and constraints placed upon them by virtue of their sex and the ways they hope with societal expectations and constraints".

In comparison to the women-centered approach, gender equality approach is concerned with the underlying factors or conditions producing inequality of differences between the sexes in relation to access and optimal utilization of services (Standing, 1997). Using the iceberg phenomenon to illustrate the difference between the two approaches, the women-centered approach will be tackling the symptoms or signs in the tip of iceberg, whereas the gender equality approach will enable us to identify the underlying factors in the bottom of the iceberg.

In family planning, almost all explanations related to human fertility, either implicitly or explicitly, have some decision making ideas at their heart. At the very least, decision making plays a partial role (Leibenstein, 1981). Thinking about gender equality approach, therefore, is thinking about how power relations at the household level af-

decision making. The following questions are examples of gender equality approach:

- * Does involving husbands in the choice of contraception use or method make any difference?
- * Are family planning decisions made by way of "no decisions" decision to avoid a husband-wife conflict?
- * How does information contribute to the process of decision making in family planning? How does the power of information differ between woman and man or wife and husband?
- * What does it mean for women if men are making decisions based on incomplete information?

Men Involvement in Family Planning: What is in the Policy?

Although the notion of universal human right was already ratified in the United Nations Charter of 1945, it took another 30 years for women to be systematically and carefully thought about by the international bodies when the United Nations launched the Women's Decade (1975-1985). Regarding family planning, the concept of universal human right was first applied to family planning at the 1968 International Human Rights Conference in Teheran (Freedman and Isaacs, 1993; Correa and Reichmann, 1994), which stated that:

... the right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect".

Apparently, the above paragraph does not yet take into account the interaction between men and women, by assigning couple as the smallest unit in the policy. Further population and development policies have extended from the recognition of couple's human right to individual's right and to indicate that people should have access the means to exercise these rights (Freedman and Isaacs, 1993). This was brought up in 1974, at the World Population Conference in Bucharest, Romania, only one year before the International Women's Year Conference in Mexico City in 1975. In this event, women's activists were instrumental in ensuring that the conference grounded its assertion to the right to reproductive choice on a notion of bodily integrity and control (Correa and Reichmann, 1994).

The Women's Decade made an impeccable result in international legal instrument, known as the Convention of the Elimination of All Forms of Discrimination against Women (CEDAW), ratified in 1979. In this convention, it is clearly stated that any distinction, exclusion or restriction made on the basis of sex is classified as discrimination against women (refer

to Article 1) (Cook and Maine, 1987), which should be eliminated on the basis of equality of men and women. In the field of health, explicit statement was made to abolish discrimination in access to health care services, including those related to family planning (Article 12, 1). More specifically, the abolishment of any discrimination in family planning should be achieved by having "the same right to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (Article 16, 1(e)).

From the last quotation, it is eminent that both man and woman should be guaranteed the same right to make informed reproductive choices. It is not only women who should maintain all the burden associated with family reproduction, given that women already bear more consequences and risks during pregnancy and childbirth. Nonetheless, explicit emphasis on the contribution of men in reproduction is still disproportionately addressed (Johansson *et al*, 1995).

The 1994 Cairo International Conference on Population and Development articulates further the significance of women and their status as central to sustaining global development efforts. This

conference also succeeded in elaborating the urgent need to have men responsibility and participation in reproductive health, and calls for the promotion of "gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles" (Cohen and Richards, 1994). Furthermore, any efforts to improve men responsibility and participation should be undertaken in the pursue of women empowerment, explicitly stated in the Beijing Platform of Action (Johansson *et al*, 1995):

"Shared responsibility between women and men in matters related to sexual and reproductive behavior is also essential to improving women's health".

In summary, men involvement in family planning has been incorporated into the policy of reproductive health to the extent that their shared responsibilities are recognized and means to enable men to fully participate are also addressed. In addition, it is also stated that increased participation of men should not be seen as a mode to create a greater gender disparity by giving more power to men, but should be further developed into programs which strengthen women empowerment.

PROGRAM LEVEL: HOW ARE MEN INVOLVED IN FAMILY PLANNING?

The first ultimate question at the program level is to ask why do we need to involve men in family planning. This poses a variety of responses, from a very pragmatic reasoning up to a hypothetical one. The following is the list of possible answers (Gulhati, 1986; Network, 1992; Hulton and Falkingham, 1996):

- * Men are already involved and we have to understand to what extent are they involved. Example of this would be the role of men in reducing fertility in developed countries before 1960s.
- * It takes two
- * It's the right thing to do
- * Men want to be involved if they are asked
- * Men in general tend to neglect their health, so it's good to involve them for their own health
- * It has nothing to do with men's health, but women's and children's
- * Can they be held responsible for their children if they are not included in the decision making?
- * Men have limited knowledge on this matter
- * Economic and social responsibility for their family
- * Will forge a stronger bond between them and their children and to promote a greater responsibility

men have paternal responsibilities

- * Improve men's personal growth on a sensitive issue
- * Men can impregnate women everyday, but women can only get pregnant once a month
- * Decision in fertility is in the hands of men, women have little power over such decisions
- * Higher continuation rate among women when men are consulted
- * New emerging diseases: AIDS and STD

a. Men as Managers and Providers

More men than women are in the position of managers. In family planning, similar situations occurred. There are relatively few men working at the lower levels, therefore, have less direct contact with clients, and relatively few women who are physicians, decision makers, or top level managers. In a way, men have already been involved professionally or bureaucratically, which leads to having more power (Helzner, 1996). This is not to say that if women have access to such position, it will be easy for them to gain the same power nor to have a positive attitude towards women empowerment. The following is the illustration of male participation as contraceptive distributor.

Attempts to recruit men as contraceptive distributors have undertaken in several countries. As an example, in Peru men were recruited as community-based distributors and their performance was compared to female distributors. It was found that male distributors were more likely to serve male clients and sell male methods (condom), and female distributors were to more likely to serve female clients and sell female methods (pills). Therefore, recruiting male distributors will attract more male clients. However, in this study, drop out rates of male distributors was not addressed, which may be a potential problem in future implementation since recruitment for male distributors was more difficult than female (Foreit et al, 1992). A similar example was also available from Kenya, by recruiting male Kenyan shopkeepers distributing non-prescribed contraceptives, as part of the scheme run by the Nairobi-based African Medical and Research Foundation (AMREF) and the Flying Doctor Service (People) (Network, 1992).

b. Programs to Enhance Men's Involvement: Outreach Clinic and Information Campaign

Several examples from developed and developing countries will be used to illustrate efforts to encourage men to visit a

family planning clinic. The first example drawn from Britain in the form of integrated clinics (but a separate space for woman and man), targeted for youth; and the second example was a special clinic for men, taken from the experience of Profamilia Clinic in Colombia. That men are welcomed in a family planning clinic is theoretically well accepted, even though the reality is far from what is expected by program managers (Network, 1992). Other examples, not only restricted to family planning but to include a broader scope on teenage pregnancy prevention program, can be found in the publication of the California Wellness Foundation and the Urban Institute which describes 24 promising prevention programs in United States focusing on the male role in reproduction. These programs have different approaches that can be used for addressing the male role, such as sports, club or youth group, school-based, employment, health care, criminal justice, and community-wide (Sonenstein *et al*, 1997)

From all examples, it is obvious that when decision has been made to provide services for men, the first message to be seen by the potential users is that this is not just adding men into the available service for women, and the service must be created based on current needs, knowledge and attitude of men. Indeed, focusing on the male role in reproduction and not just having

male participants is the main selection criteria of the programs documented by Sonenstein et al (1997). This could have large consequences from the practical point of view (such as selecting providers, allocating space, choosing the content of service) up to program philosophy. From the program point of view, offering service for men also means more costs to be born by the manager. The Profamilia Clinic in Colombia, therefore, is also diversifying its content of services to aim for a self-financing clinics. Men and women often have different reasons to access the clinic. Other considerations would be whether this clinic will be unisex or bisex clinics, and also family planning clinic or combined with an STD clinic.

To a certain extent, men involvement may be enhanced by providing outreach clinics targeted for them. However, the result of contraception use and spread of information will be highly dependent on the utilization of such clinics and limited to those who use the clinics. The following type of intervention may be capable of reaching a larger population of men.

The largest and the first information campaign targeted to men in Africa was performed in Zimbabwe, known as the Zimbabwean Male Motivation Project. This three year project started in 1988 in collaboration with the Johns Hopkins University was aimed at increasing

knowledge in family planning, promoting favorable attitudes, increasing the use of modern family planning methods, and promoting male involvement and joint decision making between spouses about contraception and family size. Using three main strategies, i.e. radio drama series, educational talks for men, and pamphlets on family planning, this project was able to show significant impact on knowledge, attitude, and practice of men on family planning. Among those were the increase use of modern methods from 56% to 59% in 16 months (20% greater than prior to the campaign) and condom use from 5% to 10% (Piotrow et al, 1992). The latter has to be interpreted cautiously, since other activities outside this project was probable with the improved awareness of AIDS/STDs and condom social marketing at the same period.

A comparable positive result is also emerged from educational intervention in Pakistan (Network, 1992), by creating 60 community educator teams consisting of man and woman. These teams were asked to visit families throughout the city. After a period of 4 years, the contraceptive prevalence among married couples increased from 9% to 21%, with methods changing from very temporary to longer lasting methods and a few vasectomy which was regarded as breaking the record in this country.

information and services, rather than lack of interest has kept men from taking a more active role in family planning.

c. Range of Contraceptive Methods for Men

The most direct involvement of men in family planning is their use of contraception. For centuries, the development of contraception so far led to four types of male-dependent methods, i.e. condoms, vasectomy, withdrawal, and periodic abstinence. Among those, condom has been the only reversible contraceptive available for men. Yet, prior to condom promotion for AIDS, its use has remained steadily low in most countries and more likely in a short-term basis relationship. Among the 18 countries analyzed (Network, 1992), only two countries (Pakistan and Bangladesh) had an increase of more than 1% among couples during the 1980s. Besides their low level of use, discontinuation of male-dependent methods is typically even higher than for methods used by women, with the primary reason of method failure (Ringheim, 1996). Moreover, three out of four male methods are coitus dependent. What is left is vasectomy, a method which is almost irreversible and received low acceptance in general. These current available methods placed men with

hardly any choices but two difficult extremes, either coitus dependent or irreversible, none of them are easy to persuade men to use.

On the other hand, promising ideas and research and development for male-dependent methods are underway. This includes the expansion of a new no-scalpel method of vasectomy in China, hormonal contraceptive (testosterone enanthate or testosterone buciclate), chemical interference (such as Gossypol), and antifertility vaccine. However, these ideas may not be available until the next 21st century (Cohen and Richards, 1994), not alone taking into account how these new contraceptions are perceived by women. As Catley-Carlson said, "new contraceptive methods are only as good as the context in which they are offered" (Catley-Carlson, 1997).

With limited contraception choices for men coupled with low acceptability and use, it appears that direct involvement of men in family planning by taking more male-dependent methods may not be achievable in the near future to make a significant impact on fertility reduction and improved family well-being in general. Therefore, indirect role of men in family planning seems to be more feasible by way of supporting women's choice of family planning. This, however, may not be accomplished unless a complete understanding of men's knowledge, attitude and practice as

well as their role and capacity in the decision making process at the household level are well understood.

Individual Level: What do we know about men's knowledge, attitude and practice (KAP) in family planning?

First of all, it is surprising to know how little well-founded knowledge there is concerning men and reproduction. In a review by Hulton and Falkingham (1996), only 4 out of 42 surveys in the World Fertility Survey during 1970s and early 1980s interviewed husbands. The situation was slightly changed between 1986 and 1995, in which 26 out of 74 completed Demographic and Health Survey collected data from male respondents. Even in United States, data about men's involvement in contraceptive decision is scarce, and most of it focuses on adolescents (Edwards, 1994).

Research on men's KAP on family planning has been approached in different ways, i.e. using men only, couples, or alternatively using men only as respondents but the data is then compared to a larger existing survey on women. In case of attitude and practice, it is also possible to ask women about their partner's attitudes and practices. However, findings have revealed that women in general tend to consistently un-

derestimate men's attitudes and practices or they are more likely to report their own contraceptive use if both couples approved. On the other hand, when men is asked, they may overestimate their own role.

Discussion: Does Men's Involvement Lead to Gender Equality?

In this section, perhaps more questions than answers will be raised. The most critical question to ask is whether men's involvement this would actually mean sharpening current inequalities in the power relationship between women and men or would it facilitate women's reproductive right in the spirit of gender equality. Most heard examples such as husband accompanying the wife to an antenatal clinic may be interpreted as enforcing gender equality if this does not serve as a requirement for the woman to receive a service nor for women to receive a better quality of service. Likewise, an informed consent from the husband to obtain a family planning method may not empower woman, if lacking the consent is identical to no service for woman. Helzner (1996) gave a warning statement that "male involvement efforts which attempt to reach women through men rather than to increase male use of contraception may make men feel that

Summary of findings from research on men only

Author (Year)	Country (N)	Design	Main Results
Brindis et al (1998)	California, USA (1,540)	Clinic-based survey	The likelihood of use of last intercourse was increased among males who agreed with their partner about the method and those who had never impregnated a partner (1.4 and 1.9 respectively).
Obionu (1998)	Nigeria (380)	Survey	90% of respondents agreed that couple should decide the number of children. While more than 32% of men believed that the wife alone should use FP methods, only 10% thought it was the husband's role to use family planning methods.
Grady et al (1996)	USA (2,526)	Survey	Gender equality in decisions about having sex, contraception, and child raising responsibilities was favored by 60.8%, 78.2%, and 87% of men respectively. Men with non-egalitarian orientations perceive female as dominating decisions about timing of sex and men having greater responsibility in contraceptive decisions. Men who felt women as most responsible in contraceptive were older, black, have a hispanic partner, less educated or have a highly educated partner compared to men with egalitarian orientation.
Were & Karanja (1994)	Kenya (355)	Survey	63.9% of men said that decision making on family size should be made by couple and 33.6% by husband alone; 78.6% in favour of couple counselling, 56.9% said that wife alone should actively participate in FP compared to 31.5% by couple and 10.1% by husband only
Pillai (1993)	Zambia (85)	Survey	78% of men discussed FP with their wives, only 29% felt that women alone are responsible for FP.
Mbizvo & Adamchak (1991)	Zimbabwe (711)	Survey	83.5% of men approved FP; 80.6% ever-used contraceptive and among these, 58.5% said that they should dominate the decision in FP, 48.3% said that men alone should decide. 60% of men said that obtaining FP information was women's job and wife obtained the supply 78.2% of the time.
Piotrow et al (1992)	Zimbabwe (892)	Before-after, no Control group	52% of respondents were exposed to the campaign. When exposed men compared to the non-exposed, the exposed group had better knowledge, 61% and 47% respectively said that men should make FP decision, 31% and 45% said that it should be a joint decision. Before-after comparison: joint decision on family size increased from 32 to 54%, husband alone decreased from 54% to 30%.
Khalifa (1988)	Sudan (1,500)	Survey	Decision to use FP: among 88% men who answered, 44.7% said that it should be made by couple, 34.1% by husbands, 5.4% by wife, and 14.5% by professionals. Decision not to use: 37% by husband alone, 33.3% joint decision, and 2.5% by wife alone. Decisions to use FP among current users: 69.6% joint decision, 13.9% by husband, 9.7% by professionals. Supply for contraception: 61.3% obtained by husband, % by wife.

Summary of findings from research on both men and women

Author (Year)	Country (N)	Design	Main Results
Henry J. Kaiser Family Foundation (1997)	USA (503 men and 502 women)	Telephone survey	Most men (67%) and women (71%) believe that men should have a greater role in choosing contraceptive and ensuring its use. Most men reported their awareness that women want them to be more involved in contraceptive choice (71%) and use (77%). However, most respondents agreed that women feel more responsible than men for their children and they have the most influence on the decision to have a child. More than a third of men and women believed that men feel excluded from contraceptive decision making, and more than half of men reported lack of knowledge on contraception.
Kim & Marangwanda (1997)	Zimbabwe	HH Surveys, statistics, client interviews	88% of men and women were exposed to the campaign, recall was achieved more among the men, educated, and married respondents. Knowledge and approval of long-term contraception increased among women more than men. About 42-51% of men and 37-57% of women reported discussing FP with their spouses.
Valente & Saba (1997)	Bolivia (2,354 men and women)	Before and after intervention	85% were exposed to the intervention, and positive attitude toward reproductive health increased from 86% to 91%. Intention to use or continuation of FP use in the future rose from 25% to 60% among the males.
Bertrand et al (1896)	Zaire (3,140 men and 3,485 women)	Survey	Similarity in the attitudes, beliefs, knowledge levels and practices of men and women regarding fertility and family planning. When they differed, men tend to be more pronatalist than women.
Hulton & Falkingham (1996)	10 countries in Asia, Africa, and Latin America (69,623)	Survey	Overall, men have greater knowledge of male methods than women. Although women's knowledge of female methods is higher than men's, the difference is not large. Men's ever and current use are also greater than women's, nonetheless knowledge is not a good indicator of use.
Isiugo-Abanihe (1994)	Nigeria (3,073 couples)	Survey	88% of men and 78% of women said that men's views are more influential in decision making. 40% of men and 50% of women mentioned that family size was a joint decision, although women are likely to have compromised their position. When couples were asked about their responses toward men as decision makers, the greatest disparity was in men's role to decide when to have sex, whereas the lowest agreement was about using FP methods.
Sahway (1994)	Ghana (661 couples)	Survey	Only 35% of women and 39% of men discussed FP with spouses. When couple approved FP, wives are more likely to report contraceptive use. Attitude and preferences of wife are more important to determine whether she uses contraception than those of her husband.
Ezeh (1993)	Ghana (1,010 couples)	Survey	53.6% couples approved FP (husband was slightly higher than wife), 21% disapproved. Spousal influence is only exercised by husband.
Terefe & Larson (1993)	Ethiopia (527 women)	RCT: with and without husband participation	A greater proportion of couples in experimental group were using modern FP at 2 months (25% and 15%) and 12 months (33% and 17%). By 12 months, experimental subjects were more likely to have started using modern contraception.
Moti & Mott (1985)	Nigeria (296 women, 345 men)	Survey	72% of women never discussed FP with spouses. 10.4% of monogamous (mon) and 0% polygynous (poly) couples said that husband is the decision maker, 23.5% mon and 15.6% poly said that it was a joint decision, and 64.3% mon and 81.3% poly stated "no-one" made the decision. 43% wives and 47% husbands approved FP, but only 15% had actually ever done anything to prevent pregnancy. Only 48% couples agreed on family size.

decisions about contraception are their alone to make and may, therefore, reinforce patriarchal views".

From the literature review, men may be involved directly or indirectly once they accept family planning. Direct participation of men means actual shared-responsibility by men and women in using family planning methods, i.e. for women to choose a female-dependent method and for men to choose a male-dependent method. While this is certainly promising both in terms of trends of male-dependent users across time as well as the development of a wider choice for men in the future, its impact on fertility reduction will not be as significant as the increase use of female-dependent methods by women. The latter is where men may contribute indirectly in a family planning program, i.e. by making a more positive attitude and better decisions based on current knowledge and attitude.

Hypothetically, if men have more access to knowledge and positive attitudes toward family planning, although this is a bad indicator of contraception use itself (Hulton and Falkingham, 1996), it is expected that they at least would contribute to create a healthy environment for women to practice family planning. At this point, more questions may be asked: With better knowledge and attitude, would men make better decisions, would it lead to a more equal

process of decision making, or would they be more likely to be in favor of joint decision making? Data from the literature review do not necessarily suggest the same direction as we may have assumed. It appears that knowledge and attitude on one hand and decision making on the other hand operates at a different level. Decision making, albeit influenced by information, may be more associated with gender disparity in the community in general, rather than specific information on family planning. Therefore, programs which attempt to merely provide information on family planning in isolation to addressing other gender-related concerns may fail to influence the decision making process.

A more reasonable objective to achieve by involving men in family planning may be to facilitate a better communication between men and women in order to make a joint decision. Creating a mutual communication between men and women would certainly reinforce gender equality, ignoring whether it would lead to an appropriate decision or not. This hypothesis is, however, not effortless to prove. As an example, an intervention study conducted in Zimbabwe by means of information campaign showed that although the proportion who said that family size should be a joint decision was increased from 32% before the campaign to 54%

the exposed and non-exposed men revealed that joint decision making about family planning was less common among the exposed men (31% in favor of joint decision as compared to 45% of non-exposed men) (Piotrow et al, 1992).

In addition to the content of decision making, another issue which was less explored in the literature is the process of decision making. The fact that decision on family planning is in the hands of men is already well known and may be generalized across countries. However, in order to improve the role of women in the decision making process, we need to raise questions not only related to factors affecting the decision making process but also to describe the process itself. How decisions are actually made is less clear. So far, literatures used in this paper only illustrate what decisions are made and who makes the decision in a quantitative fashion. Furthermore, only in one study the possibility of having a "no decision" decision was mentioned (Mott and Mott, 1985) and there was another

may compromise in the bargaining process, perhaps to prevent from a family conflict (Isiugo-Abanihe, 1994). A qualitative type of methodology may be applied to explore the process in more depth. Only when more knowledge in this area is gained, one may feel optimistic to have a win-win situation. This is, a situation where the involvement of men would reinforce gender equality.

Conclusion

In light of applying gender perspective to analyze men's involvement in family planning, three levels of men's involvement, i.e. at the policy, program, and individual level, have been presented with special reference to the content and process of decision making on family planning. Overall, lack of investigation in the process of decision making at the household level is diagnosed. Yet, its understanding is critical to determine if men's involvement in family planning would synchronize all efforts to empower women for a better sharing between men and women.

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Abstract

The problem of inequality in income distribution has for long been a focus of research interest. There is also a high possibility that this problem is responsible for the social stress and disturbances. In order to address this issue, there is a need to approach it through the gini index both over time and between regions, rural-urban, and also between groups in order to get an empirical observation, particularly in provincial level of Java. We can draw a general conclusion that the inequality in income distribution in West Java is low. In this connection, there is a tendency that the degree of inequality is high in areas the middle of development is relatively higher and then in urban areas. Thus, development policies aimed at improving on community income distribution should therefore, prioritize these areas.

Pendahuluan

Melalui Indeks Gini (IG), distribusi pendapatan relatif bagi penduduk secara keseluruhan dapat dinyatakan dengan satu angka saja. Meskipun demikian, IG mempunyai beberapa kelemahan yaitu: (1) indeks tersebut tidak peka terhadap perubahan-perubahan yang kecil, tetapi penting dalam penyebaran; (2) indeks tersebut memperlakukan perbedaan-perbedaan absolut secara sama rata dengan tidak mempedulikan di

mana timbulnya dalam spektrum pendapatan: umpamanya pendapatan Rp 10.000,00 di antara yang berpendapatan tinggi diberikan bobot yang sama dengan penerima berpendapatan rendah; (3) indeks tersebut sangat dipengaruhi oleh nilai rata-rata yang dipilih untuk kelompok pendapatan yang teratas (lihat Dwight Y. King dan Peter D. Weldon, EKI, 1975).

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