‘PLEASURE IN THE FUTURE’

A STUDY OF MODERN MALE CONTRACEPTION USE AMONG MARRIED COUPLES IN YOGYAKARTA, INDONESIA

Issac Tri Oktaviatie Ratnaningsih
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Thesis Submitted for Master Degree

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Cover picture was downloaded from the internet, 8/8/2010

Issac Tri Oktaviatie Ratnaningsih
ABSTRACT

This study is an anthropological and exploratory-qualitative investigation of the phenomenon of low male contraception use in an Indonesian setting. The objective of the study was to find an explanation of the sociocultural aspects, or other circumstances, that influence low male contraception use in Yogyakarta and the dynamic of married couples’ negotiation during the decision-making process regarding modern male contraception use. This study was carried out with Rapid Appraisal Procedures. Focus ethnographic interviews were performed with a total of 40 men and women (20 married couples). Focus group discussions were held with married men and women and participant observation was done in groups of men and women in order to achieve insight into the problem of low male contraception use and how it is perceived from the ‘native’ (emic) point of view. The research was performed from mid-May to the end of June 2010, in two villages; Karangmojo and Purwosari in the Gunungkidul district, Yogyakarta province, Indonesia.

Although this study cannot be generalized, I discovered there are many circumstances surrounding female and male contraception that either discourage or encourage modern male contraception use. Female contraception’s side-effects, sufficient information about modern female/male contraception choices and the side effects as well as the advantages of the various methods, gender equality awareness, role model of male acceptors and social networks had significant effects on male contraception use among married couples. Cultural notions, religious views and even the State’s policy (which is gender-biased), myths and negative images for male contraception and lack of access to a social network are all associated with the lack of information about both female/male contraception choices. This lack of information obstructed spousal communication when negotiating for male contraception use and ultimately discouraged couples to use modern male contraception.

In spousal communication to negotiate family planning (FP) and contraception use, women are generally inferior to men and should obey their husbands who are considered as heads of the household and have the authority to determine whether or not the couple will use contraception. A social network enables men/women (couple) to have broader communication with others and to acquire adequate information regarding modern female/male contraception choices and the advantages or disadvantages of methods as well as improve their gender equality awareness, which may increase their chances of negotiating the use of modern male contraception as a couple. Furthermore, a wider social network improved a man or woman’s opportunity to meet male contraception acceptors and see and learn from their testimony. Access to this network affected the agency of a man or a couple to take a risk and use male contraception, despite the fact that female contraception was more accepted by the community.
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CHAPTER I
INTRODUCTION

Study Rationale

...time is not yet showing 8 a.m., but this old man who worked as a PPKBD\(^1\) told me to leave immediately, “while it is still early”, he said. The bright morning atmosphere makes this old man rushed to spur on his motorcycle towards one of sub-village hall close to the Puskesmas (community health center) in this village, where three men and their wives have been waiting, each of whom seem a little worried reflected in their faces. The pak dukuh (chief of sub-village), and PLKB\(^2\) are also seen accompanying them. This is a day when one of the three men had said, “the day of execution”. Half an hour later they leave with a rental car to go the hospital in Yogyakarta (capital city) along with the PPKBD who supports those three men to have a vasectomy... [field notes, June 10, 2010]

That is a field note I wrote while conducting research on male contraception use among married couple in Yogyakarta, Indonesia from mid-May to the end of June 2010. Why were only women generally using contraception and men were not? Why did a KB (planned family) seem to be woman’s matter and not a couple’s matter? Why did women keep using female contraception even though they experienced side-effects from female contraception? What factors influence this condition and make men merely passive about using male contraception? Those questions motivated me to investigate the sociocultural dimension and circumstances surrounding the family planning (FP) program in Indonesia, in particular male contraception use among married couples.

The effort to study my topic on male contraception use in Indonesia FP was triggered by my concern over the number of cases of female contraception’s side-effects experienced by Indonesian women and the gender inequality that allows women no choices for their reproductive health rights (Faturochman et al. 1998). Although women often experience side

\(^1\) PPKBD is abbreviation of Pembantu Pembina KeluargaBerencana Desa (Village FP Management Assistant), a chief/coordinator FP cadre in a village level who responsible to give report to PLKB

\(^2\) PLKB is abbreviation of Petugas Lapangan Keluarga Berencana (FP Field Worker) as the lowest level employee of BKKBN (Indonesian National Family Planning Coordinating Board)
effects from female contraception, it seems impossible for them to avoid their use since if they choose to not use them they experience unplanned pregnancies and even unsafe abortions since safe abortion is illegal in Indonesia (Alkaff, 2006).

Unsafe abortion is one of the causes of maternal deaths in developing countries that have no legal policy for safe procedure (Population Reports, July 1994). Furthermore, Indonesian woman generally avoid pressuring their husbands’ use of contraception because they are concerned that a woman’s control over a man will be considered as going against their (patriarchal) culture (Herartri 2004; personal interview on preliminary study with Indonesian couples April 2010). Therefore, I can see the link between the old effort of controlling population growth that was targeted only to women, the existing women experiences on adverse side-effects of female contraception, gender inequality, unsafe abortion and maternal mortality rate.

My professional background as an anthropologist and an NGO activist who is concerned about reproductive health rights advocacy and the above mentioned women’s reproductive dilemmas has raised my curiosity to gain insight into the problem of low male contraception use in the Indonesia setting. I then carried out a qualitative research study to understand what sociocultural aspects and other circumstances influence this phenomenon.

Study Background

Based on statistics, the Indonesian population is currently more than 240 million and it ranks fourth among the most populous countries in the world after China, India and the US (CIA-The World Factbook 2009). Furthermore, estimates project an exploding Indonesian population of more than 280 million by 2025 that will adversely affect the socioeconomic life of Indonesian society. Therefore, controlling population growth in Indonesia is an urgent issue that should be addressed with birth control or family planning.

As in most parts of the world, family planning in Indonesia is generally identified as a woman’s issue (Glasier, Anakwe, Everington et al. 2000; Herartri 2004; Shiffman 2002). This is evidenced by the higher use of female methods than male methods as well as by the number of female contraception choices (pill, injection, IUD, implant, tubectomy) that are available

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3 Based on The Indonesia Central Statistics Bureau, 2005. Projection means indication of future demographic change built on assumptions about future patterns in fertility (birth, mortality) and migration.
compared to male contraception, which are limited to condom and vasectomy in Indonesia (Indonesia Demographic and Health Survey (IDHS) 2007). This disparity in contraception choices has been criticized since globally family planning programs tend to focus on women and do not include men as target clients even while men generally have the authority to decide about family size and the unmet need\textsuperscript{4} for female contraception remain high due to women’s fear of side effects (Hardon et al., 2001:78-79).

Currently, the Indonesian government is searching for modern alternatives for male contraception options beyond condoms and vasectomy, through clinical trials such as hormonal contraception using testosterone undecanoate (TU) with depo-medroxyprogesterone acetate (DMPA) by monthly injection (Solomon et al. 2007; Wilopo 2009). This project of male contraception clinical trials is in line with government efforts to include men in family planning, not only as a result of the impact of global policy regarding birth control but also based on the assumption that male contraception may have fewer side effects and therefore could be more acceptable than female contraception (Solomon et al. 2007). Even though in 2000 the Indonesian government ratified a global policy in the field of reproductive health, including family planning with male participation meaning encouraging male contraception use on behalf of gender equality awareness, it is still hard to increase the number male acceptors in this country. The obstacles for male contraception use include: inappropriate information about male contraception, existing personal and sociocultural perceptions of male methods, a bad image of condoms associated with prostitutions, and vasectomy associated with impotence or as an act against God’s will since it prevents a man’s reproduction (Ali, et al. 2004; Bunce, et al. 2007; Gutmann, 2005; Kulczycki, 2004; Heinemann, et al. 2005; Petro-Nustas and Al Qutob 2002).

Statement of the Problem

Justification

Since the adoption of the Universal Declaration of Human Rights in 1948, there has been an emerging awareness on the need for equality between men and women that is recognized as an organizational framework in international law and policy. Rights of gender equality then provided the formal basis for the international discussion of women and men’s position from

\textsuperscript{4} Unmet need for contraception is defined in Demographic Health Survey (DHS) as women with reproductive age who would avoid pregnancy but do not use contraception.
The issue of men, as the subject of family planning, has come to the forefront largely following the International Conference on Population and Development (ICPD) mandate in 1994 that emphasized integrating men into reproductive health programs along with the promotion of gender equity (Harden et al. 2001:78; Solomon et al. 2007:3).

During Suharto’s New Order era in the 1970s to the 1990s, Indonesia family planning program was a massive indoctrination operated by the Indonesian government in a repressive way. The program was conducted by a huge and powerful governmental bureaucracy through the state agency that had primary responsibility of the program, the National Family Planning Coordinating Board (BKKBN) formed in 1970 and an even larger number of grassroots volunteers (Cammack and Heaton 2001). Through the program of ‘family planning safari’ - contraception installation collectively at the same time - Indonesian women were pushed to use contraception without sufficient counselling and did not have a chance to negotiate choice about which contraception was appropriate for them (Faturochman et al. 1998). The program was also promoted and legitimized as a component of the larger national drive toward social and economic development and modernization (Ancok 1991; Cammack and Heaton 2001; Faturochman et al. 1998; Shiffman 2002).

One of the keys to success of Indonesia’s family planning program was securing the support of the country’s Muslim leaders. Birth control is a delicate matter in Islam and Muslim approval of the government’s program was obtained gradually through variety of national and local efforts (Cammack and Heaton 2001:568). Until now the emphasis of Indonesia family planning are married couples who have more access to contraception methods rather than unmarried couples as an outcome of Indonesian law on Population Development and Welfare Family in 1992 that forbids unmarried couples to access information of contraception (Alkaff 2006:1; Budhiharsana 2004:6).

The Indonesian government has ratified the recommendations of the ICPD, Cairo 1994, and mandates of the Millennium Development Goals (MDGs), which state that reproductive health issues should not focus only on women. Yet in Indonesia, the level of male participation in family planning (male contraception use) is low; the highest percentage of condom use was only 1.3 and male sterilisation (vasectomy) has never reached one percent since 1991 (Indonesia Demographic and Health Survey (IDHS) 2007).
Several anthropological studies in other countries examine how culture and social organization influence contraception patterns and men’s authority in determining contraception use (Ali et al. 2004; Dudgeon and Inhorn 2004; Kulczycki 2004; Were and Karanja 1994). Furthermore, according to the IDHS 1997 report, as analyzed by Supriahastuti (2000), the socio-economic variables that affected the use of male contraception (vasectomy) in Indonesia were religion, education, residence, and home territory. The author also analyzed the effect of spousal decision-making on male contraception use which led her to the conclusion that joint spousal decision-making might increase the use of male contraception. A quantitative-case control study in Indonesia by Purwanti (2004) showed that there was a significant relationship between husbands’ positive perceptions about contraception and male contraception use influenced by age, number of children, and the pattern of decision-making.

Other studies using quantitative methods have been conducted in many countries, including in Indonesia, to reveal couples and male attitudes and motivations for male contraception use. Influencing factors include: perceptions of manhood/masculinity, religious beliefs, gender roles, family economic hardship, side effect of female contraception, perceived effectiveness of male methods and knowledge/sufficient information on male methods (Cammack and Heaton 2001; Gutmann 2005; Heinemann et al. 2005; Solomon et al. 2007 and Vogelsong 2008).

The quantitative studies lacked a consideration of the sociocultural dimension surrounding the phenomenon of family planning and what factors affect low male contraception use. Thus, a further study to investigate the sociocultural dimensions that affect low male contraception use in Indonesia family planning and to explore the dynamic of the negotiation process by identifying what aspects or circumstances are useful for married couples in family planning decision-making that also encourages male contraception use will be crucial to contribute to Indonesian policy for developing the more culturally sensitive family planning program.

Study Objectives

My study aims to explore the sociocultural dimensions or other circumstances influencing low male contraception use in Yogyakarta, Indonesia and the effect of couples’ negotiation on decision-making processes.
The specific objectives of this study are: 1) to explore factors that influence couples’ choices in determining contraception use, 2) to gain insight into married couples’ perceptions of modern male methods of contraception, 3) to investigate factors that influence men/married couples in using modern male methods of contraception, 4) to understand the spousal communication process and how gender roles affect couples’ negotiation in determining family planning, and 5) to understand how social networks influence the use of male methods of contraception.

In order to identify factors that influence modern male contraception use, I present an analysis diagram that shows the probability of married couple's decision to choose modern male contraception. Below are aspects of the analysis diagram:

1. The global issue of gender equality awareness regarding the subject of FP adopted by a married couple in Indonesia through the Indonesian FP program and policy that affects spousal communication. This spousal communication cannot be separated from the influence of gender relations within a couple.

2. The pattern of gender relations and the process of communication among married couple to negotiate modern male contraception use is influenced by circumstances: cultural and religious values, understanding of the gender role among man and woman, the pattern of parenting in family, economic status and individual/couple resources. Regarding the knowledge of female and male methods choices include side-effects, an extensive social network increases the chance of married couple to decide to use modern male contraception.

3. The decision to use modern male contraception is based on sufficient information about male contraception, the availability and accessibility of male contraception, perceived side-effects, effectiveness, duration of effectiveness and gender equality awareness that enables negotiation among couples.
**Analysis Diagram** (figure 1)

**Research Questions**

In order to attain my objectives, this study tried to seek the answer of the following research questions:

*What sociocultural values and other circumstances encourage or discourage modern male contraception use among married couples in Yogyakarta*

- Sub research questions:
  1. *What factors affect married couples to use contraception and to choose specific kinds of contraception?*
  2. *How do married couples perceive modern male methods?*
  3. *What factors influence men/married couples to use modern male methods?*
  4. *What are the spousal communication processes of negotiating contraception and how is this influenced by gender relations in Indonesia?*
  5. *How does social capital that manifested in social networks influence the use of modern male contraception?*
CHAPTER II
REVIEW OF LITERATURE AND THEORETICAL FRAMEWORK

Literature Review

Efforts to increase male participation in family planning programs means encouraging men to use contraception, a subject that has been studied only to a limited extent. To date, a number of studies in Asian, African and American countries have addressed the acceptability of and constraints to male contraception, in consideration of a multitude of social and cultural contexts such as religion, tradition, and misperceptions due to inappropriate information (Ali et al. 2004; Bunce et al. 2007; Gutmann 2005; Hossain 2003; Kulczycki 2004; Solomon et al., 2007). Yet, the volume of studies on female contraception still overwhelms the number that examines male contraception.

I will review previous studies on male contraception use and concepts as well as theoretical approaches that are useful to frame the research questions of my study. Firstly, I want to address the previous studies relating to historical and political context of global and national (Indonesian) policy on family planning programs to achieve better understanding of the context on the issue of low male contraception use. Secondly, I will focus on research findings regarding sociocultural aspects which influence acceptability and attitudes toward male contraception and gender-power relations on the decision making process. Lastly, I attempt to discuss a critical approach of the ‘mindful body’ (Scheper-Hughes and Lock 1998), ‘social capital’ (Bourdieu 1986), agency, social networks, patriarchy, gender relations and masculinity.

Historical and political context: global and Indonesian policy on family planning

Recently, based on predicted enormous world population growth reaching approximately nine billion in 2050 (Cleland et al. 2006), discourse on family planning has re-emerged as an international issue. As recommended by ICPD (1994) and the Millennium Development Goals (MDGs) (UN 2000), emphasis is placed on male involvement by encouraging male contraception use as opposed to the old effort to address only women. Unfortunately, global policy remains focused on providing contraception services to women globally and most family planning programs have ignored men as a group and as individuals because efforts have been
directed to improve women’s health rights and consequently there is little information and services provided for men’s reproductive health—in particular male contraception methods (Hossain 2003; Singh et al. 2003).

The Indonesian program of family planning is recognized as a model case and has become one of the most effective in the developing world over the past three decades in promoting contraception use and contributing to fertility transition (Shiffman 2002:1). However, originally, Indonesian policy-makers were only concerned about decreasing fertility rates with women as the target and men were ignored by reproductive health programs.

The goal of global development has been to assign principles of equality and gender equity as one of the targets of development itself (ICPD 1994; UN 2000). Increasing male participation in contraception use in Indonesia is a strategy to create more equality and gender equity. Nonetheless, the reproductive and sexual needs of women are often culturally subordinate to those of men, and locally men have rights over women’s reproduction and sexuality (Dudgeon and Inhorn 2004). Therefore, in order to provide equal rights to women in their personal and social lives as a cumulative effect of reproductive health, men must participate in family planning.

**Sociocultural aspects influence on acceptability and attitudes toward male contraception**

**Couples’ beliefs and perceptions**

A recent study in Indonesia using both quantitative and qualitative methods by Solomon et al. (2007), examined the cultural meanings, acceptability, and implications for studying men’s sexuality, and couples’ perspectives on new contraception technology (male injection-hormonal contraception) during the process of a clinical trial to refine hormonal regimens: TU-DMPA. By interviewing twenty four couples (men and their female partners) from the low economic level in Jakarta and Palembang, it was found that this new male contraception method had a chance for wide acceptance by couples in Indonesia. The study reported that men first raised the idea of acceptability on the basis of benefits connected to their participation in the trial since the method was given for free but then often adjusted as they noticed changes in their bodies: an increase in muscular strength, weight gain, and increased sexual desire. These effects on the men’s bodies during the efficacy trial were perceived by their partners as good physiological changes that indicated a condition of well-being and enhanced the quality of the couple’s sex life. However,
since the majority of informants were from economically disadvantaged backgrounds in Indonesia, their motivations and experiences toward the method cannot be generalized to other social status.

Vogelsong (2008) conducted a study that examined the trial of a combined regimen of TU-DMPA using survey methods in various countries, including Indonesia. This trial causes male infertility within 12 weeks of initiating the drug and can provide effective contraception and is well tolerated according to the author. From the survey data, the author found that the main reason for male participation in the clinical trials including in Indonesia was because of their partners’ experiences with bad side-effects from their female contraception methods which had increased men’s willingness to share the responsibility of reproductive issues.

Based on those literatures, my study attempted to explore how Indonesian married couple’s perceptions of cultural beliefs affect to the acceptability of male contraception use.

**Religion**

In Indonesia, based on a quantitative analysis of IDHS 1997, Cammack and Heaton (2001) performed a survey to understand regional variation in acceptance of a family planning programs supported by qualitative research in two different provinces; North Sulawesi where most inhabitants were non-Muslims with the highest rates of modern contraception use in this island and in South Sulawesi where most population were Muslims with low use of contraception methods. The authors revealed that religion was one aspect that played an important role in family planning decisions in Indonesia. This study indicated that even though religion was not an important variable at the individual level, regions with high concentrations of Muslims have lower rates of contraception use (Cammack and Heaton, 2001).

Heinemann, et al. (2005) performed a study using a cross-cultural survey of male contraception use in several countries on four continents (including Indonesia) and had similar results as Cammack and Heaton. In this study the authors found that in Indonesia, contraception decisions are often influenced by an individual’s religious beliefs on how they perceive what is prohibited (haram) and what is permitted (halal). Most respondents from Indonesia were Muslims and the highest percentage were men with more than two children who considered male contraception only if it was approved by their religion. Therefore, my anthropological study investigated how religion influences couple’s motivation in using male contraception.
Gender role (Masculinity)

Various studies outside Indonesia show that the use of male contraception is influenced by the male’s gender role and perception of masculinity in society. This may either advance or hinder male contraception use. In a study of vasectomy as a permanent family planning method among Mexican men, Gutmann (2005) found that Mexicans had the public opinion that there were links between vasectomy and manliness. “The relationship of vasectomy to manhood and manliness (hombria), and men’s concerns about the outcome of the operation with respect to their subsequent sex lives, is described by some men as a consuming anxiety about being able to still satisfy a woman sexually in the future” (Gutmann 2005: 95). Thus, the concept of masculinity among Mexican men in terms of their sexual pleasure is correlated with the ability to fulfill women’s sexual desire, which they assumed would be vanquished by vasectomy.

Conversely, a study carried out by Landry and Ward (1997) on men’s perspective toward vasectomy in six countries: Bangladesh, Sri Lanka, Kenya, Rwanda, Mexico, and USA by interviews with 218 men who had had a vasectomy and their partners, discovered that the concept of masculinity related to vasectomy was a symbol of a man’s sacrifice. Some informants in the study stated that having a vasectomy is considered as a man’s pride. “…men were stronger and thus should take responsibility for the operation…” (Landry and Ward 1997:61), coupled with the recognition that Asian and African informants in the study claimed that a man as head of household had to take the responsibility in family planning as an emphatic response to women’s suffering. Thus, by taking part in family planning, specifically using male contraception, men are allowed to express their manliness.

My research explored how the gender roles and views on masculinity in Indonesia influence acceptance of male family planning methods.

Dynamics of the negotiation process

Studies conducted by Bunce et al. (2007) among Tanzanian men who undergo vasectomy and the clinical trial of hormonal contraception: TU-DMPA by Solomon, et al. (2007) in Indonesia, discovered that both men and women pointed out their partner’s influence on decision-making regarding male contraception use. Wives played an important role in male contraception use due
to women’s health and the side-effects of female contraception, which allowed them to negotiate for their needs.

On the contrary, Petro-Nustas and Al-Qutob (2002) found that among Jordanian community, only men from the upper social classes were aware of family planning as a joint decision between husband and wife, while most men from lower social classes perceived family planning or birth spacing as the responsibility of women only. Furthermore, a study by Ali, et al. (2004), found that almost two thirds of the total respondents among Pakistan men never had and always avoid interspousal communication about family planning. This was described as being against cultural norms, as such communication with wives was not deemed important. While those who had interspousal communication regarding family planning and birth control (43%) were motivated by their concern about their wives’ health and family finance.

Based on those previous findings, therefore, I explored how spousal communication and what factors influencing couples’ decision-making on male method use in Indonesia setting.

**Concepts and theoretical framework**

*The ‘mindful body’*

In this critical discourse analysis, Schep-Hughes and Lock (1998) identified the human body as a component which represents “three bodies”; 1) ‘individual body’ reflects how an individual interprets their own experience and social structure 2) ‘social body’ means that a man or woman’s body belongs to a social group which has symbolic meaning controlled by sociocultural constructions 3) ‘body politic’ refers to the state and governmental regulation of the first two bodies in all aspects of gender, reproduction and sexuality (348-368).

This approach was valuable to ‘reconceptualise reproduction’ in understanding the transformation from a biological event to a socially constructed process (Greenhalgh 1995:14). The concept of ‘mindful body’ was useful to understand how social constraints influence both man’s and woman’s perception on family planning and particularly in male contraception use, how a community defines masculinity associated with male contraception, and how men perceive their bodies/how they think about their social roles regarding male reproduction in relation to family planning. This approach was sufficient to explore how a sociocultural construction and state policy shape couples’ perspective in family planning and the ambiguity of
women who often experience negative side-effects from their contraception methods but do not want their husbands taking contraception.

*The ‘practice theory’*

Bourdieu (1986) argued that everybody occupies a position in a multidimensional social space defined by the ownership capital; economic, cultural, symbolic and social capital. He analyzed society using the concepts of *field* (a social arena in which people maneuver and fight to pursue coveted or desirable resources) and *habitus* (schemes of perception, thought and action that are acquired and long lasting) where individual agents internalized the objective social structure into the mental and subjective experience of the agent. The subjective structure of the agency then synchronized with the existing objective structure and urgency in social community. In the theory of practice, individual agents learn to crave what is possible and not to want that which is not available to them.

Bourdieu explained symbolic capital (self-esteem, dignity, social prestige and attention) as a crucial power resource. This recourse may be used to produce or reproduce symbolic violence, which forces thought and perception to the dominated social agents who then assume that the social order as something that is "fair" for them. Another capital is social capital that includes the value of social network which can be used also to produce or reproduce inequalities (Bourdieu, 1986:248-252).

This approach helped to provide insight into the agency of men who participated in family planning despite the fact it is socially constructed and traditionally identified with women. Using this concept, I tried to understand how men tried to seek sufficient information regarding family planning and negotiated their position within the community before they decided to use a male contraception. As stressed by Bourdieu, talk is a means by which agency is socially constructed, in collecting and choosing among alternatives that are structured by gender roles (Carter 1995:79).

Further, this theoretical framework was valuable in order to grasp the effect of social networks as a manifested by social capital on the dynamic of the negotiation process among married couples regarding family planning and the process of decision-making on how they determined their contraception methods. The concept of ‘social capital’ (Bourdieu 1986) enabled me to explore how the extensive social networks provided married couples with adequate
information/knowledge about family planning and specifically alternatives of male contraception that allowed them to have more choices. Hence, it was the social capital itself that may have overcome the limits of other forms of capital.

A study in Kenya by Behrman, et al. (2002) indicated that the causal effects of social networks on contraception use are significant and are typically larger for men than for women. Furthermore, social networks primarily affect a respondent’s contraception choices through social learning by providing information rather than by exerting social influence (Behrman et al. 2002). In accordance with the effort of community building networks, the Indonesian government used the Family Welfare Movement, (Perberdayaan dan Kesejateraan Keluarga or PKK) as an army of volunteer village family planning workers during the Suharto era (70s-90s). The PKK was ideally suited for the task of family planning promotion, since it had a strong village presence and its mission to improve social welfare at the village level for families was congruent with BKKBN objectives (Shiffman 2002); thus it was appropriate to use male groups to promote male contraception use as well.

**Gender relations**

The two theoretical approaches mentioned above are in line with Connell (2009) who argued that bodies, in terms of gender roles and gender relations for the issue of reproduction, have agency and are socially constructed. The consequences of gender practices are borne in bodies (man and woman) and the bodies are transformed in a social embodiment. The bodies that act as both object of and agents in social practice are engaged in social construction (Connell 2009:66-71). Moreover, Connell explained well how a patriarchal system maintains men’s subordination of women through state policy and at the household level. Hence, this approach was useful to determine gender relations among married couples and the power of husbands over wives, associated with their roles as head of the household, in the dynamic of negotiation when determining family planning and contraception use.
CHAPTER III
METHODOLOGY

Research design

The study is an exploratory-qualitative research\(^5\) to achieve insight into the problem of low male contraception use in Yogyakarta, Indonesia, and how it is perceived from the ‘native’ (emic) point of view. Therefore, this study design was appropriate given the limited timeframe—six weeks from mid-May to the end of June 2010.

Study location

Yogyakarta province has the lowest total fertility rate (TFR) in Indonesia, which indicates the success of the FP program is high compared to other provinces.\(^6\) My research was performed in two villages located in the Gunungkidul district, a rocky mountainous area in the south of the Yogyakarta province, which has an attainment rate of new modern contraception (male and female) acceptors to May 2009, and thus is ranked number three among five other districts.\(^7\) In the past until the decade of 80s, the Gunungkidul district was famous for being a poor arid region and having a lack of natural resources. Today conditions are improved and this area is well-known as the source of migrant workers since many local people leave the district to work in big cities such as Surabaya, Bandung and Jakarta, the capital city of Indonesia. Unfortunately, there are still many areas in this district that remain barren and rely on rain for water. I randomly selected two villages, separated by more than 60 km, Karangmojo, and second village, Purwosari.

\textit{Karangmojo village}

The first village, Karangmojo is located in the northeast of Wonosari, the capital city of the Gunungkidul district. Karangmojo is one of nine villages in the Karangmojo sub-district. This

\(^5\) An exploratory study is a small-scale study of relatively short duration which is carried out when little is known about a problem” (Hardon et al., 2001:178).
\(^6\) Based on IDHS 2007, TFR in Yogyakarta province is 1.8; the lowest rates compared to other provinces in Indonesia and this is below the national average 2.6 per woman of childbearing age.
\(^7\) The information is based on the report from BKKBN DIY 2009.
village has the largest Islamic boarding school (*pesantren*)\(^8\) in the region. Since most Indonesians are Muslims, this site allowed me to determine how religion might affect the perception of married couples about male contraception and the phenomenon of low male contraception use.

The total area of Karangmojo is 111,500 km\(^2\) with a total population of approximately 8,000 people in 2,349 households. Most inhabitants (90%) of Karangmojo are Javanese, originally from the Gunungkidul district, while the others are from outside the district and even beyond the Yogyakarta province. Karangmojo consists of 16 sub-villages and 65 RT (neighbourhood associations).\(^9\) The main livelihood of the communities is farming with irrigated wetland paddies. This village is located in a sloping area and has many water resources such as rivers and wells, thus people in this village plant sweet potatoes, soya beans, mug beans, sorghum, peanuts, water spinach, spinach, chilli peppers, corn, cassava, coconuts and various fruits such as banana, *jambu*, papaya. Many households plant spices, for example curcuma/turmeric, ginger, lemongrass and *lengkuas* in their home yards. Most women work on farms with men and some women are housewives who take care of their children and domestic chores or run small shops in their homes. There are only a few women in this village who work as PNS (civil servant) or teachers.

In order to supplement their household economy most people raise cattle, poultry, pedigree poultry, ducks, sheep, goats or cows. Goats, sheep and cattle are more common since this village is famous for sate stalls spread throughout the area including the outskirts of the village. Karangmojo is a semi urban-village and bypassed by the main route of public busses from the Gunungkidul district to Jakarta. Thus, there are many shops, markets and restaurants along the main road while inside the village the environment is more traditional.

People in Karangmojo are generally Muslim while the others (9.5%) are Christians and Catholics. Muslims in this village are divided into several groups marked by the ownership of the mosques which differs among groups. The existence of *pesantren* and Islam values that differ from the majority of Javanese-Islam in Yogyakarta, which still practices indigenous customs, affect the traditional customs of the local communities in this village. Instead of practicing *kenduri* (banquet gatherings with offerings) for their ceremonial events for instance, today

---

\(^8\) *Pesantren* is not only an Islamic educational and proselytizer institution but also as a place of reproduction of the Moslem theologians and the guardian of traditional Islam, which has significant influence for religious social change on communities ([http://www.pondokpesantren.net/ponpren/index.php?option=com_content&task=view&id=115](http://www.pondokpesantren.net/ponpren/index.php?option=com_content&task=view&id=115))

\(^9\) Kecamatan Karangmojo Dalam Angka 2008 (Karangmojo sub-district report 2008)
people in Karangmojo prefer to conduct *pengajian* (gatherings for listening to religious speeches).

**Purwosari village**

The second study area was Purwosari, which is located in the southwest of Wonosari and on the border with the Bantul district. This district has the highest prevalence of male contraception use, especially male sterilization in Yogyakarta, which I thought would likely influence the attitude of male contraception use in the study area.\(^{10}\) Purwosari is one of five villages in the Purwosari sub-district with the total area is approximately 2,700 hectares divided into ten sub-villages and 98 RT (household associations). The total population in Purwosari is 8,900 inhabitants spread over 2,570 households, of which almost half (1,160 households) are categorized as poor families.\(^ {11}\)

This village is situated on a barren hill close to the Java Sea, which is famous as an arid region that relies on the rain for water. There is no clean-well water in this village. People take showers and cook with water from rainwater tanks or with water from artificial lakes that are rain-fed, since most natural lakes dried up in the last decade. During the dry season, July-August, people often buy water from tank cars that bring clean water from Yogyakarta, the capital city. Those who cannot afford to buy clean water, buy the water in groups.

The main livelihood of the community is agricultural tree crops, such as teak and *sengon* wood. Some people work in the country forest and most people who do not have much land plant cassava, peanuts, corn and chili peppers. Farmers in this village must walk seven to ten kilometres everyday to reach their farmland while vegetables and spices are supplemental crops planted close to their homes. Another job for people in this village is to work as a migrant worker. Many men work not only as farmers but also as migrant workers particularly as construction workers in other cities, such as Yogyakarta, Solo, Surabaya or Jakarta. Therefore, women in this village often have double responsibilities to manage domestic work and their farmland simultaneously. This situation encourages *gerakan* (mutual assistance) among women farmer groups.

Unlike Karangmojo, religious life in Purwosari is more diverse, although Islam remains the largest group, it is not divided into extreme groups. Most Muslims, regardless of specific

\(^{10}\) Based on the finding of a previous quantitative study that found that male contraception use in Indonesia was affected by residence and home territory (Suprihastuti 2000)

\(^ {11}\) Kecamatan Purwosari Dalam Angka 2008 (Purwosari sub-district report 2008)
beliefs or groups, can attend the same mosques within their neighbourhoods. Moreover, Muslims here still practice traditional customs such as *kenduri* (banquet gatherings which provide offerings) and *slametan* (salvation rituals) as ceremonial events.

Five years ago Purwosari was included in a new main road that connected Java-Bali via the southern route. Therefore, there are many shops along the streets today. People in this village said that the new road would help their transport from one sub-village to the others and even to other villages without any difficulty when the public transport is officially operated through their territories.

**Study population and sample size**

The purpose of my study was to explore the problem of low male contraception use in depth; therefore, I used a purposive-maximum and snowball sampling procedure. This allowed me to select informants/study participants for their ability to provide appropriate data consisting of rich and meaningful information (Green and Thorogood 2004:102-104).

Married couples who had one, two or more children met the criteria for being included in the study. Ultimately my informants were married couples with the following profiles. Four couples who had already used/were using modern female contraception. 12 couples who used modern male contraception (condom and vasectomy) and four couples who did not use any contraception and who used natural methods/non-modern contraception.

![Figure 2. Sample size of married couples interviewed in two study locations by specific category of contraception use](image)
Other informants were identified in the community and participated in four focus group discussions (FGDs) divided by gender but who had similar socioeconomic backgrounds and used a variety of contraception methods and those who did not use any contraception.

Table 1a. Sample size of married couples in the focus group discussions (FGDs) among men and women in two research areas by specific category of contraception use

<table>
<thead>
<tr>
<th>Study population: community in FGDs</th>
<th>Location</th>
<th>Modern Female contraception</th>
<th>Modern Male contraception</th>
<th>Non-contraception &amp;/ Non-modern contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community women in FGD</td>
<td>Karangmojo</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Community men in FGD</td>
<td>Karangmojo</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Community women in FGD</td>
<td>Purwosari</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Community men in FGD</td>
<td>Purwosari</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Additional study participants were key informants consisted of local authorities, religious leaders, a midwife, a PLKB, a PPKBD/sub-PPKBD (FP cadres) and a male cadre/representative of male acceptors who are working in the community as promoters of male contraception.

Table 1b. Sample size of key informants interviewed in two research areas

<table>
<thead>
<tr>
<th>Study population: Key informants</th>
<th>Locations</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious leaders</td>
<td>Karangmojo + Purwosari</td>
<td>2</td>
</tr>
<tr>
<td>Local authorities</td>
<td>Karangmojo + Purwosari</td>
<td>2</td>
</tr>
<tr>
<td>PLKB</td>
<td>Karangmojo + Purwosari</td>
<td>2</td>
</tr>
<tr>
<td>PPKBD/Sub-PPKBD</td>
<td>Karangmojo + Purwosari</td>
<td>4</td>
</tr>
<tr>
<td>Male cadre</td>
<td>Purwosari</td>
<td>1</td>
</tr>
<tr>
<td>Midwives</td>
<td>Purwosari</td>
<td>1</td>
</tr>
</tbody>
</table>
Further, my ‘gate keepers’ were the midwife, local authorities, a PPKBD and my colleague from the PKBI (The Indonesian Planned Parenthood Association) of the Gunungkidul district who became my research assistant in those villages with whom I had contact before I did my fieldwork. They helped me to find two couples with whom I lived with during my fieldwork and they also helped me to identify all prospective informants of my study. The snowball technique was also used to determine informant couples, FGDs participants as well as the key informants.

**Study definition**

Keluarga Berencana (KB) or planned family/family planning (FP) is commonly interpreted as contraception by most Indonesian community and this was true for the respondents in my study areas. The community in my study locations categorized contraception in three ways; *KB dewe* (self contraception/natural methods), *KB perempuan* (modern female contraception) and *KB pria* (modern male contraception). Natural methods referred to a calendar system, *dadah walik* (massage) and withdrawal, while modern female contraception included pills, injections, IUDs (spiral), implants, female sterilization (tubectomy). Modern male contraception included condom use and male sterilization (vasectomy). Therefore, I shall use ‘contraception’ or ‘FP methods’ to discuss modern contraception use and the natural methods as non-modern contraception.

Furthermore, family planning (FP) refers to birth control based on the name of the government program to control fertility in Indonesia which is perceived by the community in two study areas as limiting the number of children or to control birth spacing.

**Data collection techniques and subjects**

In order to ensure comprehensive information, I collected both primary and secondary data. Considering the limited time of the fieldwork, my study was carried out using Rapid Appraisal Procedures by doing focus ethnographic interviews, focus group discussions and participant observations with informal conversations.

I lived in the two villages during the five weeks of my fieldwork: first in Karangmojo. My reason to start in Karangmojo was because acceptor data (list of the prospective informants)

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12 ‘Rapid Appraisal Procedures’ are ethnographic techniques involve shorter periods of time in the field (Hardon et al. 2001:225).
and my base-camp were already prepared and my assistant could help me to identify a base-
camp and look for prospective informants in the second study locations from here. In
Karangmojo I lived with couple who used condom likewise in Purwosari.

**Ethnographic interviews**

Ethnographic (in-depth) interviews were useful to explore how informants responded to
modern male contraception, how they perceived the problems of low male contraception use and
what contraception methods were available for married couples that they consider as effective FP
from their own cultural, social and health beliefs.

I performed in-depth interviews with 20 married couples from two research villages,
means 40 persons consisted of 20 husbands and 20 wives who were interviewed separately. In-
depth interviews were also conducted with all key informants. Some couples who were using
male contraception were interviewed as case studies in order to understand what factors
encouraged or discouraged male contraception use, spousal communication to negotiate the
method, couple negotiation influenced by gender relations and finally, how the couple’s social
networks influenced their use of male contraception. All interviews were noted and recorded and
were conducted in the informants’ houses or in a location and time of convenience for the
informants.

**Focus group discussion (FGD)**

Four FGDs of married couples, divided by gender, were performed in the two study sites
on weekends (Saturday/Sunday) because this was the appropriate time for farmers, labourers and
official workers. This technique helped me to explore and confirm various aspects of a particular
issue in a limited of time period (Hardon et al., 2001). The approach was adequate to investigate
community perception, beliefs, knowledge and attitudes regarding male contraception use,
information that might have been less accessible without group interaction. The groups consisted
of 7-11 participants with similar socioeconomic backgrounds but who used various methods of
contraception: female contraception user, male contraception user (condom and vasectomy) and
non-contraception user and or non-modern contraception user. I conducted FGDs for wives in
the evening as during their spare time after work and before they prepared dinner for their
families. For husbands, I had to conduct FGDs at night, after 7 p.m., as this was their
comfortable time and usual time for meetings in the village. All FGDs were organized in neutral settings such as *bale dusun* (a sub-village hall) or schools and were recorded both electronically and manually (notes).

**Participant observation**

I also performed participant observation and conducted informal conversations with groups of men and women, a group of women farmers, local female workers, housewives, and a group of vasectomy acceptors: *Priya Tulodho*\(^\text{13}\) from Nglipar another village. I had to go to another village, 40 km from my study locations to find this group of male acceptors since there were no vasectomy acceptors yet in the two study areas. I joined the group community meetings and activities and I enjoyed our informal conversations in the neighbourhood, in the field or along the street while they worked on their harvest.

This technique is an essential ethnographic technique to understand the context of community beliefs, behaviours, and social structure. Through participation in the daily life activities and community gatherings, specifically in *Priya Tulodho* groups, allowed me to learn the sociocultural rules for people attitudes towards family planning and how the social networks influenced spousal communication and negotiation on male contraception use.

**Background characteristic of married couples in in-depth interviews**

The characteristic of married couples in two research areas are illustrated below in Table 2. Most couples (65 percent) have one to three children, which is in accord with the FP program in Indonesia that states that two children are best. In general, the married couples involved in this study were Muslims (90 percent) and 10 percent were Catholics or Christian. Twenty percent of all couples were living with other members of their family, such as parents or parents-in-law. The level of basic education was higher for women than men (54 percent vs. 46 percent) since elementary and junior high school (nine grades) is considered a basic education in Indonesia. On the contrary, the level of higher education (academy/university) was 40 percent higher among men compared to women.

\(^{13}\) *Priya Tulodho* is a Javanese language which means man who gives a good role model (as a male/vasectomy acceptor).
Table 2. Characteristic of married couples in in-depth interviews

<table>
<thead>
<tr>
<th>Characteristic variable</th>
<th>n (20 couples)</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of children</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>13</td>
<td>65.0</td>
</tr>
<tr>
<td>4-6</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>&gt;6</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Living with other family member</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>80.0</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>18</td>
<td>90.0</td>
</tr>
<tr>
<td>Catholic</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td>Christian</td>
<td>1</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 – 29</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>30 – 34</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>35 – 39</td>
<td>5</td>
<td>35.7</td>
</tr>
<tr>
<td>40 – 44</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>45 – 49</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>50 – 59</td>
<td>3</td>
<td>33.3</td>
</tr>
<tr>
<td>≥60</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uneducated</td>
<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>Elementary</td>
<td>5</td>
<td>55.6</td>
</tr>
<tr>
<td>Junior high school</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Senior high school</td>
<td>5</td>
<td>38.5</td>
</tr>
<tr>
<td>Academy and higher</td>
<td>7</td>
<td>70.0</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil Servant (PNS)</td>
<td>1</td>
<td>33.3</td>
</tr>
<tr>
<td>Farmers</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Construction workers</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Housewives</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><em>Dukuh</em> (a chief of sub-Village)</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Teacher</td>
<td>4</td>
<td>80.0</td>
</tr>
<tr>
<td>Private sector</td>
<td>7</td>
<td>77.8</td>
</tr>
<tr>
<td>Pension</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>


**Data analysis**

All interviews and FGDs were conducted in Indonesian and Javanese and were tape recorded and transcribed. A summary of the data were translated into English but I kept key words in the local languages because many Indonesian/Javanese words cannot be accurately translated into other languages. All transcripts were categorized and coded for the process of analysis. In order to analyze the data I summarized research findings according to themes, using a data master sheet and present some quantitative results with charts or tables. I analysed and compared all findings of the various study populations (women, men, key informants) and methods (interviews and FGDs) for consistency and differences.

**Ethical considerations and reflection of fieldwork**

I realize that my study was about a private and sensitive topic—family planning. I approached the informants with respect as I am an unmarried woman and assured them that their answers would be confidential. I asked for permission to conduct my study from local authorities (at the district level and in the village) since this is an official regulation to conduct research in Indonesia, as well as permission from all informants before including them in the study.

During my fieldwork I had gate keepers and a research assistant who assisted me with requesting permission, identifying potential informants, prospective base camps and organizing the location for FGDs. A gift was provided as an expression of my gratitude to the participants and was given at the end of the fieldwork to avoid informants’ bias.

Every interview, FGD and even observation of the dynamics of couples in the decision making process for male contraception use were based on ‘informed consent’ both verbal and written, although I realized that it was sometimes difficult to gain informed consent during participant observation. Some informants refused to sign written informed consent since it was uncommon for them to do that. They said that it was not necessary to provide written informed consent to do research in the village. I explained the aim of my study and solicited verbal consent when I reached the location and met the prospective couples with whom I lived during my fieldwork.

Furthermore, I also realized that my position as an NGO activist, who is involved with reproductive health advocacy, might affect the data collection process if I ignore my bias.
Therefore, I referred all informants’ questions regarding family planning to the local health providers and I refrained from giving further explanation about aspects of family planning and especially about modern male contraception until after I finish my fieldwork. One interesting and shocking experience was learning that the vasectomy acceptor group in Nglipar and from PLKB (in and outside of my study areas) actually had surgery free of charge, including the transportation fee to the hospital in Yogyakarta, the capital city. I was surprised by this finding because I saw that all new prospective vasectomy acceptors in one of my study areas had to pay for a rental car despite being in PLKB. Moreover, there was a monetary incentive from the government equal to 15 EUR for each new vasectomy participant and 10 EUR for the PLKB per each person/vasectomy acceptor but this was never revealed to the community, the new vasectomy acceptors, or the PPKBD who worked extra hard to reach the target clients in my study areas. As an NGO activist I wanted to reveal this kind of fraud but then I realized I was in my research phase and not working in an advocacy agenda. I had to avoid my researcher’s bias as an NGO activist to advocate for community’s rights by encouraging them to actively search for appropriate information about the procedure of male sterilization in other communities rather than give them an explicit answer when they asked about this issue.
CHAPTER IV
FAMILY PLANNING: WOMEN’S MATTERS VS COUPLE’S RESPONSIBILITY

In this chapter I will illustrate how Indonesian communities in Yogyakarta perceive family planning (FP), whether it is actually a camouflaged woman’s matter or a couple’s responsibility, by describing the meaning of FP, the methods used by couples, their motivations to use a specific contraception and communication process for negotiating contraception.

The meaning of family planning

In my research I found various meanings of FP given by couples who use contraception and those who do not. Most informants in in-depth interviews, 12 women and 13 men who have used modern contraception (female and male methods) and believed that they had enough children said FP was the way to avoid unplanned pregnancy and to stop having more children. For instance, a woman who had two children and a moderate economic status, living in a village, realized that she could not afford to have more children since she wanted to give her children a better education.

My husband and I need to take FP because we do not want to have more children. Nowadays education becomes more expensive while my husband is still working as temporary worker and I myself have been selling food, but we cannot rely on it to finance school. Furthermore, having many children will be hard for me to take care of them all.
[Woman 36 years, two children, from an in-depth interview]

Among those who interpret FP as a method to limit the number of their children, more women (16) and men (15) argued that FP helps not only to plan better and higher education for their children in the future but also to overcome economic hardship by reducing their household expenses.

FP is useful for me and my wife since we have many children. Our economic condition is not good enough to support us, then if we still add more children, we cannot afford school or even household living. Therefore, I asked my wife to take FP to stop pregnancy
and to reduce our economic burden. [Man 50 years, four children, from an in-depth interview]

Others meanings for FP came from couples who still wanted more children but realized that they had to maintain the space between children in order to provide maximum affection for each child. In this study, seven women and five men stated that they accepted FP as a method to control birth spacing, which could not be separated from their economic reasons. Since the FP program was introduced to the local community, people were aware of the demand for FP that married couples desired in order to maintain their family’s welfare.

For me FP is to control birth spacing, secondly it relates to the situation of my household’s economy and lastly, because I am still traumatized from delivering my first baby. [Woman 28 years, one child, from an in-depth interview]

There were three men and three women who said that they understood that FP was a way to have enough space between children; therefore, it is allowed by religion as long as the goal is to control birth spacing and not to limit the number of children. This idea was expressed by those who believed that the goal of FP is not to stop having more children.

People thought I have too many children and maybe they thought that we did not take FP as well, but we did. Because we were married when my wife was still very young then our children became so many but with enough space 3-4 years in between them. We took FP to control birth spacing but not to stop having children. Now my wife is already menopause then we will not have any more children. [Man, 60 years, eight children, from an in-depth interview]

One woman, who was a FP cadre, told me that after delivering her third child she wanted to use FP to control birth spacing because she considered their economic situation as unstable. But her husband did not permit her to use contraception. Her husband is a street vendor in Jakarta and comes home at unspecified times, sometimes once every two weeks or sometimes only once a month or longer. Since her husband did not allow her to use contraception, she stopped working
as a FP cadre because she was ashamed that she could not be a good role model for other women. However, she continues to suggest FP to other women, and especially that young couples use FP.

*I assume FP is useful to control birth spacing, so that I took contraception once before my husband knew it. He believed FP is restricted by our religion and he forbids me to use contraception. I actually wanted to take FP to maintain the space in between my children but since my husband forbids me to use it I had no choice, otherwise I will sin not to follow him as my husband...* [Woman 50 years, eight children, from an in-depth interview]

There were also informants (four women and three men) who follow a group of Moslem traditionalists who oppose FP, since they believe the program is a sin. As illustrated by one example, a man told me he believed that FP is fetal homicide.

*FP is similar with murder therefore, it is forbidden by religion. For those who take FP were considered as murders from my religion perspective. And fetal homicide is considered as a sin...* [Man 45 years, 10 children, from an in-depth interview]

**Family planning methods used**

Yogyakartan communities (men and women) in my two study locations mentioned that they recognized two types of FP methods (contraception), natural methods and modern contraception. I use the term “modern contraception”, based on the community’s perception in in-depth interviews and FGDs, to distinguish between natural methods and medical contraception. Community members (men and women), who were respondents for this study in in-depth interviews and FGDs, defined natural methods as preventing pregnancy without modern contraception but using *hazl* (coitus interruptus/withdrawal and known as *tupot* or *metu copot* in the Javanese language), calendar method, or *dadah walik* (massage). The first two natural methods, coitus interruptus and the calendar system, were generally used by couples who did not want to use modern contraception. Natural methods are considered as alternatives and more acceptable for those who experienced or are afraid of modern contraception side-effects and for
those who believed that natural methods are permitted by their religion. However, *dadah walik* (massage), which is usually performed by a traditional birth attendant (TBA) on woman’s tummy after delivering baby, is considered less effective to prevent pregnancy as evidenced by women’s pregnancies after they had been massaged. Generally, people in the village recognize that modern contraception include both female and male methods. Although they said that they knew about female and male methods, they did not pay attention to male contraception and it was more common for couples to use female contraception. Regarding male contraception, in general, married couples in the village had only heard about condoms and less often about male sterilization (vasectomy).

The distribution of contraception used both the natural methods and modern contraception among married couples in two study areas is illustrated in table 3.

### Table 3. Distribution of contraception previously and currently used by married couple

<table>
<thead>
<tr>
<th>Method</th>
<th>Interviews (20 couples)</th>
<th>FGDs (17 men &amp; 19 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Couple</td>
<td>%</td>
</tr>
<tr>
<td>Condom</td>
<td>7 35.0</td>
<td>9 52.9</td>
</tr>
<tr>
<td>Vasectomy/male sterilization</td>
<td>7 35.0</td>
<td>5 29.4</td>
</tr>
<tr>
<td>Tubectomy/female sterilization</td>
<td>1 5.0</td>
<td>1 5.3</td>
</tr>
<tr>
<td>IUD (spiral)</td>
<td>7 35.0</td>
<td>11 57.9</td>
</tr>
<tr>
<td>Pill</td>
<td>3 15.0</td>
<td>6 31.6</td>
</tr>
<tr>
<td>Injection</td>
<td>10 50.0</td>
<td>14 73.7</td>
</tr>
<tr>
<td>Implant</td>
<td>2 10.0</td>
<td>4 21.1</td>
</tr>
<tr>
<td>Coitus interuptus/withdrawal</td>
<td>3 15.0</td>
<td>4 11.1</td>
</tr>
<tr>
<td>Calendar</td>
<td>4 20.0</td>
<td>5 13.9</td>
</tr>
<tr>
<td>Massage</td>
<td>1 5.0</td>
<td>1 2.8</td>
</tr>
</tbody>
</table>

This table presents that injection is mostly used by married couple both in in-depth interviews (50 percent) and in FGDs (73.3 percent). Conversely, *dadah walik* (massage) and female sterilization are less used by couples since the massage is regarded as ineffective and female sterilization (tubectomy) requires big operation for woman. Most men and women in my study areas were generally afraid of the operation processes therefore, they avoided to choose contraception method with operation procedure.
Natural methods

The reason that some villagers (two couples in in-depth interviews and three women in FGDs) gave for not using any modern contraception methods was having experienced side effects from female contraception. This group also refused male contraception methods since it was considered uncommon in their communities. Natural methods were used by five couples, some of who also used condoms. The following excerpt illustrates the experience of one woman who had side effects from female contraception.

*I have never used any contraception since when the first time I tried to use an IUD, I was nervous and my blood pressure jumped into high because I was frightened by the fitting of the IUD. After that, I have never used any contraception, since a year ago my husband asked me to choose one of them. I chose monthly injection but after 3 months my heartbeat was getting faster and I felt uncomfortable, then I stopped it. We used only calendar method and withdrawal since I delivered my first baby and after the second one. I do not want my husband to use a condom because I felt disgusted by it and I am afraid of vasectomy. Yet, as I know it, there is no one who has undergone a vasectomy here.*

[Woman 49 years, two children, from an in-depth interview]

One married man, who used condoms in combination with the calendar method, likewise those three men from an in-depth interview who used calendar method, said that mixed methods felt more comfortable for him and his wife. He uses a condom only during his wife’s fertile period but he does not use it one week before and one week after menstruation since they believe that is an infertile period for a woman.

*A condom is one alternative and the best choice for us as a FP method since my wife experienced many side-effects of female contraception from pill, injection and IUD. I myself was also hurt during our sexual intercourse when she used an IUD. But a condom did indeed reduce my sexual pleasure even though my wife does not feel the same. Therefore, we used mixed methods with a calendar as well, in order to gain maximum sexual pleasure.*

[Man 41 years, two children, from an in-depth interview]
Another reason for using natural methods was that it was more accepted by a couple’s religion. This is shown by the decision of a part-time teacher who did not refuse a FP program but rather used a natural method instead of medical contraception. He argued that the natural method is healthier for women since it does not disrupt the menstrual pattern.

*I have been using a calendar method and sometimes withdrawal for almost five years now. I understood FP is not only to control birth spacing in order to manage household’s economy but also to take care of a mother’s health. My wife has used injection for two years after she delivered our son. It was her idea to take contraception but then I told her to stop using it and forbid her to use any contraception. In my opinion, medical contraception is against God’s will to provide man’s reproductive capacities. I agree to prevent pregnancy by natural methods, which are healthier for both, man and woman.*

[Man, 44 years, one child, from an in-depth interview]

**Female contraception**

The following female contraception methods are commonly used by women in the villages: injection (monthly or once every three months), IUD (popularly known as spiral), implant, pill or female sterilization (a tubectomy, which is quite rare chosen by women). Women in the villages can easily obtain all these forms of contraception from a private midwife and Puskesmas, except for sterilization since it requires surgery in a hospital. The oral pill is available from the sub-PPKBD, which provides pills and condoms as distributed by the BKKBN.

In my study there were 16 couples who used female and male contraception. Most, 12 couples who used male contraception, their wives have also used female contraception and four couples had never used female contraception before. The couples who used female contraception did so because this is the FP method that is best known and most popular in the two study areas. Furthermore, FP cadres, PPKBD or sub-PPKBD, often advise married couples to use female contraception.

*I have used “dadah walik” (massage) to prevent pregnancy but still have many children. I used an implant a year ago but then I delivered the last baby, and now the implant is still in my arm. Two months ago the PPKBD asked me to undergo sterilization since my
last two babies had malnutrition and had to be hospitalized for one week. Now I will not worry that I will have more children. [Woman, 35 years, 8 children, in the community]

Fourteen women who are currently using and or who have used female contraception said they chose this method as it was more heavily promoted by FP cadres, widely used by neighbors or recommended by a midwife. One woman said she had been using female contraception for 15 years now. She decided to use contraception since the midwife in her village told her to use it if she wanted to control birth spacing.

I have used a spiral for five years for the first time after I delivered my first baby. Before I had the second child, I took it out then after the baby was born, I used it again for seven years. I took a spiral at that time because it was common among women here and it was still rare to have an injection. Now I have been using a three-month-injection for almost four years since I felt uncomfortable in using spiral. I took the injections after I saw many neighbors used them. [Woman, 39 years, two children, from an in-depth interview]

Likewise what were revealed by most men and women in FGDs.

...I wanted to use IUD but the midwife suggested me to use injections. As I knew the midwife often recommend female contraception, if only we got contraception side-effects then she will give alternative for condoms... [Woman, 27 years, two children, from FGD in Purwosari]

It was commonly accepted that female contraception were more easily accessed and widely used by most couples in the village for years. Those who used female contraception argued that information about female contraception was more available than male methods, thus, they decided to use female contraception.

I completely leave contraception matters to my wife since it is more common for woman to take contraception in the village. Even though she asked me before she decided to use one of them, I just followed what she wants. I know that female contraception have been used by many women in my neighborhood and are easy to access. I and most husbands here are only following our wives. [Man, 27 years, one child, from an in-depth interview]
Male contraception

There were other views from married couples about contraception choices. Twelve married couples in this study decided to use male contraception despite the fact that female contraception were more generally known and widely used by many couples in the villages.

*I was a FP cadre and I knew all female and male contraception methods. I was using a spiral (IUD) for five years then one day I realized that I did not get my period. After I delivered the last baby, my husband asked me whether we would continue to have more children or not. I said no and he decided to have a vasectomy. Although I was FP cadre, I was worried that my husband would be impotent because at that time it was still very rare for men to be sterilized.* [Woman, 60 years, four children, from an in-depth interview]

According to 12 men using male contraception (condom and vasectomy) that I interviewed, four had wives who had never used female contraception. One of these men is a FP fieldworker and often offers FP advice to his neighbors and even provides them with free condoms.

*I have been using a condom for five years now, since my wife does not want to use contraception. I know it is uncommon for men to use a condom even more than a vasectomy in the village. I often suggest to other young couples to use a condom as well since it does not have any side effects for us. If I was not a PLKB (FP fieldworker) probably I would not know about male methods.* [Man, 35 years, two children, from an in-depth interview]

Similar to a previous informant, whose wife had never used female contraception, one woman said that she had never used any female contraception and it was her idea to use condoms even though it was uncommon for women at that time to ask for male FP methods in the village.

*Before we used condoms we only used calendar system or withdrawal. The first time I used a condom it was during the program of mass IUD fittings for women in the village. I was afraid and people thought that my husband had forbid me to use contraception. I was a little bit ashamed because I already had five children then I asked PLKB for some condoms. I brought them home and told my husband that I got a new interesting*
contraception. My husband agreed to use it until I got my menopause two years ago.

[Woman, 53 years, eight children, from an in-depth interview]

Other women revealed that they felt happy when their husbands decided to undergo male sterilization. Yet, this was considered a strange decision among married couples in their neighborhoods. Sometimes women were mocked that their husbands were *ora lanang* (impotent) after they had undergone a vasectomy.

*People in this village thought that a man would be impotent after he had been sterilized. I told them that their perceptions are not right. I said that my husband became healthier after vasectomy and I felt free of any complaints from female contraception that happened to me before.* [Woman, 38 years, two children, from an in-depth interview]

**Motivations for method of contraception used**

Among the 32 men and women (who used modern contraception) whom I interviewed, I found a variety of motivations for choosing medical contraception, for both female and male contraception. One motivation to use female contraception came from husbands and wives who are using and who have used them in the past. They explained, for example, that it was because female methods were considered more practical, cheaper and easier to access than male contraception.

*I have used three months injection for the first time I took contraception since it was offered by a midwife. After one year I had hip pain but never got menstruation then I changed into IUD. I think it is more practical to use female contraception than male contraception. For example, a condom which should be used every time we make love and should be bought at a price that is not cheap if we want the best quality. Vasectomy is uncommon here and most people are afraid to have the operation. With an IUD a woman can chose whether she wants it for a long period of three or five and even seven years. That is more practical and economical for people like us in the village.* [Woman, 28 years, one child, from an in-depth interview]

This woman argued that she had used contraception because it is a woman’s responsibility to maintain spacing in between children since it is the woman herself who is pregnant and delivers
babies. Even though she once experienced IUD erosion, she continued to use the device and will not discuss male contraception with her husband.

*I felt that I should use contraception because my husband is working and I am working as well but at least I would not be allowed to carry something heavy because of this IUD. Furthermore, as a wife I should respect him as a head of household. It was my idea to use female contraception and when I asked my husband, he agreed. He gave me freedom to choose which contraception that was comfortable for me. I will not request that my husband use male methods as long as I feel comfortable with female contraception.*

[Woman, 28 years, one child, from an in-depth interview]

That is in line to what I found from FGDs with men,

*…..most people here said KB means contraception used is women’s responsibility since women who are deliver babies…. [Man, 43 years, two children, FGD with men in Purwosari]*

In agreement with the informant above mentioned, one woman initially did not ask her husband to have a vasectomy because she believed that she must take female contraception except female sterilization because it requires operation that is more complicated than male sterilization. However, when she experienced many side effects, she changed her mind. She stated that if she had not had any side effects from female contraception she and her husband would not have chosen a vasectomy.

*I have taken three months of injections, the pill and an IUD but there were no female contraception that fit well with me. I had many problems with my body since I have used contraception. And I do not like condoms since they do not feel comfortable and are impractical. In the meanwhile, I got information about vasectomy from the PLKB that it would not bring have any side-effects. I discussed a vasectomy with my husband and he agreed to have a sterilization. But if I had no problems with female contraception, I think a vasectomy would not be our choice since I believe that taking contraception is more common for woman. Contraception is one of a woman’s roles.* [Woman, 36 years, two children, from an in-depth interview]
I cross-checked with this woman’s husband to determine whether or not he had the same reasoning as his wife. Surprisingly, I got a different answer.

_I was interested to have a vasectomy for a long time ago when I heard about it from an old man here. My wife was pregnant and delivered our two children and I felt that is more like a woman’s sacrifice in a marriage. This encouraged me to use contraception in order to control the number of our children as our commitment and responsibility. Furthermore, when she had many side-effects from female contraception, it aroused my willingness to share and take turns with the role of taking contraception. Although she did not have any side-effects from contraception, I remain interested to undergo male sterilization but I cannot take a risk if she does not agree with me. Hence, when she asked me to have sterilization it was like a dream came true._ [Man, 37 years, two children, from an in-depth interview]

Based on the findings from my interviews, I heard various motivations from men and women for using male contraception. Most men (9 out of 12 men) who are using male contraception (condom and vasectomy) said that it was because their wives experienced or were afraid of side effects from female contraception. These men wondered whether they would have chosen to use male methods if their wives had not had problems with female contraception.

Only two men risked undergoing vasectomy without their wives asking them to do so despite the fact that it was considered as uncommon in their communities. These two men made their decision to show their love for their wives by viewing their affectionate attention and protecting their wives’ health. One of the two men was even willing to be a role model of a “good man” for the community demonstrating that using male contraception, as part of FP, is not only a woman’s responsibility but also a man’s.

_We have used three months of injections, condom and mixed with withdrawal. I said that a condom is not comfortable because it reduces sexual pleasure. Then I had an opportunity to involve in the government program to undergo sterilization that actually was something I wanted since I was 15 years old. I do not want to see my wife sacrifice, as it happens to women generally; get pregnant, deliver and take care of babies but still have to take something from the outside which is often harmful into their bodies (female_
contraception) in order to prevent pregnancy. Since we agreed not to have more
children, I found that as a man, I can access male sterilization without any side-effects
for both of us. Our sexual life also has been more enjoyable and our intimacy increases.
So, why don’t I have male sterilization? Thus, men in this village will see that I will be
just fine after the operation. [Man, 39 years, two children, from an in-depth interview]

Communication process for negotiating contraception

Most married couples in my study (18 couples) stated that they communicated with each other
about FP and contraception choices but most of them had more discussions about female
contraception. Nevertheless, in the two study sites, the husband has the authority to determine
whether couple/ wife will use and not use contraception. For two couples who refused FP
totally, discussion of contraception in their marriage did not occur.

We never talk about FP or even more about contraception. My husband told me that FP
is “haram” (restricted by religion) for Moslems. Therefore, we never discussed it. I knew
people said that we are like rabbits, we have children like “beternak” (breeding) and
sometimes I am actually ashamed of it therefore, I hardly ever take part in any
community activities. I must obey him as he is my husband and imam (leader) in our
family, otherwise God will punish me and we as women will not be in God’s Heaven.
[Woman, 45 years, 10 children, from an in-depth interview]

All couples said that FP is a couple’s responsibility but it does not mean that there is room for
women to choose not to use female contraception unless their husbands are willing to use male
contraception. Women who have experienced or are afraid of female contraception’ side effects
often hesitate to negotiate with their husbands or cannot even suggest that their husbands to take
male contraception. They just wait for their husband to have the idea and willingness to use male
contraception.

It was his idea to have a vasectomy since I got bad effects from contraception. I have
used pill, injection and IUD but never felt healthy. He knew it and felt compassion for me
then he asked me to discuss another choice, male sterilization, which is rare and very
uncommon here in the village. As I knew he got a book from PLKB and read a newspaper
about vasectomy. I am happy that he could understand my problem with female contraception. [Woman, 38 years, two children, from an in-depth interview]

On the other hands, the men I interviewed rarely talked about condom use since it is considered to reduce sexual pleasure. They were also hesitant to communicate with their wives about other male contraception options since it was commonly held that male sterilization would decrease a man’s power and make a man impotent.

I did not tell my wife when I decided to have a vasectomy. I knew she would be worried about the effects of this method. As I got enough information from friends who were health workers I felt “mongkok” (confident) to take the risk. [Man, 60 years, four children, from an in-depth interview]

Four women (out of 12) whose husbands utilized male contraception could communicate and negotiate with their husbands to use a male method. Two of those four women asked their husbands to undergo a vasectomy and their husbands agreed. The last two women asked their husbands to use a condom but to do so in conjunction with a calendar system. One of these two women said that she and her husband only used a condom temporarily. Her husband asked her to resume using female contraception after their second child turned two because he did not feel comfortable using a condom.

My husband has the same opinion as I do about using a condom after I discussed the method with him. We do not want to have more children but I am still breast-feeding our baby. For me, it is fine to use a condom but my husband does not like it and he asks me to choose a female contraception that will be more practical and comfortable for him. [Woman, 27 years, two children, from an in-depth interview]

To summarize, couples revealed various meanings for FP. Most of them said that FP was to control number of children and birth spacing related to their household’s economic situation. They realized that having qualified children who are well educated (with high education such as academy/university) is a priority and show this by using FP methods. In contrast, those who do not agree with the idea of FP avoid all FP methods including natural methods as well as modern contraception. This group came from Karangmojo and their rejection was in the name of
religion, whereas I found a different reason for those who did not use modern contraception in Purwosari. The Purwosari group identified health factors as the reason to avoid using modern contraception, specifically to prevent modern contraception side-effects. These findings based on in-depth interviews with couples and FGDs with community (men and women) in two study locations indicated that religion in Karangmojo influenced couples’ decisions about FP and contraception use as has been assumed before this study.

Most couples in this study, who use and have used female contraception stated that their choice of female contraception was based on their opinion that female methods were considered more practical, cheaper and easier to access than male methods. There were also a variety of motivations from couples when choosing specific contraception. However, most couples agreed that although FP is a couple’s responsibility, when it comes to contraception choices, men are passive and let their wives choose which female contraception will be used. In other words, for those who are willing to stop having any more children/to control birth spacing, seems there is no option for women not to use female contraception unless they experience contraception side effects and their husbands are willing to use male contraception.

Most male methods were chosen to avoid female contraception side effects and not because husbands realized that contraception use is also a man’s role within a marriage. The findings show that men whose wives are unable to take female contraception due to side effects had no choice but to use modern male methods to avoid pregnancy since their wives cannot use modern female methods.

Women generally expected their husbands would take turns using contraception but they hesitated to negotiate this issue. However, most husbands waited for their wife’s opinion regarding female contraception or their complaints about side effects of female contraception before considering using male contraception. From both genders I found different expectations and motivations for using male contraception. Men generally tended to use male contraception only if their wives experienced female contraception side-effects whereas women expected their husbands to use male contraception regardless of whether or not they had problems with female contraception or had asked them to do so. It appears that female contraception’s side effects and gender equality awareness were basic to negotiation of male methods among married couples. In the following chapter, I will examine more closely how people in Yogyakarta perceive male methods first from the community’s perspective and then from the informant’s perspective.
CHAPTER V

MALE CONTRACEPTION ARE IDENTICAL TO REBYEK/REPO T AND KEBIRI

In this chapter I discuss my findings in Yogyakarta on the local population’s perception of existing male contraception. I explain the meaning of rebyek/repot and kebiri, local terms that are attached to condoms and vasectomies. Rebyek/repot is Javanese for condom and means “impractical” since one has to buy a condom for each use. A few respondents also used the word uwik/uthik which has a similar meaning to rebyek/repot and is typically used only in the local Javanese language of the Gunungkidul district since I did not hear these terms in other parts of Yogyakarta. Kebiri means “castration” and that is the common perception in the villages, adapted from animal castration since the majority of people in the study areas are farmers.

Community’s perception about male contraception

Based on FGDs with married men and women, interviews with informants (couples), key informants and informal conversations with groups of women and men during my participant observation, I found similar expressions used for male contraception. Most respondents believed that a condom is rebyek/repot since it is less practical than other contraception, especially female contraception. Furthermore, they identified male sterilization (vasectomy) as kebiri since they assume that it is like animal castration and a man’s penis is cut so he cannot reproduce.

During discussions in four FGDs (total participants 36) I disclosed that a condom was an alternative for using the calendar system or withdrawal. Most participants said that common reason to use a condom was because one’s wife experienced side-effects and could not use female contraception. Most respondents (33) including those who were currently using a condom agreed that a condom is uncomfortable and impractical.

I used a condom since my wife could not use female contraception because of bad side-effects to her body and someone offered me condoms for free. We have used a calendar system and withdrawal but my wife was always worried and it interfered with our sexual life. We do not want to have more children so I have to use condom to prevent pregnancy. It is not comfortable but at least it is better than withdrawal…. [Man, 45 years, three children, in FGD with men in Karangmojo]
I have used an implant, injection and IUD but never felt comfortable with them. We have used a condom a couple of times but it was “rebyek”, we felt uncomfortable and unsatisfied then we stop using it. Now we do not use any contraception, only the calendar system but to be honest, I always feel worried and afraid of being pregnant… [Woman, 37 years, two children, in FGD with women in Purwosari]

…besides “repot”, usually a condom makes both a man and a woman unsatisfied thus, we decided to have a vasectomy since I could not use any female contraceptions because of its bad impact to my body. After undergoing male sterilization our sexual life has been increasing. It is much fun to do sexual intercourse with husband without a barrier...

[Woman, 40 years, four children, in FGD with women in Karangmojo]

Obstacles to condom use included reducing sexual pleasure and impracticality from the community’s perception as well as shame and stigma. From the community’s perception based on FGDs, a man who buys a condom is thought of as a *suka jajan* (as prostitutes user) or considered a *suami takut isteri* (husbands who are afraid of or have less power than their wives). These common perceptions of condom use make men ashamed to use a condom if they have to buy it themselves.

_In the past, a condom was subsidized by the government and we could get them from the FP cadre but since one year ago it was not free anymore. Now we have to buy, my husband wants to use it but never wants to buy, he always asks me to buy. He says that he is ashamed if there are neighbors who see him buying condoms… [Woman, 44 years, 1 child, in FGD with women in Purwosari]

…I heard that people talked about men who are using condoms as being identified as “suami takut isteri” and because his wife is not obedient to her husband, but I do not care. We use condom and mix it with a calendar system. He got condoms for free from PLKB and I think he will not use them if he had to buy them. I know my husband, he would be ashamed if other people knew that he uses a condom… [Woman, 44 years, three children, in FGD with women in Karangmojo]_
…for me and I am sure for many men here, the ideal contraception is female contraception. I used a condom once because my friend gave it to me, it was “repot” and I felt dissatisfied. Furthermore, it is uncommon for men here in the village to use male contraception. It is more pleasurable if it is a wife who uses contraception and not a man, moreover if a man must buy condoms…oh, it is shameful. [Man, 39 years, two children, in FGD with men in Karangmojo]

While discussing vasectomy, most participants (27 out of 36) in four FGDs agreed that the method sounded frightening since they assumed it was like animal castration.

...I have no idea about male sterilization, which part that should be removed. I thought that it means cutting “prisilan” (man’s testicles), it sounds scary… [Woman, 25 years, four children, in FGD with women in Purwosari]

Even those who had undergone male sterilization confessed that they were afraid of having surgery. Like most people in the village, they thought that vasectomy was like kebiri and were afraid that it would reduce a man’s power but they had no choice since their wives experienced bad side-effects from female contraception and PPKBD asked them to have a vasectomy.

My two children were born by caesarean and the doctor suggested my wife not get pregnant anymore. She is afraid to use female contraception and I must take this method. I knew that my perception was wrong it is unlike “kebiri” what generally people think. Even now I feel stronger and healthier… [Man, 33 years, two children, in FGD with men in Purwosari]

Other concerns related to vasectomy were that it might reduce a man’s power, and the community perceived that it would increase a man’s opportunity for marital infidelity.

...but if the sperm duct was already cut off then some years later a man wants to have more children, how can it be since the operation to connect it is more expensive? Moreover, it might make it easier for a man to have an affair… [Man, 53 years, two children, in FGD with men in Karangmojo]

….if men can be sterilized, how about being faithful to their wives? It sounds like it
would allow them to have a chance to seek another woman without a trace, doesn’t it?
[ Woman, 40 years, two children, in FGD with women in Purwosari]

When I asked about vasectomy related to religion, most participants including those who had had a vasectomy, perceived that this method is restricted by religion. They argued that this method is against God’s will because it cuts off a man’s ability to reproduce, unlike a condom or female contraception which allow male reproduction.

…in people’s understanding female contraception prevent pregnancy, but a man remains able to reproduce so that does not violate human destiny. A condom is quite similar to “hazl” ( withdrawal), which is allowed by the Moslem prophet, but sperm has been released in a glove. Beside “repot”, it is uncomfortable. It remains more comfortable if it is a woman who takes contraception. [Man, 45 years, three children, in FGD with men in Purwosari]

As far as I know, KB (FP) methods like injection, a pill that aims to control birth spacing are not considered as sin but maybe not for the method that cuts a part of man’s genitals, isn’t it? This method sounds like pregnancy termination, just like we throw away God’s gift so that it looks like a sin… [Woman, 38 years, four children, in FGD with women in Karangmojo]

…from the perspective of religion as I have heard, male sterilization is considered as murder. Sperm is considered as “bibit” (seed embryo of fetus) and if it has been thrown away it will be considered like as fetal homicide but it depends on a man’s beliefs… [Man, 50 years, in FGD with men in Karangmojo]

Lack of sufficient information about vasectomy causes fear but on the other hand, the community has great interest to know more about this method of male contraception. Some participants were interested in having a vasectomy after they heard testimony from vasectomy acceptors since I invited them to be FGD participants.

….I hesitated before, I thought that a vasectomy cuts a man’s penis. After I listened to friends here who have undergone male sterilization, it aroused my curiosity and I want to get more information about the method. If it does not have side effects for a man’s power,
physically and sexually, I think I would like to undertake this method… [Man, 43 years, two children, in FGD with men in Purwosari]

Most women in two FGDs agreed that male sterilization would be ideal for them if it did not cause side-effects. They expected that their husbands would want to undergo the procedure.

I am interested in this method and I want my husband to take a turn to use KB (using FP method). If he wants, I will directly register… [Woman, 38 years, three children, in FGD with women in Purwosari]

It would be so good if all men wanted to use contraception, therefore they would feel how it is hard for women who are already pregnant, deliver babies and take care of them then still have to use contraception which often harm our bodies… [Woman, 36 years, two children, in FGD with women in Karangmojo]

Based on informal conversations with a group of women farmers, female workers and housewives, most women expected that their husbands would be willing to use male contraception since they had experienced side effects from female contraception. However, the women realized that this accommodation was not as easy as they had hoped. They also confessed that condoms were considered impractical and the women were afraid that a vasectomy would reduce a man’s power.

….usually contraception is for woman, it is rare for men to use male contraception. Men always say that a condom is uncomfortable and unsatisfying. A vasectomy is like “kebiri” so men do not want to have it. We do not know whether it would reduce man’s power or not, because most men in the village are farmers and construction workers. [Woman, 33 years, two children, in a housewife group]

Ya, I am concerned about the effects of male sterilization since I am a farmer. What if I could not work anymore? My family would not eat... [Man, 50 years, three children, in women farmers group]

I have used contraception and experienced their side-effects. Is it true that if we use hormonal contraception for long period of time it will cause cancer? I and most women
are actually afraid of it but we have no choice not to use contraception. I think if men want to take a turn to use male contraception it would be good. We get pregnant and deliver our babies so men should take a turn to use KB (contraception) so that they will know how hard it is… [Woman, 35 years, three children, in female workers]

I found different stories from male (vasectomy) acceptors groups who lived outside of the village. They argued that in their village in Ngilpar, there were more than 80 men who had already undergone sterilization since a chief of the sub-village had had a vasectomy. Furthermore, this group was recognized by the president of Indonesia for their success in maintaining a community-based FP (male method) program.

Currently there is no one in this village who thought that a vasectomy was like kebiri; rather a vasectomy was considered one of a couple’s needs. I heard for the first time from people outside of the village that “pak dukuh” (a chief of sub-village) tried first and then we followed him since we knew that was safe for both a man and a woman. Our effort was to free women from illnesses that are caused by female contraception. We created an organization and called it “Priya Tulodho”, which means “good role model for others” (men). We developed productive economic activities based on this group but open to all communities. We realized that many community activities facilitated communication and so new information was spread to the public including male contraception issues. [Man, 38 years, two children, the secretary of Priya Tulodho]

….now every couple who realized they have enough children will directly undergo vasectomy so that wives avoid contraception’ side-effects. We encouraged all men and women to be actively involved in any community activities, so that they will get new information regarding FP, gender equality awareness, agriculture issues as much as they need. These community activities allow people to learn what they do not know before and it has been shown to increase the prevalence of male acceptors whereas this has not happened in other villages. [Man, 65 years, four children, member of Priya Tulodho]
Based on interviews with key informants, I discovered similar issues regarding male contraception. A midwife from one study area said that people in the village needed more information about male methods and to hear the testimony of male acceptors.

...condoms are safer, actually for women. They will not cause side-effects to their health while a vasectomy is more ideal especially for those who do not want to have more children. Unfortunately, in this neighborhood there is no vasectomy acceptor so there is no role model who can show men and women that the method is better for a couple. But few days ago there was dissemination about vasectomy, initiated by PPKBD, we hope there will be new acceptor candidates, at least one man... [Midwife, 39 years, two children, from an in-depth interview]

The midwife also illustrated how the community perceived male methods based on her clients’ statements and on her own experience in her marriage.

Most of my clients choose female contraception and argue that a condom is “repot” (impractical) since it should be used and bought whenever they need it and it reduces sexual pleasure. Vasectomy is thought of as animal castration that will reduce a man’s power. Additionally, this village is a patriarchal community meaning that commonly men do not want to be involved in using male contraception, they thought KB (contraception use) is a woman’s matter. As a consequence, there is a low rate of male contraception users and it relates to the lack of information and counseling for couples, especially for men. I myself as health provider could not convince my husband to use a condom since it is believed to be uncomfortable but moreover, a vasectomy is assumed to be the same as castration. I would be very happy if my husband wanted to use a male contraception. [Midwife, 39 years, two children, from an in-depth interview]

A similar opinion came from the sub-PPKBD (FP cadre in sub-village) who claimed that a condom is impractical and she never got sufficient information about male sterilization.

...condom is “uwik” or “rebyek”, we have to use it every time we want to have sex and my husband said it is uncomfortable, thus I use female contraception since a vasectomy sounds like “kebiri”. I do know yet which part of man’s genitals must be cut, what are the
consequences for a man or whether it makes a man impotent or not. People also said that it is considered “haram” for Moslems. But if there is no side-effect, I would like my husband to do that as long as he agreed… [Sub-PPKBD, 50 years, two children, from an in-depth interview]

One religious leader who was interviewed conveyed a different perception about male methods, but still hesitated to use a permanent method (vasectomy). He argued that there was no obstacle from a religious perspective.

…if it is solely on the basis of religion, I think it is not a challenge, it is not a principle matter, but people’s beliefs that they can educate many children also should be respected as long as they can. Different from female contraception, I think a condom is effective and it does not cause any side effects as female contraception generally do. A condom is more acceptable since it can be used only a few minutes before ejaculation to minimize discomfort and it is not a permanent method. Vasectomy is less acknowledged whether it causes any side effects for men (physically and sexually) or not. Generally people in the village are farmers who need extra energy to work and who are different from office workers. It is also important to consider if a man wants to have more children after vasectomy. But most important thing is to assimilate the community to control birth spacing therefore we will have qualified generation… [Moslem leader, 50 years, five children, from an in-depth interview]

Insufficient information available to the community was also recognized by two PLKB as a problem for male contraception use in two study locations. They argued that the cause of this problem was a lack of resources, especially operational costs to provide public dissemination about modern male contraception. As one of consequences of government decentralization in Indonesia in the last ten years, the FP program was offered at a district level whether it was a main program of the district or not, depending on the policy of the local government. Consequently, due to many cuts in financing the FP programs are adjusted to the respective regional budget as noted by one of the PLKB.
...we considered our limitation to give appropriate dissemination to the community since there was no sufficient budget for that. We need financial support to gather people in order to give them information about modern male contraception... [PLKB, 40 years old from an in-depth interview]

**Informants’ perception about male contraception**

In this section I examine the informants’ perception of male contraception and I discuss all findings by dividing them into three groups of informants; non-contraception user, female contraception user and male contraception user.

In interviews with married couples, who do not use any contraception and modern contraception (eight men and women), I found one man who appeared awkward when he talked about condoms. He revealed that he did not know about either a condom or a vasectomy but then he said that he had heard about condoms before. I saw that this man, who did not agree to use the FP program, was ashamed to talk about condoms due to the negative image of condoms that are associated with men who are *suka jajan* (prostitutes’ users). This man argued that contraception (female and male methods) may increase that chances that a man or woman could be unfaithful with their partners.

*What is condom actually? I have never seen or even touched it. No, I have never discussed KB (contraception) with my wife and others. I do not like to take KB (contraception) since there are many couples who divorce because their wives are having an affair with other men after using a contraception. Furthermore, KB is woman’s matter not a man’s, since it is a woman who delivers a baby...* [Man, 45 years, ten children, from an in-depth interview]

A second man, who also did not use any contraception, said that a condom is not simple and he believes that whatever the FP method is, it aims to prevent pregnancy which means the waste of the seed embryo of the fetus therefore, it is forbidden by religion.

*Based on my understanding from Qoran, Moslem are restricted to use any contraception including condoms since they interfere and throw away the seed embryo. Even more a*
male sterilization, it is like “kebiri” isn’t it? It must be a negative effect from it… [Man, 52 years, eight children, from an in-depth interview]

Other couples who are using FP with natural methods and never used male contraception stated what they had heard about the method. They perceived that male contraception, especially condoms, were not simple, impractical and male sterilization was like kebiri. This is illustrated by one woman used a calendar method.

I have no experience with male contraception as I heard that condoms are unsatisfying for a woman. There are still only condoms here for a man but only a few men who are interested to use it. Furthermore, people said that it is “uwik” (impractical), not simple. It is “repot” (impractical) due to how they are used, should be bought and if they are used improperly there is a risk of leaking. Information about other methods such as vasectomy is not yet adequate in the community but I heard that there are a few men who already use it. I am not sure about the risks and the advantages of this method, whether it may reduce man’s power or not. What if my husband could not carry out his duties as a man? But if that is safe it would be good. If my husband wants to take it I will support him. In my opinion, the important thing is the matter of safety but if woman is more fit/suitable to use contraception then it should be her to use them… [Woman, 44 years, one child, from an in-depth interview]

Similar expressions came from couples (eight men and women) who are taking female contraception. They chose female contraception because the methods were considered as more practical than male methods.

….to be honest, I think contraception that is simpler and more practical is for woman. A condom is not only more risky for leaking but also if it comes to limited/less stock, it would be hard to find in the village. It would be shameful for a man to seek a condom. In short, a condom is “repot” (impractical) for me. Moreover, I feel uncomfortable if I should use it. Regarding my religion, I believe that contraception use does not matter. The Moslem prophet suggested that we breastfeed our children until two years which means that He thought we could manage and control birth spacing. A vasectomy, in my opinion, is like “kebiri”. It sounds like it eliminates the grace of God because it cuts the
sperm duct, whether it would be allowed by religion or not, I am not sure… [Man, 37 years, two children, from an in-depth interview]

Furthermore, one man, from the group whose wives are using female contraceptions, gave me an interesting statement and demonstrated that appropriate information about male contraceptions is still needed.

...when my wife wanted to use female contraceptives, she always asked my opinion, I just followed her since it came from the FP cadre that women should use contraceptions if a couple did not want to have more children. I have tried a condom but I think it was ’uwik’ (impractical) and dissatisfying. There has been little information and I am still unclear about male contraceptions, especially for male sterilization since all dissemination about contraceptions are always aimed at women. We do not know yet the detailed information about it but if there will be a new regulation that a man should use KB (contraception), I think all men here would consider it. Now I still hesitate about vasectomy but if there are men who follow the program, I would like to try in order to maintain a FP program from the government. I believe a FP program is important for us and it is nothing to do with religion. Religion is for our life hereafter but FP is for our life now. Some people say that many children bring good fortune, this might have been appropriate in the past but not for nowadays. Now having many children will bring many problems related to a household’s economic status…. [Man, 39 years, two children, from an in-depth interview]

Based on my interviews with couples whose husbands are male acceptors, condom or vasectomy, I found various perspectives and experiences behind their choice to do so. One surprising and sad story about male contraception was told by a man who had had a vasectomy. This man had a ketedun/penyakit tedun (hernia). He told me that the community, under local authorities at the time, tried to help him to get medication for his problem. He was brought to the hospital to have an operation but he never knew that he was also sterilized during the procedure. He had never been asked permission to be sterilized and he only knew that he had to have an operation to cure his hernia. After his hernia was repaired, he realized that he could not have more children and became impotent. People in his neighborhood knew about the story.
...because I had a “ketedun” (hernia) and felt pain, I followed them to be brought to the hospital. I thought it was only to cure my disease. Neither my wife nor I can read, therefore, all the documents were signed by “pak dukuh” (chief of sub-village) as was common at that time. Maybe they made a compromise with a doctor. After the operation people told me that I had been sterilized but I didn’t know what it meant. A few months later I realized that I could not have sex with my wife anymore. We have only one daughter and she is mentally handicapped but we have no chance to have more children. I had never been told that I was going to be sterilized. However, a man like me cannot feel disappointed, I had been cured from “ketedun” and God gave me longevity which was a big blessing for me and my family, although the consequence is like this now....

[Man, 55 years, one child, from an in-depth interview]

The above story illustrates the fear of vasectomy that is spread in the community. Based on this case, vasectomy seems to prove that male sterilization makes a man impotent. This is in agreement with the concerns mentioned by other male acceptors participating in FGDs with communities I discussed earlier.

*It is uncommon here for a man to be sterilized. Most men and women are frightened that it will reduce a man’s power both physically and sexually. Moreover, women are afraid that if their husbands undergo sterilization they will have an affair with another woman. I saw many couples here who do not have harmonious marriages because the wives often refuse to have sex once their children grow up. The women refuse their husbands since they cannot use female contraception due to side-effects and their husbands do not use male contraception. Because my wife experienced a bad impact from her contraception, as her husband I did not want to be selfish, for that reason, I undertook this method.*

[Man, 40 years, two children, from an in-depth interview]

Other vasectomy acceptors mentioned that after have had a vasectomy they faced many questions from neighbors. Some women were mocked by people saying that their husbands were considered *suami takut isteri*, therefore, they wanted to undergo male sterilization.

*Some people said that my husband must be less powerful than me, I do not care. It was our agreement to stop pregnancy without suffering from any illness complaints. I thought*
it is better than a condom since it does not “rebyek” and have the risk of leaking. I heard many stories about condom failures and we do not want it. Some women asked me whether I am afraid that my husband would be unfaithful or not. I said that I believe him and I know my husband. I notice people are not only curious but also want to do the same thing like us but maybe they still wait by seeing my husband and whether he gets any side effects from the operation or not… [Woman, 37 years, two children, from an in-depth interview]

When asked about ideal contraception, all vasectomy acceptors said that their choice was ideal for them. Condom users said the same; they said that instead of female contraception, a condom is the best choice. Furthermore, most couples who used male contraception argued that the methods are not forbidden by religion.

My religion never discusses contraception, but yes about FP. As I know it, that is no problem from religion perspective as I have heard from other religions such as Moslem. I had a vasectomy a long time ago when I heard from my commander who had undergone a vasectomy as well. This method is the best of all, especially female contraception that are more disadvantageous for my wife due to their side-effects… [Man, 60 years, four children, from an in-depth interview]

I believe that FP is not only about contraception and contraception methods but is only part of the way to reach a planned family, which is also recommended by our prophet (Moslem prophet). The difference is because in the prophet’s time there were no contraception methods, thus he used “hazl” (withdrawal) and suggested that we breastfeed our babies for two years. For me, KB (contraception) is for both, man and woman and a condom is the most ideal as long as I can access it for free from the PLKB. Moreover, it is more practical than female contraception, which requires consultation with the physician. I have used condoms since my wife did not want to use female contraception then I decided to use it without asking for her agreement. [Man, 33 years, one child, from an in-depth interview]

This man also mentioned other concerns about vasectomy which were similar to findings from FGDs with communities.
In my opinion, a vasectomy is more complicated not only because it should cut a man’s sperm duct but also it may increase a man’s infidelity. Other considerations are demands to not have more children, whether it could be connected again or not? If we just want to have no children anymore we can use a condom and it is not necessary to cut it off…. 
[Man, 33 years, one child, from an in-depth interview]

On the contrary, one woman said that she considers contraception as forbidden by religion.

I knew it is considered as a sin but I have to limit the number of my children, otherwise their life will be more difficult. I asked for God’s forgiveness but if it becomes a government program it should not be a sin. I experienced many side effects from female contraception hence, I asked my husband to take sterilization. In the meantime, he also was willing to do that after he heard stories about vasectomy from his friends in town…
[Woman, 59 years, four children, from an in-depth interview]

In summary, based on stories in this chapter, we can see that community perceptions in FGDs correlate to informants’ perceptions in in-depth interviews and are in agreement with phenomena noted by key informants. FGDs enabled me to achieve spontaneous ideas from the community (men and women) regarding modern male contraception use among married couple. I learned about the respondents’ perceptions, attitudes and community acceptance in general for modern male contraception. I could not obtain this information only by interviewing informants using in-depth interview techniques. However, I was able to collect valuable information from in-depth interviews with informants (couple) and key informants. This technique allowed me to probe for additional explanations from the informants about their perception of modern male contraception even though I recognized that their information was subjective. I could find the red thread from the community told me in FGDs and from in-depth interviews’ as the variety of techniques were useful to further analyze the low modern male contraception use among married couples.

All the findings show that modern male contraception are less accepted since the methods are considered less practical than female contraception. Furthermore, most people in the community thought that female contraception were more accessible since they can obtain them from the sub-PPKBD or midwife who live in their neighborhood.
Other circumstances that influence low acceptance of male methods are the images associated with the methods. People not only correlate condoms, for instance, with discomfort and the risk of leaking but also with immoral habits that are considered shameful. Vasectomy has been conceived of as castration that reduces a man’s power physically and sexually. In addition most people in Karangmojo doubt whether a vasectomy is permitted by religion since there are different perspectives among the community and religious groups regarding the practice that cuts a part of a man’s genitals while in Purwosari, the community was more concern in its side-effects.

Furthermore, since FP is accepted for contraception use, and it is generally used by many women since the program was introduced by the government, FP allows men to decide that contraception use is a woman’s matter. On the other hand, women feel that birth control means contraception use is part of their role as a wife. Interestingly, women expected their husband to be willing to take turns using contraception since they experienced female contraception side-effects. Hence, gender relations are an important issue regarding a couple’s communication when negotiating male contraception use. In the next chapter I analyze problems and circumstances surrounding low male contraception use, integrating the two chapters of research findings in order to gain insight into the matters that encourage and discourage modern male contraception use.
CHAPTER VI
CIRCUMSTANCES SURROUNDING MALE CONTRACEPTION

From the previous discussions I identified four interconnected influences that either discourage or encourage modern male contraception use among married couples in Yogyakarta. First, patriarchy and gender relations related to the Indonesian FP program; second, religion and insufficient information about contraception in general, but especially male contraception which contributes to the emergence of myths and misperceptions; third, the availability of contraception choices and a couple’s motivation for contraception use and lastly, the association between social networks and spousal communication when negotiating male contraception use.

Patriarchy and gender relations on Indonesian family planning

A salient issue discussed with married couples and the community regarding FP was their views on whether FP is accepted as a woman’s matter or a couple’s responsibility. This issue was critical to explore in order to understand how the informants perceived contraception in general before I made further inquiries about the acceptance of modern male contraception use.

From the findings and as I discussed before, I found that most couples in in-depth interviews associated KB (FP) as contraception use. When I asked couples about KB their thoughts turned immediately to contraception methods and not merely the meaning of FP overall. I had to probe to hear the informant’s views on the meaning of FP, which could be described as a method to limit the number of children and or to maintain space between children. Informants who did not agree with FP program stated that FP is considered a sin and restricted by religion since the goal is to control fertility.

Although most couples and communities, who accepted FP program, agreed that FP was a means to control the number of children and or birth spacing and that FP is a couple’s responsibility, I found it did not mean there was an equal dialogue between men and women. Woman did not have the option to easily choose to use or not use contraception and most husbands did not take male contraception of their own volition without waiting for their wife’s complaints. Furthermore, when married couples were faced with contraception choices, men tended to let their wives actively access female contraception. KB means contraception use is
still considered more suitable and practical for a woman thus, it is generally accepted in Indonesian society as a woman’s matter since most contraception users are women.

The above phenomenon is closely linked to actions by the Indonesian government in carrying out FP as a national program and forming public opinion what they have implemented. An FP was introduced by the Indonesian government to the community in the early 70s as a state policy to suppress and limit the number of births. This program was followed by famous slogan *dua anak saja cukup* (two children is enough), which now has been changed into *dua anak lebih baik* (two children is better) in order to improve family welfare (Rohim, 2009). Ironically, the improvement of family welfare through the FP program seems to be aimed at women, who are considered directly responsible for reproduction activity. It has been shown that family planning programs from the beginning were more focused on targeting female acceptors with the provision and mass installation of female contraception for free for all women in urban and rural areas (Faturochman, et al. 1998). As a consequence, the image of family planning became recognized as woman’s matter rather than a couple’s responsibility.

Furthermore, women’s reproductive health seems has been ignored as evidenced by the number of female contraception installation without given sufficient information and counseling about its side-effect (Faturochman et al. 1998), which still happens until nowadays. Consequently, many women have experienced side-effects from female contraception and contraception failures which actually not only harm women but also men as husbands. This birth control policy reflects what Connell said about the state structure of patriarchy, which has influence in the reproductive arena (1987:126). In the Indonesian context, the state attempts to control the population through a woman’s body and neglects woman’s rights. Indonesian family planning can also be explained by what Scheper-Hughes calls ‘body politic’ when the state government regulates a woman’s body in regard to gender and reproduction by accommodating a patriarchal household system to control fertility (1998:365).

A patriarchal household system is reproduced by governmental policy as demonstrated by the FP program. The program focuses exclusively on women even when promoting male contraception since women are considered active only in domestic life and thus are easier to reach for information dissemination than men. Moreover, the recruitment of FP cadres in the community as focused on women since the Indonesian FP program began and positioned FP issues (include contraception use) as part of women’s life rather than couple’s life. The
government that promotes the FP program, especially male contraception, assumes that women will negotiate the use of male contraception with their husbands. This neglects the fact that women’s ability to negotiate with their husbands is influenced by the parenting system she has internalized from her family. Often mothers and even mothers-in-law teach their daughters or daughters-in-law to use female contraception and emphasize that it is part of a woman’s responsibility to manage FP. Most people in my study areas, especially women, believed that a woman who is delivering babies has a responsibility not only to raise her children but also to do all domestic work including maintaining her family’s well-being as part of what is called kodrat perempuan (woman nature/destiny). Therefore, KB means contraception use is also perceived as part of a female’s nature since it relates directly to the process of a woman’s reproduction. This likely links to the finding of a previous study by Herartri (2004), that women in West Java could decide to use female contraception although men are regarded as head of the household, but it does not mean that their husbands share their power with their wives within the family. Herartri found that women were responsible for both childcare and the family’s well-being (2004:1).

My findings illustrate a patriarchal structure of gender relations in all practices which place men in authority over women as discussed by Connell (2009:74-76) and generally men are more powerful than women when determining whether a couple will use contraception or not. A wife should ask her husband before she decides to use any contraception. This is based on cultural norms, which state that a husband is the head of the household and he has authority (power) over his wife including FP methods use. Moreover, in the community’s perception, based on religious beliefs (mostly Muslim), men are imam (leader) of their families thus, women as wives should obey their husbands otherwise the women believe that God will punish them. This situation is hard for women who do not want to have any more children but their husbands refuse to allow them to use contraception. Women who do not want to have more children but are unable to use female contraception due to side-effects and whose husbands will not use male contraception face the same dilemma. Eventually, a woman must depend on her husband in the matter of contraception use. It is likely that women who experienced female contraception side-effects and cannot negotiate their husbands’ use of male contraception, feel more responsible for contraception since they realize that it is a woman who is pregnant and delivers babies. These women’s experiences are reflect what Scheper-Hughes (1998) describes as a ‘social body’ when
a woman’s body belongs to the social field and thus women are required to follow what is socioculturally constructed by their communities.

Other studies in Indonesia, such as Cammack and Heaton (2001) (based on the quantitative analysis of IDHS 1997) and Heinemann, et al. (2005) (a quantitative survey method) also found the significance of individual religious beliefs in influencing the decisions on contraception use. The findings of Cammack and Heaton (2001) showed that regions with high concentrations of Muslims have lower rates of contraception use while Heinemann, et al. (2005) discovered that most Muslim respondents considered male contraception only if it was permitted (halal) by their religion. This is in agreement with my findings that some Muslim men and women, even those who accept a FP program perceive that a vasectomy is haram (forbidden) by religion since it cuts a man’s sperm duct and makes a man permanently infertile.

**Between myth, masculinity and insufficient information on male contraception**

My research findings showed that the Indonesian community tended to refuse male contraception due to its associated bad images. A condom is not only considered as rebyek/repot (impractical) because one has to buy a condom for each use but also believed to reduce sexual pleasure for many couples and it has a negative image regarding infidelity that is shameful and a vasectomy is imagined as kebiri (man castration). Particularly for vasectomy, most people said it was menyalahi kodrat (violates nature) that was against God’s will and based on my findings has even been thought of as castration—to cut a man’s testicles or even a man’s penis. This misperception about male sterilization creates significant resistance to the idea of vasectomy generally in groups of Muslims.

Other groups of Muslims who refused FP also rejected the idea of male sterilization by altering the slogan of the Indonesian FP program to say ‘dua anak lebih’ baik (more than two children is good). This resistance was based on their understanding that a FP program means contraception use is aimed to inhibit the conception of a human being. Those people’s perceptions were in agreement with literature that found that a vasectomy is perceived not only as a way to permanently prevent having more children but also as something that destroys God’s creation since the procedure cuts a man’s sperm duct (Rohim, 2009). Although there is no agreement among all ulama (Muslim leaders) in Indonesia in terms of halal (permitted) or haram (prohibited) regarding contraception use, the idea of refusing FP has been spread by some
Muslims groups, especially after the era of the New Order from the 70s to 90s. Rejection of a FP program in the name of religion was supported by the argument of democratization, freedom and human rights which are interpreted as the protection of the international agreement/law in individual’s rights to continue their family’s line but unfortunately, without considering woman’s reproductive health rights (Rohim, 2009).

Other concerns about vasectomy were that informants believed that it would reduce a man’s power physically and sexually (the man becomes impotent). These consequences of condom use and vasectomy, which were imagined by most respondents is contradictory to what is believed by society as ‘cultural capital’ (Bourdieu, 1986). Cultural capital that is historically constructed and must be owned by Javanese man; adherence to religious doctrine, banyak anak banyak rezeki (has many children would bring many good fortunes), man as a husband should control his wife in opposition with lelaki takut isteri (man who is less powerful than woman) and man must be potent to satisfy his wife sexually. These efforts to obey religion and masculine attributes are useful to sustain one’s existence and dignity as ‘symbolic capital’ for men generally in a Javanese community. This linked to the concept of ‘mindful body’ (Scheper-Hughes & Lock, 1998) which states that a man’s body is a representation of the ‘social body’ and has symbolic meaning controlled by sociocultural constructions, thus a Javanese man is expected to have those above-mentioned qualities. This is in agreement with the discussion about the body as ‘a social agent’ by Connell (1987:83) which considers the male body as having a socially constructed definition of masculinity.

‘Symbolic capital’ in regard to the FP national program in Indonesia involves not only woman’s oppression but also force of symbolic violence. I found that those who do not take FP program were ashamed or stigmatized by those who participate. One informant, a Muslim who was forbidden to use FP, has many children and claimed that she was ashamed to be involved in community activities. On the other hand, those who participate in a FP program were also stigmatized as people who did not obey their religion. This tension made men (and women) hesitated to undergo a vasectomy because it was considered not only a sin but also it interferes man’s masculinity. Similar findings regarding vasectomy among Mexican men were that it was considered damaging to the image of a man’s masculinity (Gutmann 2005). The Mexican community perceived that male sterilization was linked to their ability to fulfill a woman’s
sexual desire as the concept of manhood and *hombria* (manliness), which was assumed to be reduced by a vasectomy.

Hence, sufficient information about contraception methods would influence couple’s choice in FP methods use. As I mentioned before, the target client of the Indonesian FP acceptors were women and consequently, the target of information dissemination was also only women. This government policy neglected gender relations in Indonesia which place a woman in an inferior position to a man. Therefore, a woman should ask for her husband’s permission before they decide something. Regarding the promotion of modern male contraception use, women again, become the target of dissemination. Those who promote male contraception use, expect that women will communicate and negotiate male contraception use with their husbands.

Inappropriate information and counseling about male method choices and female methods (in regard to the side-effects of female contraception) have made the community unaware of health issues and especially woman’s reproductive health. Moreover, the myths and negative images of male contraception that are widespread throughout the community made men and women hesitate and even reluctant to consider the topic for spousal communication. This situation placed many women in my study in conflicting circumstances—the desire to be free of female contraception side-effects and the expectation of a husband’s willingness to use male contraception despite their fear of the negative implications for male contraception, which they heard in their communities. Lastly, women stuck with the discomfort experienced by their bodies on the pretext of saving family harmony as the basis of a social harmony, which became the jargon of the patriarchal society attitude about women’s bodies.

**Contraception choices and agency**

The availability and choices for female and male contraception are not equal which means that there are more varied choices for a woman compared to a man and this influences a couple’s motivation to use contraception. Female contraception that is effective for a long period of time is considered more practical and economical for most couples. Even though there were some female contraception failures, such as translocation of implant and IUD, female contraception (except tubectomy/female sterilization) are still considered as more practical and effective by the community, especially when those methods are compared to condoms which are believed to reduce sexual pleasure or a vasectomy that requires a surgery procedure.
Only those couples who were brave enough to break with social custom, constructed since a long time ago, decided to take male contraception. Although a condom is considered as repot/rebyek it was seen by users as more free from side-effects. Although a vasectomy requires an operation, it was considered not only safer from side-effects and even more comfortable than a condom because it did not reduce sexual pleasure but also it was perfect for those who did not want to have any more children.

Most men in my study chose male contraception to respond to female contraception side-effects that their wives had experienced. Other men had a vasectomy in the name of love for their wife and to show that manhood that is identified with a man’s bravery to sacrifice and be sterilized. A study performed by Landry and Ward (1997) found similar findings from Asian and African informants who perceived that a man as head of the household had to take the responsibility for family planning as an empathetic response to women’s suffering. Therefore, male sterilization allowed them to express their masculinity, which was accepted as a symbol of man’s sacrifice.

Outside of the practicality and effectiveness of contraception, modern male contraception, as I have previously discussed, has several social aspects which make couples reluctant to choose it. Regardless of reason that couples chose male contraception, people in the community had many opinions—both positive and negative. These couples often experienced verbal abuse (about physical weakness) and symbolic violence. Those who used male contraception were regarded by society as suami takut isteri (husband inferior to wife) and for vasectomy acceptors they were even thought as ora lanang (impotent) and because they were unable to reproduce anymore. An example of symbolic violence that I found from transcript data was one vasectomy acceptor who said that neighbors taunted him by saying arep nyilih nggo pejantan wedhuse which in Javanese expresses ‘we want to lend your testicles for my male goat’, since the community thought that vasectomy was similar with animal castration to cut man’s testicles or even man’s penis. All aspects of an Indonesian man are considered to be missing from male acceptors since they use male contraception, and these aspects are part of what is believed by the community to a ‘cultural capital’, which, of course, supports the other needs of a man—‘symbolic capital’, as I have discussed before.

Although contraception choices for men are not as varied as for women, it does not mean that couple (husband and wife/man and woman) have no choice as evidenced by their decision to
use condoms or undergo vasectomy. These couples, individually or in partnership, clearly have the freedom to choose. From an agent’s point of view it is her or his freedom to choose any kind of contraception. This is what Scheper-Hughes and Lock (1998) described as a manifest ‘individual body’ in which a person has control over her or his own body to choose what she or he wants. Conversely, in terms of symbolic violence, the position of an individual or agent is not free. As mentioned previously, both male and female’s bodies have symbolic meaning and sociocultural construction controls them by values that are operationalized and are believed by community to be a part of ‘cultural capital’ and ‘symbolic capital’.

Thus, the pressure from elites in terms of contraception use, neighbors’ gossip that is peer pressure or the view that such choices are considered *haram* (prohibited by religion), and in confronted with the government’s official recommendation that ‘two children is better’ have created an environment where choice is no longer free. Therefore, the choice of contraception method and use is closely associated with ‘cultural capital’ owned by an agent.

Agents play a role in what Bourdieu (1986) referred to as ‘playing a game’ meaning that agency involves an individual strategically engaging in and manipulating the rules of social situations. For example, vasectomy acceptors counter the notions of society, which thinks that they have lost their cultural capital; a man cannot reproduce and becomes impotent, a husband is less powerful than his wife or he is considered to have violated the rules of religion and that lowers a man's pride as his symbolic capital. Through male sterilization men are able to show the opposite, that they are fully potent enough to satisfy their wives since they become stronger physically and sexually and the harmony of their families is maintained. They have shifted the value of masculinity to not be limited to the ability to reproduce, but to the ability to increase the frequency of sexually satisfying their wives without the worry of pregnancy so that they can keep the family’s harmony. This is certainly contrary to those men who are refused sex by their wives since their children are grown up and their wives cannot use any female contraception due to side-effects. One informant disclosed that many married couples’ harmony in his neighborhood was disrupted because of a lack of conjugal intimacy or lack of the quality in the sexual relationship as a consequence of not wanting to have any more children but the men not being willing to use any contraception. Men who have no chance to have sex with their wives may no longer show their manliness in terms of the ability to fulfill a woman’s sexual desire,
which inspires concerns about the result of male sterilization as reducing a man’s power physically and sexually.

A vasectomy, therefore, allows a man to show his manhood and manliness as an expression of the responsibility of the man as the head of the household who can rescue his wife from the side-effects female contraception. Moreover, a vasectomy acceptor reconstructs or reproduces a man’s pride in terms of masculinity by showing either his physical strength or sexually satisfying his wife as it was expressed as *habitus* and his ‘cultural capital’—in their language *lebih jos* (much stronger than before). Similarly, wives whose husbands undergo vasectomy or use condoms can show to other women that they are healthier as they can pray five times a day and fast (for Muslims) as required by religion, since most women might not do those rituals when they use female contraception and have continuous menstruation or spotting as contraception side-effect.

A couple’s choice to take modern male contraception can also be explained by what Scheper-Hughes and Lock mean by the concept of ‘individual body’ (1998). A woman interprets her life experiences in regard to female contraception use and its side-effects as a disturbance that will have implications for her family harmony while a man who chooses male contraception perceives that it is his responsibility to overcome the couple’s problem regarding FP methods use. Therefore, both a man and a woman decide to take modern male contraception, such as condom and vasectomy, despite the fact that female contraception is more acceptable in their communities and consequently, either the man or the woman faces the negative opinion of society. Both man and woman eventually promote the ‘body-self’ experiences (Scheper-Hughes and Lock, 1998) in regard to his/her personal rights and choices that different from public opinion. Hence, those who tried to liberate themselves from suffering of female contraception side-effects and faced the challenge of negative opinion from the community are representation of individual (and social) agents who are not only victims of oppressive socioculturally systems. (Greenhalgh 1995:25).

The influence of social networks on male contraception use

The agency of a man or woman to take a risk to access male contraception even though they risk facing negative perceptions from their community and despite the fact that female contraception is more acceptable in their communities were influenced by the pattern of spousal
communication and equal relationship between husband and wife for negotiating male methods. That is related to an extensive network which enables the agent to gain wider knowledge and appropriate information regarding female and male contraception choices. The network of social relationships that is defined by Bourdieu (1986) as ‘social capital’ is useful as a resource to support everyday activities, including information access and the availability of opportunities and social status. Thus, social capital can be used to obtain the agent’s cultural capital.

Social and cultural capital that is characterized by network ownership and adequate information for all contraception methods relates to choices and the side-effects of each method, affects the decision for couples to use male contraception. In other words, if a community member is active in her or his neighborhood or even in outside of neighborhood for instance, she or he would have more access to a new or any kind of information about the situation surrounding them. Information becomes capital which facilitates her or him to act more than a less informed other who is inactive.

Either social or cultural capital enables agents to have more information not only about FP but also regard to gender equality awareness. These capitals exercise the dynamic of interspousal communication for negotiating male contraception use. Women who experience female contraception side-effects and have appropriate information about male contraception may negotiate male methods with their husbands who also have sufficient understanding about male contraception. The process of communication and negotiation among couples will be easier to them who understand better about gender equality between husband and wife. Therefore, women’s experiences of contraception side-effects and gender equality awareness might become a couple’s basis to discuss male contraception use and increase the possibility that they will use male contraception.

This is in agreement with previous studies among Tanzanian men who undergo vasectomy by Bunce et al. (2007) and a clinical trial of hormonal male contraception among Indonesian men in Palembang and Jakarta by Solomon, et al. (2007). Both authors discovered that wives played an important role in male contraception use due to women’s health and the side-effects of female contraception, which allowed the women to negotiate for their needs. A similar finding was also reported by Ali, et al. (2004) who stated that from 43% of his respondents in Pakistan had interspousal communication regarding family planning and birth control because of their concern about their wives’ health.
Unlike those who do not know or lack information about male methods and even for those who lack gender equality awareness, some informants continued to have misinformation about male contraception originating in the community and consequently, they remained unaware of female contraception’s side-effects or even about woman’s reproductive health in general. Petro-Nustas and Al-Qutob (2002), who studied the Jordanian community, found that most men from lower social classes perceived FP or birth spacing as the responsibility of women only. Ali, et al. (2004) had similar findings that almost two thirds of the total respondents among Pakistan men never had and always avoided interspousal communication about FP since communication about this subject with wives was not deemed important and was considered as against their cultural norms. This unconscious or conscious action as a consequence of gender inequality hinders the process of couple’s negotiation to use male contraception.

My study findings indicated that those who have taken male contraception were men or whose wives have an extensive network among pamong (local authorities) such as pak dukuh (chief of sub-village), pak RT (chief of kampong), those FP cadres who have been active in and outside of their villages, PLKB, teachers who become member of any organizations in outside of their villages, PNS (civil servants), peasant and traders who were sociable and well acquainted with others included local authorities. Through the participant observation in a group of vasectomy acceptors, I found that ‘social capital’ might increase the efficiency of action such as dissemination of information.

In the group of Priya Tulodho I saw that their social networks helped all member of the network to adapt, learn and become creative with cooperative support from each network’s member. This is likely that men or women who have an extensive social network which enables them to access sufficient information about male methods will enhance their chances to negotiate male contraception use within couple. This is similar to Behrman, et al. (2002) who indicated that the causal effects of social networks on contraception use are significant and are typically larger for men than for women as a consequence of unequal gender relations since most men generally have wider public roles rather than women whose roles are limited to the domestic area. Furthermore, social networks primarily affect a respondent’s contraception choices through social learning by providing information rather than by exerting social influence (Behrman et al. 2002).
The first man who had a vasectomy and became one of the founders of *Priya Tulodho* was *pak dukuh* (chief of sub-village). The information that I got from the secretary of *Priya Tulodho*, whom I interviewed, was that they developed productive economic activities as the organization’s activity, which was open for all community members and not limited to vasectomy acceptors. This idea was based on their assumption that the many community activities facilitated communication and the spread of new information to the public including the subject of male contraception.

On the other hand, it shows that the Javanese community in general is also a paternalistic society which affects people’s actions based on what has been done by those who are respected, such as parents and community leaders. The concept of a paternalistic society that may increase people interests in the use of male contraception was also revealed by most informants in my study. From FGDs for instance, most participants expected that their local leaders (religious, cultural leaders and local authorities) should be involved in the campaign for male contraception use. They even expected that there would be some of local leaders who would be willing to show their efforts to use male contraception. The same argument was stated by religious leaders who were interviewed, that I ought to run a FP program specifically promoting male contraception use and that the government should ask local and religious leaders, who mostly are men, to give appropriate information about male contraception.

Most couples who were interviewed argued that as long as there is a role model of male acceptors in their neighborhood it will boost both a man and a woman’s attention to the importance of male contraception use. From my participant observation in several groups of people, respondents looked forward to a male acceptor role model respected in their communities; the people would follow a role model to do the same thing but as long as there is no good testimony, people will not consider male contraception. All participants in my study also expected more dissemination of female and male contraception choices within their existing community activities so that they could choose contraception by weighing all the advantages and disadvantages of each method.

Hence, sufficient dissemination of male contraception use is crucial for all community members. Moreover, appropriate information about female and male contraception are suppose to be shared within the social network in various community activities that involve both genders, which already exist, such as village peasant groups and other village meeting forums. This would
be a good method for a FP program to campaign for male contraception use among the community and not merely frame it as a woman’s matter.

Conclusion

Based on my study findings I conclude that there are sociocultural dimensions and other circumstances that encourage or discourage modern male contraception use among married couples in Yogyakarta. First, patriarchy and gender relations play a role in a state policy of FP national program and on the household level influence the acceptance of male contraception use. Most couples in this study agreed to limit the number of their children and or to control birth spacing; therefore, they used contraception. However, their decision to use specific contraception was influenced by their perspectives on practicability, efficiency and effectiveness of the methods, all associated with their level of understanding of their choices and cultural/religious notions.

As the consequence of gender inequality in Indonesian in general, men are more powerful than women. The power of a husband over his wife is supported by such cultural notions/religious views that are gender-biased. Although most couples agreed that FP is a couple’s responsibility, when they considered contraception use they believed it was more suitable and practical for women. Therefore, men tended to let their wives take action by using modern female contraception as it was generally accepted in the community and men were merely passive in their action to access modern male methods. Religion is one argument used by some people to refuse not only FP program in general, but also as an argument, by those who are using female contraception, to reject male contraception, more specifically vasectomy.

Second, there are only a few options for male contraception compared to female contraception and modern male contraception is considered impractical and even worrying. Both condoms and a vasectomy were considered as less practical than female contraception since condoms have to be used every time couple wants to have sex and a vasectomy requires surgery. Most people in the community believed that male sterilization, considered man castration, would reduce a man’s power physically and sexually and was restricted by their religion since it removes or cuts a part of a man’s genitals and subsequently he would be permanently unable to reproduce. Insufficient information about female and male contraception choices including the side-effects is responsible for the paucity of attention to women’s reproductive health and makes
people reluctant to use male contraception. The lack of appropriate information about female and male contraception that was experienced by the communities in my study areas was associated with gender bias program, which focused only on women as target clients even for male contraception use campaign.

This above phenomenon is in line with the discussion that the power of patriarchy through the state policy plays significant role in the lack of information regarding male contraception choices for the community, based on informants’ statements that men especially have not received information about female and male contraception. Is this situation due to the fact that the elite Indonesian men may also be reluctant to use male contraception? Unlike the mass program of female contraception use, which was linked to the effort of community building networks, the Indonesian government used PKK as an army of volunteer village FP workers. Male contraception use has been tolerated but is regarded as not an important part of FP program in Indonesia. The Indonesian government seems less serious in the campaign for male contraception use and it is clear that the government conducts gender biased program through FP in order to control fertility.

Third, male and female agency on male contraception use was influenced by female contraception side-effects which were experienced by most women in my study areas, sufficient information that was gathered by couple or agents of change who use male contraception, the meaning of masculinity which was associated to a family’s harmony, the influence of role models of male acceptors and gender equality awareness among couple.

Finally, the social network plays important role in attaining the possibility of male contraception use by couple. This social capital owned by the agent of change in terms of a male contraception user, provides a chance for a man (and a woman) to gain adequate information and support from their network in order to facilitate their goals. A social network involving both genders enables a couple to have a better understanding of contraception choices and gender equality issues that will be useful in the process of spousal communication for negotiating modern male contraception use.

**Recommendations**

Based on my study findings, I propose that low modern male contraception use in Yogyakarta is because people do not know or have inappropriate information regarding the issue and not
because they do not want it. Therefore, these following recommendations are expected to facilitate the improvement of modern male contraception use among married couples.

1. Improve the performance of PLKB

   PLKB as FP field workers in Indonesia should more actively promote modern male contraception use in the community and not simply rely on or hand over the responsibility of information dissemination about contraception choices (in particular male contraception) to FP cadres (PPKBD/sub-PPKBD) who work voluntarily and do not receive a salary as PLKB.

   PLKB must not dodge the responsibility by stating they have no operational funds for public dissemination of male contraception information, since they can use the existing community meetings/gatherings/forums such as monthly farmer group meetings and household meeting forums.

   PLKB should more active in approaching local authorities and local cultural/religious leaders who are respected by the community in order to build understanding and a shared vision of the FP program that is more culturally and gender sensitive.

2. Improve integrated community-based advocacy for the FP program

   A lesson learnt from the Priya Tulodho group, BKKBN through PLKB with the local (district) government, NGOs concerned with the FP program and reproductive health advocacy and the community must establish male contraception acceptor groups in each village to provide adequate information for contraception choices and the side-effects, especially about modern male contraception, that is accessible for the community. In this way, people in the villages can up-date their information regarding male contraception sufficiently.
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## Annexes-1

### ABREVIATIONS

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BKKBN</td>
<td>Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board)</td>
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<td>CIA</td>
<td>Central Intelligence Agency</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IDHS</td>
<td>Indonesia Demographic and Health Survey</td>
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<tr>
<td>IUD</td>
<td>Intra Uterine Device</td>
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<tr>
<td>KB</td>
<td>Keluarga Berencana (Planned Family/Family Planning)</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>PKBI</td>
<td>Perkumpulan Keluarga Berencana Indonesia (Indonesian Planned Parenthood Association)</td>
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<tr>
<td>PKK</td>
<td>Perberdayaan dan Kesejateraan Keluarga (Family Welfare Movement)</td>
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<tr>
<td>PLKB</td>
<td>Petugas Lapangan Keluarga Berencana (FP Field Worker)</td>
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<tr>
<td>PNS</td>
<td>Pegawai Negeri Sipil (Civil Servant)</td>
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<tr>
<td>PPKBD</td>
<td>Pembantu Pembina Keluarga Berencana Desa (Village FP Management Assistant)</td>
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<tr>
<td>PUSKESMAS</td>
<td>Pusat Kesehatan Masyarakat (Community Health Center)</td>
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<tr>
<td>RT</td>
<td>Rukun Tetangga (Neighborhood Association)</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TU-DMPA</td>
<td>Undecanoate with Depo-MedroxyProgesterone Acetate</td>
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<td>UN</td>
<td>United Nation</td>
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RESEARCH GUIDELINE

Topic List: Modern male contraception use among married couples

The study aims to explore and understand the sociocultural dimension and other circumstances influencing low male contraception use in Yogyakarta, Indonesia and the effect of couples’ negotiation on decision-making processes. The research specifically tried to look for:

1. Factors that influence couples’ choices in determining contraception use
2. Married couples’ perceptions of modern male contraception
3. Factors that influence men/married couples in using modern male contraception
4. What are the spousal communication processes and how gender roles affect couples’ negotiation in determining contraception
5. How social networks influence the use of male methods of contraception.

Guideline for In-depth Interview, Focus Group Discussion with married couples and Participant observation

Personal characteristics of Informant
1. Gender
2. Age
3. Place of origin
4. Education
5. Occupation
6. Number of children
7. Religion
8. Living with
9. Contraception that currently use and ever used

Probing items:
1. The meaning of KB (FP)
2. Gender relations on FP and contraception use
3. FP methods (contraception) used
4. Motivation of contraception used
5. Communication process of negotiating contraception used
6. Perception on contraception; natural methods, modern female contraception and modern male contraception
7. Accessibility of appropriate information on contraception choices and the side-effects
8. The influence of family, community and social network on contraception used

Perception

1. What is the meaning of KB (FP) for you?
2. Who should responsible on FP and contraception use within couple?
3. Do you think how does your wife/husband feel about the method that you choose?
4. Do you think who is more common to use contraception in Indonesia? Why is that?
5. What do you thing about other methods and how about modern male contraception?
6. What do you think about your religion? Does it allow you to use contraception? Why?
7. What about your local culture is it common to use male method? Any consequences?
   How about public opinion to your decision in using male method?
8. What kind of contraception that is considered ideal for you?
9. If there’s any other male method (hormonal contraception; pill/injection/implant) what do you think about it? Will you interest to use it? Why?

Motivation

1. What is your reason to take contraception, can you share a bit more about that? What kind of method that you use (currently and previously)?
2. Why do you choose that method and not the others?
   For male acceptor and wife:
3. What is your reason to use male contraception? What method did you choose?
4. If there’s no bad-side effect of female contraception for your wife (for men whose wife experienced side effect of female method), will you consider using male method?
5. What is your big effort as a man/husband to use male method? (confirmation question to male acceptor)

**Communication process**
1. How did the decision making process to determine the method. Did you discuss with your partner (husband/wife) before choosing the method?
2. Does your wife/husband agree to choose the method?
3. Who has the 1st idea to take FP and to use the method?
4. What is your obstacle in choosing male method and how do you and partner overcome that obstacle?

**Self experience of contraception used**
1. How do you feel about that method? How do you think about the effectiveness of the method that you use?
2. How do you feel about your decision to use your contraception?
3. Do you experience any side-effects of the method? If so, what kind? Do you discuss with your partner about this?
4. Based on your personal experience to use your method are you going to tell any other men/women to use that method? Why?

**Information and the influence of family, community and social network**
1. Where did you get the information about the method that you use? Did you feel difficult to find appropriate information about male method?
2. Did you consider other alternatives of contraception?
3. Do you know about each side-effect of contraception?
4. Did you discuss with anyone else before you determine your method?
5. Did anyone else give you an advice/ input if so, who are they and what/how did they give it to you?
6. Did you tell anyone else (men/women) that you use natural/female/male method?
7. Did you feel comfortable to discuss about this (natural/female/male method) to your friend/siblings/family?
8. Did you ever asked for opinions by others who wanted to use natural/female/male method?
9. Do you know other men/women that also use natural/female/male method? If so, do you know what their reasons?

**Guideline for In-depth Interview with key informants**

Probing items:
1. The acceptance of FP program and contraception use among the community
2. Gender relations on FP and contraception use
3. Accessibility of appropriate information on contraception choices and the side-effects
4. Perception about modern male contraception
5. The obstacle of modern male contraception use