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## Family planning decision-making: Case studies in West Java, Indonesia

**Rina Herartri** (herartrina@student.vuw.ac.nz)  
Victoria University of Wellington

### Abstract

This paper examines women's empowerment within the process of family planning decision-making in Indonesia. In light of the 1994 International Conference of Population and Development Programme of Action, the Indonesian family planning programme has focused on women's empowerment. This study examines this issue in two villages in West Java, using in-depth interviews with both women and men, volunteer workers, government field workers, and focus group discussions with unmarried adolescents, male and female. A key finding is that although men are regarded as the head of the family, women in the study areas were the major decision makers with regard to reproductive matters. Their decisions covered not only the use of a particular family planning method but also the number of children. However, this does not necessarily mean that men share the power within the household with their wives; rather child care and family well-being are regarded as women's responsibility. The main conclusion of this paper is that couples' decisions to control fertility were facilitated by women's access to information and contraceptive services provided by the government family planning programme. This gives women an important source of power in a form of control over family size.

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## **Introduction**

By the end of 1997, 57 percent of married Indonesian women aged 15-49 years were using contraceptives, and in 2003 it had reached 60.3 percent. This extensive use of contraceptives has led to a sharp decline in the fertility rate, from 5.6 births per woman in 1970 to 2.78 in 1997 and 2.6 in 2003 (CBS, NFPCB, MOH & Macro, 1998; 2003). These figures reflect the increasing acceptance of the idea of fertility control through family planning by the Indonesian population.

Fertility decline and the rise in contraceptive prevalence have been attributed largely to the family planning programme run by the government (Freedman, Khoo & Supraptilah, 1981; Gertler and Molyneaux, 1994; Warwick, 1986). The programme has been characterized by a strong political commitment and a hierarchical administrative structure from the national down to the village level. Through its vigorous campaigns, information on the benefits of having a small family size is publicized through a variety of media (Hull et al., 1977; Freedman et al., 1981; State Ministry for Population/NFPCB, 1995). With widespread information along with endorsement of fertility control and provision of a range of modern contraceptive choices, it is expected that people will make appropriate decisions regarding childbearing and contraceptive use in order to increase family prosperity. Couples' ability to make informed choices on contraception and to make decisions on the number, spacing, and timing of children has become the main focus of current international family planning programmes (Population and Development Review, 1995).

In this paper, I use a case study approach to investigate how couples in two villages in West Java province make decisions regarding family planning. I examine factors that influence them in making reproductive decisions. I also investigate the process by which such decisions take place, which can also give a picture of the structure of family planning services delivery at the villages.

## **The Indonesian family planning programme**

The Indonesian family planning programme has evolved from a private endeavour in 1950s to become a government programme in 1970. Now it is the world's third largest government family planning programme. When established in 1970, the programme's goals were to reduce and control population growth and to lay the foundation for the acceptance of the 'happy and prosperous small family norm'. The specific objectives are stated as follows: 1) to reduce the birth rate; 2) to improve maternal and child welfare; 3) to enhance the people's awareness of population problems; 4) and to improve the quality of Indonesian human resources as an asset to development (State Ministry for Population/NFPCB, 1995). The definition of the 'small-family' norm has continuously changed as a response to people's changing attitudes to family size. Initially, since a large family was still considered desirable, the campaign proposed to limit family size to four, then three, and eventually it became a two-child norm (Suyono et al., 1995). In 1974, a demographic goal was set, i.e. a 50 percent reduction of the 1970 fertility rate by the year 2000 (Suyono et al., 1978). This target was already achieved before the target date, as shown by the 1994 Indonesian Demographic and Health Survey (CBS et al., 1995).

The foundation of the Indonesian family planning programme was strengthened by the passage of Public Law No. 10/1992 regarding "Population Development and the Development

of Prosperous Families” (*Perkembangan Kependudukan dan Pembangunan Keluarga Sejahtera*). This law contains a number of statements concerning the nature of the Indonesian family and family decision-making, and also principles concerning the rights and responsibilities of couples with respect to contraception (Government of Indonesia, 1992). In 2000, in light of the Programme of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo, the Indonesian family planning programme took on a new vision and mission statement. Since then, the vision has been “Quality Families by 2015”, while the main mission is to empower and motivate the community to build small and high quality families. Women’s reproductive health has become one of the major programmes. The main strategies are improving the quality of family planning services along with increasing men’s participation in the programme. Community participation and empowerment, including women’s empowerment, are also parts of the strategies (BKKBN, 2001).

At its commencement in 1970, the programme employed a clinic-based approach where family planning services were provided through clinics owned by government and non-government institutions. Potential clients were motivated by field workers to come to the clinic to get contraceptive services. During mid 1970s, as a response to the increasing demand for pills and to reach more potential users, the programme established contraceptive supply centres in each village. The centres are run by village volunteers who are usually women. This policy marked a shift of the programme’s approach from clinic-based to community-based. Since then, the programme has continued to emphasize community participation as its main strategy (State Ministry for Population/NFPCB, 1995).

The extensive use of family planning methods has been achieved through expanding a range of service outlets in various settings in both rural and urban centres throughout the country. Currently, the family programme has a presence in virtually every village in Indonesia. At the grass-roots level, family planning programmes are managed and implemented by village volunteers through a community institution called PPKBD (*Pembantu Pembina Keluarga Berencana Desa*). Over time, the role of PPKBD has changed from being just contraceptives distributors to becoming the ‘managers’ of the village programmes (Hamijoyo and Chauls, 1993). In 2002, around 70 percent of villages throughout the country were reported to have established PPKBD (BKKBN, 2002). Along with mass media and the centres for family planning services, the network of field workers and volunteers at grassroots level plays an important role in ensuring family planning information reaches the majority of the fertile couples.

Few studies have examined the decision-making process regarding childbearing and family planning in Indonesia (e.g. Irwanto et al., 1998; Hull et al., 1999). The following case studies attempted to provide an understanding of the process of decision-making regarding family planning.

### **Theoretical framework**

The concept of community participation entails that development programmes allow the community to make their own decisions. Scholars (e.g. Arnstein, 1969; Chambers, 1995; Oakley and Marsden, 1984) argue that the concept of ‘participation’ includes people’s involvement in decision-making processes, in implementing programmes, and in evaluating such programmes. They also suggest that participation is an empowering process, which enables local people to do their own analysis and to make their own decisions. In family

planning, empowerment implies that people should be able to make their own decisions regarding the number, spacing, and timing of their children, as recommended by the 1994 ICPD in Cairo. This is achievable through access to information and access to safe, effective, affordable and acceptable methods of family planning ( Population and Development Review, 1995).

A couple's reproductive decision-making process is influenced by many factors (e.g. Hull, 1983; Hollerbach, 1983). The couple's perceptions, evaluations, norms and attitudes towards fertility choices are formed and shaped through social interaction within the village setting. In this line of thinking, fertility decisions may not be limited to individual families, rather they are influenced by other sources, such as relatives, or extra-familial sources, such as neighbours, community leaders, professionals, and state authorities.

Additionally, a couple's decision-making is affected by the government programmes, which not only make modern contraceptives available, but also actively encourage the acceptance of fertility limitation (Easterlin, 1978; Freedman, 1979; Lesthaeghe, 1980; Simmons and Phillips, 1992; Watkins, 1987). The legitimacy endorsed by government programmes to encourage participation affects the social climate within which individual contraceptive decisions are made (McNicoll, 1975; Watkins, 1987). Using diffusion theory, Rogers (1973) and Retherford and Palmore (1983) argue that government-sponsored programmes can also facilitate rapid diffusion of family planning at the village level. The family planning programmes' emphasis on 'accessibility' and 'community-based distribution system' encourages couple's participation. Although mass media facilitate awareness and provide basic information about contraception, acceptance itself is more likely to be encouraged or discouraged by opinion leaders 'closer to home' who share many of the same characteristics as the couples (Retherford and Palmore, 1983).

Another approach to fertility decisions is based on the perceptions of the value of children. Fawcett (1983) points out that numerous studies in developing and developed countries have shown a moderately strong correlation between measures of perceived satisfaction along with costs of children and various measures related to family size and the practice of birth control.

Female education is frequently cited as inversely affecting fertility through a number of mechanisms. For example, it can increase age of marriage, child survival, and contraception use (Cochrane, 1983; Mason, 1997). These mechanisms operate partly through greater autonomy or power of educated women. Hence, the concept of female empowerment is vital to the understanding of reduced fertility and increased contraceptive use (Mason, 1997). This study aimed to draw together the decision making process and women's empowerment through the use of participatory methodology at the village level.

## **Methodology**

This study uses a phenomenological approach. A qualitative research design is used based on a case study approach in two villages within the province of West Java. The two villages are situated in two districts, Sumedang and Subang. A qualitative research design encourages families to actively participate in the research. The flexible guides for interviews and discussions enable them to express their thoughts, which are based on their own perspectives. As emphasized by Chambers (1997), a participatory approach is the best means to explore people's realities.

While the objective of a case study is to provide insight into an issue or to redraw a generalization (Stake, 2000; Yin, 1994), considering the nature of qualitative research, these two cases cannot form the basis for generalization either for West Java or the whole Indonesia. As stated by Merriam (2002), the intent of qualitative research is not to generalize findings, but to gain in-depth understanding.

Data collection methods for this study included observation and semi-structured interviews in the two villages with married women (15-49 years old), married men (whose wives are between 15-49 years old), contraceptive users and non-users, PPKBD volunteers, family planning field workers, village midwives, and family planning officials at sub district and district levels. In addition, focus group discussions were conducted with female and male adolescents. Guidance was provided by the National Family Planning Coordinating Board.

### **The study area**

The study areas are located within two districts, Sumedang and Subang. Sumedang is located at the central highlands while Subang is on the northern coast of West Java. West Java is Indonesia's biggest province in terms of population with 35.7 million people in 2000, which is approximately 17.3 percent of Indonesia's total population (BPS, 2003). West Java was among the first provinces to implement the government family planning programme in the 1970s (State Ministry for Population/ NFPCB, 1995). By the end of 2002, 55.7 percent of reproductive age couples in West Java were participating in the programme (BKKBN and BPS West Java, 2002). Although the total fertility rate is on the decline, the 1997 total fertility rate of 3.03 births per woman was still above the national figure of 2.78 (CBS, NFPCB and MOH, 1998).

West Java is the homeland of the Sundanese, the second largest ethnic and linguistic group in Indonesia after the Javanese who occupy the central and eastern parts of Java Island. The cultures of these two ethnic groups are related, although there are also some distinctions. The majority of the Sundanese are considered devout Muslims and more strongly adhere to Islam than the Javanese (Garna, 1984; Koentjaraningrat, 1985; Peacock, 1973). Currently, 97.5 percent of West Java population are Muslims, the rest are Protestant, Catholic, Buddhist, Hindu and some indigenous religions (Ministry of Religious Affairs, 2003). Most Sundanese, particularly in rural areas, engage in agriculture. Rice farming and fishing, along with trading, have been the main occupations of the Sundanese. Landholdings of the Sundanese villagers are small, around 0.2-0.3 hectares (Garna, 1984).

Women in West Java marry quite young, younger than women from other provinces. Although the median age of first marriage in this province has been increasing from 15.7 years in 1973 to 17.5 in 1997 (for women 40-44 years at the time of the survey), it is still below the national average of 18.1 years (CBS, et. al., 2003; Kasto, 1982 in Singarimbun, 1991). Marriages used to be arranged by relatives of the bride and groom. They selected the future spouse and decided the date of the wedding (Suhamiharja, 1984; Budiarto and Purwantini, 1987). In some cases, it is still likely to be arranged soon after the girl's first menstruation. It is the parents' concern to have their daughters married at young ages, around 13-15 years, to avoid stigmatization as an old maid. Newly wed couples generally try to set up their own households soon after they marry. Nevertheless, despite living separately in their own home, couples maintain close ties with their parents (Garna, 1984; Suhamihardja, 1984b). This

implies that although the nuclear family is the basic unit for most decisions, other members of extended families are influential in all matters including reproductive decision-making.

In Sundanese communities men are regarded as the head of the family, and they are responsible for family income. Meanwhile, women are responsible for running the household and taking care of the children. If additional help or income are needed, however, wives also work outside the house. Among Sundanese villagers it is common for husbands and wives to work together either in agriculture or in small-scale business activities (Garna, 1984; Suhamihardja, 1984).

The Indonesian Value of Children (VOC) Study in 1975 revealed that Sundanese placed more emphasis on the psychological or emotional aspects of childbearing, such as companionship, happiness, and improved relations between spouses, than the economic consequences. The study also showed that the Sundanese did not indicate strong sex preferences and drew little distinction between sons and daughters (Darroch, Meyer & Singarimbun, 1981). However, other studies have shown that couples in rural areas desire both sons and daughters. Sons are considered to be the backbone of the family and provide economic support, while daughters are regarded as care providers for the parents (Adiwisastra, 1996; Budiarto and Purwatini, 1987). As for the qualities desired in children, the VOC survey revealed that strong moral qualities, especially religious habits, are the most important traits (Darroch et al., 1981).

### **Village A, Sumedang**

Village A has a population of 3,015 people comprising 1,039 families, with an average of 2.9 members per family. The family planning programme has been implemented here since the late 1970s. At the village, PPKBD and some other volunteers (known as *kader*<sup>1</sup>) carry out the day-to-day activities under the supervision of the family planning field worker and the village midwife. The PPKBD in this village has been working since 1982 and is highly respected by the villagers.

By the end of 2002, 92.6 percent of currently married women of reproductive age were using contraception. This figure was the highest in the sub district and well above the sub district average of 81 percent. Injectables were the most popular contraceptive method, chosen by 67.1 percent of the users, followed by pills (10.9%), implants (8%), IUD (7.1%), and female sterilization (6.7%). Only one man had decided to be sterilized. Most women obtained the pills from the PPKBD, while injectables, IUD and implant were provided by the village maternal clinic or sub district health centre. Sterilization was carried out at the district hospital.

The socio-economic conditions of the residents are relatively high, as indicated by the family enumeration results<sup>2</sup>. The 2002 data showed only one family classified as 'pre-prosperous',

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<sup>1</sup> Volunteers working for government programmes at the village are usually known as 'cadres' or *kader* in Indonesian term.

<sup>2</sup> For planning and operational purposes, every year BKKBN conducts family enumerations in all villages throughout the country. Previously, this only covered demographic and family planning data, but since 1994 they also cover socio-economic data and are known as 'prosperous family' enumerations. Based on the enumeration, families are classified as pre-prosperous at the lowest level through to prosperous level III plus. The enumeration is carried out by the family planning field worker, PPKBD and other volunteers.

while the majority were classed as prosperous levels II and III. About 58 percent of the population over 19 years old have primary education, and more than 40 percent are high school graduates. Only a few older residents have no schooling or only some primary education.

The main sources of livelihood are farming rice, fruits and vegetables, as well as raising livestock (chickens, goats and ducks). Most of the farmers own a small piece of land and only a small number work as labourers. Some others are petty traders and carpenters, and a small number work as teachers and civil servants. Some young people work outside the village as factory workers (mainly males) or in Saudi Arabia (mainly females), but no accurate data on their number are available.

A vast majority of the population of this village are Muslims. Islamic religious leaders are highly respected by the people and they support the family planning programme. There are regular *pengajian* (Qur'an recitations and discussions) every week at mosques, and *madrasah* (school for Qur'an learning) throughout the village.

### **Village B, Subang**

Village B has a population of 6,056 people comprising 1,949 families, with an average of 3.1 members each. The family planning programme started here at the end of the 1970s, almost at the same time as in Village A. The current PPKBD started to work in 1993. A different feature of this village is that the PPKBD is part of the village bureaucracy under the official in charge of the social and welfare affairs. A family planning field worker and the village midwife supervise the PPKBD's work.

By the end of 2002, 69.5 percent of reproductive age couples were participating in the programme, a figure slightly lower than the sub district average of 71 percent. Injectables (39.4%) and pills (28.4%) were the most commonly used contraceptive methods, followed by IUD (22.1%), and male sterilization (9.1%). A small percentage of women used implants or had been sterilized (about 0.5% each). As in village A, the PPKBD provides pills, while the village maternal clinic provides injectables and inserts IUD. The other services are provided by the sub district health centre or the district hospital.

Residents of this village are less affluent than Village A, as indicated in the 2002 family enumeration. More than half of families were classified as poor or 'pre-prosperous'. Only 10 percent fell in the high prosperous categories. Education achievement is also low. High school graduates comprise not more than 20 percent of the population over 19 years old. About 70 percent have only primary education, the rest have only some schooling while some are illiterate.

The main sources of income are rice farming and fishing. Among those who engage in rice farming and fishing, only half own a small piece of land or a small pond, the other half work as labourers. Another source of income, *ojek* (motorcycle taxi driving), is becoming popular. Some motorcycle owners do this job between their routine works in the rice fields or fishponds. Women, single and married, often work temporarily in Saudi Arabia, but the village officials do not have the exact number.

The majority of the population in this village is also Muslim, however, unlike in Village A, religious leaders do not play important roles in family life. The village's mosques are often empty except for Friday prayers. Only the women have regular *pengajian* (Qur'an reciting) every week in each hamlet.

## **Results: Family planning decision-making**

In this section, results of the in-depth interviews are discussed to illustrate the factors that influence the decision-making process regarding family planning.

### **a. Access to information**

In both of the study areas, many informants mentioned PPKBD and the other *kaders*, the family planning field worker, and the midwife as the primary sources of family planning information. Since most of the people do not read newspapers, and they listen to the radio or watch TV mainly for entertainment, person-to-person communication conducted by these village implementers is very effective in delivering the messages. However, men are not interested in the information and do not participate or discuss this matter.

In addition to the family planning workers, family members, especially mothers, are important sources of family planning information. Some informants mentioned that their mothers' role was not limited to information sharing, but also influenced them to use family planning methods. In Village A, some of the women said they have been using contraceptives as soon as they got married because their mothers told them to do so. Since they got married early, at around 15 or 16 years old, their mother told them to use pills to delay the first birth until they were 'ready' to have a child. After the first birth, however, the informants said their mothers were not involved anymore and it is up to them to decide when to have the next child or the type of contraceptives to use.

### **b. Local knowledge**

Most of the informants in the two villages mentioned 'spacing' (*menjarangkan*) when asked about their intention of using family planning methods, including those who said they did not want another child. Upon being asked about their opinion of family planning, they said, "...it's good because births can be regulated, so children are not too closely spaced". This might be due to religious leaders' messages which usually emphasize spacing as the objective of family planning, rather than for limiting fertility which can be regarded as against God's will. This perception is the key to acceptance of family planning among religious communities such as the people of Village A.

### **c. Gender relations**

With regard to fertility decisions, women generally made the decisions. Men consider family planning as women's business and leave the decision to participate and to choose a particular method to their wives. Many male informants were unaware of the family planning workers' activities in the village and they seldom had contact with the workers.

As a common practice, most of the women said they consulted their husbands before making decisions. The husbands generally approve their wives intention to use contraceptives, but some men raise concerns regarding some particular methods, because of its side effect or other concerns. Nevertheless, since family planning is considered as women's business, women take responsibility for the use of the methods.

As mentioned above, men are regarded as the head of the family. The traditional division of labour between wives and husbands was evident in the two villages, though some men were also involved in household chores when their wives were busy. It is common to see men carrying small children in the two villages. Some of the women work outside the house to help augment family income, such as in *emping*<sup>3</sup> industries (in village A) or as food vendors. The role of husbands as the head of the family includes their role as dominant decision-maker. Upon being asked who made decisions for important family matters, most informants stated that the last word is usually given by the husbands. Nevertheless, many informants mentioned that any decision was usually preceded by discussion between husband and wife.

Focus group discussions with the young men in the two villages confirmed that family planning is perceived as a women's responsibility. They were not familiar with the idea that men should also participate in family planning programmes. The boys in village A mentioned that "...family planning methods are only for women, not for men" and they were going to leave family planning matters to their future wives. Similarly, the boys in Village B commented, "Men participate in family planning? Men cannot use family planning methods, they are for women." Interestingly, the girls in the two villages were aware that men could participate in family planning by being sterilized.

#### **d. Value of children**

In the two villages children are no longer perceived as 'additional hands' in the fields, even though most informants are engaged in agriculture. In line with parents' rising aspirations to provide an adequate lifestyle for their children, most boys and girls now go to school at least until junior high school. Parents' aspiration to provide better education was one of the most stated reasons for limiting the number of children in both villages. They wanted their children to have a higher level of education than themselves as education is seen as a pre-requisite to access to better jobs and a better future.

Children are still regarded as insurance for parents' old age security. Although most informants said they do not want to be a burden to their children in their old age, they expected the children to take care of them, especially when they get sick. Some informants in village B mentioned they wanted to have 3 or 4 children so that they have 'choices' where to live when they get old.

#### **e. Family size preferences**

It seemed the small-family norm has been adopted in these two villages. Most informants stated that young couples in their villages have fewer children than the older couples. However, the general definition of 'small' seems to be slightly different between the two

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<sup>3</sup> *Emping*: Crackers made from *mlinjo* (Gnetum gnemon). Making *emping* is the main industry in Village A.

villages. In Village A, two or three children are sufficient, while in Village B three or four children suffice. Most informants in both villages who already have two or more children said they did not want another child, while those who only have one child said they would like to have one or two more.

The informants had different attitudes regarding childbearing. Some said they planned the number of children they would like to have in the future, while others did not. The plan was either a joint decision between husband and wife or made solely by the wife. Some informants who said they did not have a plan, including those who answered 'we'll see about that later' (*bagaimana nanti*) or 'it is up to God', were actually using contraceptives for 'spacing'.

Economic pressure was one of the most common reasons for limiting the number of children. The informants stated that their economic condition would not allow them to have many children. They also contended that the cultural proverb 'more children, more economic fortune' (*banyak anak, banyak rejeki*) which is widely known in many Indonesian cultures, is no longer valid in practice.

#### **f. Sex preferences**

Most informants who said they only wanted two children stated that it did not matter whether these are boys or girls. However, when asked further whether they were going to 'try again' to get the other sex, some of them, especially in Village B said, "yes...probably". Meanwhile, some informants explicitly said that they wanted to have one of each sex.

#### **g. Age of childbearing**

As mentioned above, 15 or 16 years old is now considered by people in the two villages to be too young to have children. After three decades, the government family planning programme seems to have been successful not only in introducing the small-family norm but also the ideology of bearing children between 20-30 years old. Women 30-40 years old, who have experienced the benefits of using contraception, now persuade their newly wed daughters to defer the first child until around 20 years old. Today, young couples are mostly aware of this recommendation.

Women who chose sterilization mentioned they decided to use this permanent method because they were 'too old' to have another child. Most of them decided to be sterilized at the age of 29-31 years old. This might be because they started childbearing at an early age, between 15-16 years old. Currently, all of them already have at least one grandchild.

#### **h. Capability to control fertility as an important step in women's empowerment**

In family planning, empowerment implies that people have access to the means to control fertility that enable them to decide the number, spacing, and timing of their children. Two important elements leading to empowerment are: access to information and access to affordable contraceptive services.

In the two villages, women already had the basic knowledge of family planning concepts, such as the idea that 'two children are enough', types of contraceptives, service outlets, best age for childbearing and healthy intervals. Nevertheless, local norms and gender attitudes

affect their understanding of the concepts. One important example is the perception that caring for children and family planning are women's business and responsibility. This perception was clearly stated by the informants. Their contraceptive preferences reflect that the women bear the responsibility to use family planning methods.

Most of the women made their own decisions regarding the type of contraception they wanted to use. This was facilitated by the information, education and communication activities carried out by the village implementers. Nevertheless, rumours and inadequate information about a particular contraceptive method still prevail in these villages thereby affecting local preferences. In Village B particularly, inadequate information on IUD, implants or sterilization make poor women choose to pay for the pills or injectables rather than getting free government services for those methods.

Access to contraceptive services undoubtedly is one of the important factors that enable a couple to control their fertility. In the two villages, the PPKBDs offered pills while injectables and IUDs were provided by the village midwife. The establishment of the village clinic staffed by a midwife enabled the couples to get family planning services within their village. Many informants said they previously had to travel to the sub district health centre which meant extra expense, but now "...it's easy and handy to get contraception, we can just walk to the clinic." However, for implant insertion they still have to go to the sub district health centre and for sterilization to the district hospital. For poor families, services for implants and sterilization including the transportation costs are subsidized by the programme.

## **Conclusion**

Generally, decision-making processes relating to childbearing and contraceptive use are made by women. Childbearing and family planning are regarded by men as women's business. As a common practice, some of the women ask their husbands' approval but others make the decisions for themselves without involving their husbands.

There are several factors that influence the decision-making process:

a) Government family planning programme

The government family planning programme in both villages plays a major role in influencing people to adopt the small family norm. The programme has established a network of field workers and volunteers who provide information and services readily accessible to the rural people. These are widely acknowledged in the villages.

b) Other family members and neighbours/peers

In both villages, mothers and neighbours have a strong influence on women's decision about childbearing and contraceptive use. The influence is more intense for newly wed women since they married at an early age. Most of the newly married couples reside close to the wives' parents, this explains the strong influence of mothers. Moreover, regardless of their residence, couples usually maintain close ties with their parents.

c) Community leaders

Endorsement by community leaders has a more important influence in Village A than in Village B. In Village A, religious leaders and village officials are highly respected by the people, whereas in Village B there is no obvious leadership.

d) Socio-economic status and education

The government programme, family ideology and opinion leaders have stronger influences on family planning decisions than their socio-economic status. This overrides the factor of education. In both villages, accessible information and services, including subsidies for the poor, allowed women from different socio-economic status and education levels to use family planning methods. This is congruent with Freedman and Freedman's (1992) statement that socio-economic differentials in contraceptive use weaken in the presence of strong family planning programmes. These cases suggest the importance of the implementation of the programme by local workers at grassroots level. Their efforts in providing family planning information and services to the rural people must be continuously supported if the programme is to maintain the effectiveness of contraceptive use and reduce fertility.

e) Empowerment

The women in the two villages, especially in Village A, already have the basic knowledge of family planning concepts, such as the best age of childbearing, the healthy interval, types of contraceptives, side-effects of each method, and service outlets. This information has enabled the women to make informed choices on contraception and thus take control of their own fertility. The presence of a village midwife and maternal clinic also allowed them to have access to safe contraceptive services. However, some poor women are still faced with problems in obtaining their preferred methods on a regular basis.

Local norms and gender attitudes are key factors that affect people's understanding of family planning. One example is the perception that caring for children and family planning are women's business and responsibility. Their contraceptive preferences reflect that women bear the responsibility to use family planning methods. Thus, it can be said that women in these villages were partially empowered. They were not able to make their husbands share the responsibility to use contraception themselves or control their sexual activities. The women's role in terms of decision-making fell within the framework of the interests of their husbands.

In addition to gender attitudes, men's ignorance of family planning is partly due to the nature of the programme, which focuses the services and information on women. In both villages, family planning information sharing and activities were carried out mainly in *posyandu*<sup>4</sup> where men rarely attend.

## Recommendation

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<sup>4</sup> *Posyandu*: integrated family planning and health services post. *Posyandu* activities are carried out monthly by *kaders* and midwife or nurse, which includes children weighing, health and nutrition information, distribution of vitamin A for children and iron tablets for pregnant women, immunization, and family planning services.

The above findings suggest that characteristics of families in these villages have undergone some changes. Widespread family planning information and services have enabled the villagers to control their fertility and thus bring down family size. Therefore, future family planning and development programmes should focus their attention on:

- 1) Promoting gender equity and increasing men's involvement in family planning through tailoring information and services to their needs.
- 2) Providing information and education for adolescents in order to address the gender bias and formulate their perceptions on responsibility for the future.
- 3) Improving the quality of services for both women and men in places such as Village A where contraceptive use is almost universal among currently married women 15-49 years. In places such as Village B, efforts to increase contraceptive use are still needed, including appropriate information and back-up services to eliminate negative rumours regarding particular methods.
- 4) Promoting programmes to increase the number of job opportunities at local level as the education levels of boys and girls increased by families' aspiration for better life.

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