JIAPI: Jurnal Ilmu Administrasi dan Pemerintahan Indonesia
Volume 06, Issue 02, December 2025 (page 139-152)
ISSN: 2774-2423 (Print), 2746-5918 (Online)
https://doi.org/10.33830/jiapi.v6i2.11495

Gender Inequality in the Family Planning Program: A Case Study of Couples of Reproductive Age in Fataatu Village, Ende Regency

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Received: 11 February 2025; Revised: 16 December 2025; Accepted: 16 December 2025

Abstract

This study aims to analyze the causes of gender inequality in contraceptive use among couples of reproductive age in Fataatu Village, Wewaria Subdistrict, Ende Regency. The research employs a qualitative descriptive approach. Data were collected through observation, documentation, and interviews with 13 informants. The findings reveal several key points. First, stereotypes in contraceptive use are influenced by stigma and cultural norms that often frame family planning programs (KB) as primarily a woman's responsibility. Second, no evidence of subordination in decision-making was found, as decisions were reached through mutual discussions between husband and wife. Third, women bear a double burden in contraceptive use, willingly accepting the consequences and side effects without objection. From an external perspective (etic), women are perceived to experience inequality in contraceptive use. However, from an internal perspective (emic), as expressed by husbands and wives, the use of contraceptives by women is considered fair. Several factors drive this perception. First, local culture normalizes contraceptive use by women more than by men. Second, women tend to possess better knowledge of contraceptives, while men lack awareness of male contraceptive options. Third, women are more accepting of the side effects associated with contraceptive use compared to men.

Keywords:
contraceptive use, family planning program, gender inequality

Introduction

Gender is a social construct that differentiates roles, responsibilities, and power relations between men and women in social life. These differences are not merely biological but are shaped by norms, values, and social practices that are institutionalized within social, economic, and political structures. In the context of public policy, gender constructions significantly influence how policies are designed, implemented, and evaluated, as well as who ultimately bears the benefits and burdens of such policies. Therefore, gender analysis serves as a crucial instrument for identifying whether a policy promotes social justice or, conversely, reproduces existing inequalities.

Gender inequality arises when differences in roles and status lead to unequal treatment, manifesting in restricted access, marginalization, subordination, stereotyping, and disproportionate multiple burdens. Rokayah, Inayanti, and Rusyanti (2021) argue that gender inequality directly impedes the fulfillment of human rights, including social, economic, political, and cultural rights. Within the framework of public policy, gender inequality often

does not appear explicitly but is embedded in policy designs that are formally gender-neutral yet generate unequal outcomes in practice, particularly disadvantaging women.

In public policy analysis, the gender perspective is commonly understood as part of the gender mainstreaming approach, which emphasizes integrating the interests, experiences, and needs of both men and women across all stages of the policy cycle, from agenda setting to policy evaluation. This approach goes beyond merely positioning women as policy targets; it critically examines power relations, role distributions, and responsibility allocations produced by policy interventions. Consequently, gender analysis in public policy functions as a tool to assess whether a policy contributes to transforming gender relations or instead perpetuates structural inequalities.

In Indonesia, formal commitment to gender mainstreaming is articulated through Presidential Instruction No. 9 of 2000 on Gender Mainstreaming in National Development. This policy mandates all ministries, government agencies, and local governments to integrate a gender perspective into development planning, implementation, monitoring, and evaluation. However, numerous studies indicate that the implementation of gender mainstreaming often remains administrative and procedural, failing to address substantive dimensions of power relations and gendered role inequalities in sectoral policies, including reproductive health policies.

One of the key strategic policies in reproductive health is the Family Planning (FP) Program, as regulated under Government Regulation No. 78 of 2014. This program aims to regulate fertility, birth spacing, and ideal childbearing age through the promotion, protection, and provision of contraceptive services in accordance with reproductive rights. Normatively, the FP program is designed to improve family quality and overall societal welfare. Law No. 52 of 2009 explicitly states that contraceptive services are a shared responsibility between husbands and wives, granting equal rights and obligations in choosing appropriate contraceptive methods.

However, from a gender-based policy analysis perspective, it is essential to question the extent to which this principle of equality is realized in practice. Policies that formally emphasize shared responsibility may produce unequal outcomes when their implementation is shaped by gender-biased social norms, cultural values, and service delivery structures. This is precisely where gender analysis becomes critical in assessing the gap between policy design and implementation realities.

Empirically, Indonesia's FP program continues to exhibit significant gender disparities in contraceptive use. Most contraceptive methods are directed toward women, both in terms of method availability, service provision, and target populations for socialization efforts. Mansur and Marmi (2020) define contraception as the use of devices, medications, or medical procedures to prevent pregnancy, primarily targeting Couples of Reproductive Age (CRA), defined as married couples in which the wife is aged 15–49 years. Although conceptually CRA includes both partners, FP service delivery practices tend to focus predominantly on women's bodies as the primary sites of intervention.

A growing body of literature has examined the low participation of men in FP programs. Delia (2020), for example, found that in Macanre Village, male involvement in contraceptive use was extremely limited due to deeply rooted social beliefs that reproductive health is a woman's responsibility. Other studies similarly highlight that male contraception is often perceived as taboo, traditional masculinity norms discourage male participation, and FP socialization efforts rarely target men as active policy subjects.

National data further reinforce these findings. The 2017 Indonesia Demographic and Health Survey (IDHS) reported that only 2.7% of FP participants were men, while 97.3% were

women. Data from the BKKBN New SIGA system in 2022 show little change, with male participation at 2.48% and female participation at 97.52% (Supianto, 2023). The persistently low level of male participation over time suggests that this disparity is not merely an individual choice but reflects structural issues embedded within FP policy design and service delivery.

These inequalities become even more pronounced at the regional level, particularly in areas with strong socio-cultural characteristics. According to Statistics Indonesia (BPS), in East Nusa Tenggara Province in 2022, out of 318,148 FP acceptors, only 2,144 were men. A similar pattern is observed in Ende Regency, where male acceptors numbered only 339 out of 11,289 FP participants. At the sub-district and village levels, the imbalance is even more extreme.

In Wewaria Sub-district, the number of FP acceptors in 2023 reached 460 individuals, yet only two men opted for a vasectomy. Fataatu Village represents a concrete illustration of total gender imbalance in contraceptive use. Of the 180 Couples of Reproductive Age in the village, 96 couples participated in the FP program, and all acceptors were women.

Table 1. Types of Contraception Used by Acceptors in Fataatu Village

Contraceptive Method	Women	Number	Men	Number
Implant	✓	29	MOP	0
IUD	✓	15	Condom	0
Tubectomy (WOW)	✓	5		
Injection	✓	35		
Pills	✓	12		
Total		**96**		**0**

Source: Monthly Field Control Report at Sub-district Level

Based on the data presented in Table 1, all contraceptive methods are used exclusively by women, while no male acceptors are recorded. This condition indicates that responsibility for contraceptive use is entirely borne by women. From a gender-based public policy analysis perspective, this situation reflects an unequal distribution of policy burden, in which women disproportionately bear the health risks, side effects, and social consequences generated by the Family Planning (FP) policy.

A substantial body of research demonstrates that women as FP acceptors frequently experience physical and psychological effects, including menstrual disorders, fatigue, weight fluctuation, and emotional stress. Hendarso (2008) conceptualizes this condition as part of women's multiple burden, wherein women are expected not only to perform domestic and productive roles but also to assume reproductive responsibilities arising from gender-biased policies. These burdens are often normalized through social norms that frame contraception as a woman's obligation, given its perceived association with women's bodies and reproductive functions.

Although numerous studies have documented the low level of male participation and the dominance of women in FP programs, most existing research focuses primarily on individual behavior, knowledge, or attitudes toward contraception. Compared with a few studies, the FP program is examined as a public policy product that interacts with social structures, cultural norms, and gendered power relations at the local level. Moreover, research that integrates both

etic and emic perspectives, capturing how gender inequality is analytically identified by researchers and subjectively interpreted by policy beneficiaries, remains limited.

It is this gap that the present study seeks to address. Rather than merely describing the low level of male participation in the FP program, this research analyzes how gender inequality is produced, normalized, and interpreted within the local context of Fataatu Village. Drawing on Fakih's (2016) framework of gender injustice, the study examines key forms of inequality, namely stereotyping, subordination, and multiple burdens, in the implementation of the FP program, while situating these dynamics within local socio-cultural contexts and everyday policy practices at the village level.

Accordingly, this study is expected to contribute theoretically to the development of gender analysis in public policy by moving beyond normative policy design toward a critical examination of implementation dynamics. Empirically, it offers insights into how reproductive health policies operate within culturally embedded local settings. The findings are also intended to serve as a basis for critical reflection in formulating more gender-equitable FP policies, not only at the normative level but also in implementation that meaningfully engages with communities' lived realities.

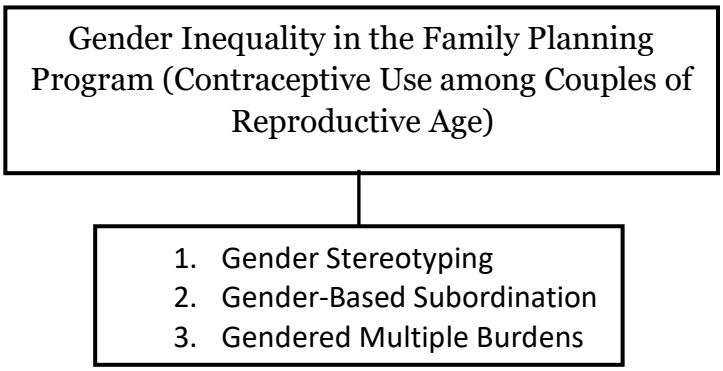

Figure 1. Research Framework

Source: Adapted from Mansour Fakih and elaborated by the author (2024).

Method

This study employs a descriptive qualitative research design using a case study approach. This approach was selected because the research aims to develop an in-depth understanding of the meanings, processes, and social dynamics surrounding gender inequality in contraceptive use among Couples of Reproductive Age (CRA). A case study design enables the researcher to examine the Family Planning (FP) policy contextually, considering the interconnections among public policy, socio-cultural norms, and everyday practices at the local level. The study was designed to comprehensively explore the phenomenon through data collection techniques, including observation, in-depth interviews, and documentation, thereby enabling a holistic understanding of the social reality under investigation.

The research was conducted in Fataatu Village, Wewaria Sub-district, Ende Regency. The study site was selected based on preliminary observations and administrative data indicating the complete dominance of women as FP acceptors and the absence of male participation, suggesting gender inequality in the implementation of the FP program. Field data collection was conducted between May and June 2024, allowing sufficient time for repeated interviews and participatory observation to generate rich, in-depth data. The relatively homogeneous socio-cultural characteristics of the village and the strong influence of gender norms make

Fataatu Village a relevant context for examining gender inequality in reproductive health policy.

Informant selection used purposive sampling, in which participants were deliberately chosen based on specific criteria relevant to the research objectives. This technique enabled the researcher to obtain data from individuals with direct experience and in-depth knowledge of contraceptive use and gender relations within the FP program. Clear inclusion and exclusion criteria were established to ensure that the collected data aligned with the study's focus. Female informants were selected from among women of reproductive age who had used contraceptive methods for a certain period and had direct experience of the effects of FP participation. Male informants were selected from husbands whose wives used contraception and who were involved in the decision-making process regarding FP use. FP officers were selected based on their direct involvement in FP service delivery and socialization activities in Fataatu Village. Individuals who were not part of Couples of Reproductive Age, had no experience with contraceptive use, or were unwilling to provide detailed information were excluded from the study.

Based on these criteria, the study involved three main categories of informants: women who were FP acceptors, men who were husbands of FP acceptors, and FP officers. The distribution and number of informants are presented in Table 1, which is placed in this section to provide a clear overview of the composition of research participants.

Table 2. Research Informants

No	Category	Number (persons)
1	Women/Wives (FP users)	6
2	Men/Husbands (non-users)	6
3	FP Officer	1
	Total	13

Source: processed by the author

The data were analyzed using thematic analysis. The analytical process began with repeated reading of interview transcripts, observation notes, and supporting documents to develop a comprehensive understanding of the data. Subsequently, data were coded by grouping information into key themes relevant to the research focus, namely gender stereotyping, subordination in decision-making, and multiple burdens in contraceptive use. These themes were then analyzed interpretively within the theoretical framework of gender injustice, enabling an analytical explanation of the relationships among FP policy, social norms, and women's lived experiences.

To ensure data validity and credibility, this study employed triangulation techniques. Triangulation was conducted by comparing data from different data collection methods, interviews, observation, and documentation, and by cross-checking information from informants across three categories: women, men, and FP officers. In addition, limited member checking was conducted with selected informants to ensure that the researcher's interpretations accurately reflected the informants' experiences and intended meanings. Through these strategies, the reliability and scientific rigor of the research findings are ensured.

Results and Discussion

Gender inequality happens when one group faces disadvantages, burdens, or limits on their rights because of unequal roles and power between men and women. Fakih argues that gender inequality is not just the result of obvious discrimination, but also comes from social systems that seem 'natural,' are normalized, and are accepted in daily life. So, gender inequality is shaped by ongoing interactions between social structures, cultural norms, and public policies that influence people's experiences over time. The Family Planning (FP) program aims to improve family welfare by managing fertility, spacing births, and determining the ideal age to have children. However, this study finds that, at the village level, the FP program does not promote equal responsibility. Instead, it often places most of the burden on women, making them both the main participants and the ones who face the most risk.

Women are the main users of contraception at every level. National data show that women make up almost all contraceptive users, while men rarely participate. This pattern is also seen in regions and villages. For example, Table 1.1 shows that in Fataatu Village, all FP participants are women, and no men are recorded. This is not just a statistic; it shows that women carry all the responsibility and consequences of contraceptive use. If public policy divides benefits and burdens, then in Fataatu Village, the FP program puts most of the burden on women, leading to health risks, psychological stress, and social challenges both at home and in the community.

To sharpen the interpretation of these empirical findings, this study employs Fakih's framework of gender injustice, which highlights key forms of inequality, including stereotyping, subordination, and multiple burdens. This framework enables an understanding of gender inequality in the FP pTo better understand these findings, this study uses Fakih's framework of gender injustice, which focuses on stereotyping, subordination, and multiple burdens. This approach helps explain gender inequality in the FP program as more than just a matter of 'who uses contraception.' It looks at how social norms, policy practices, and unequal impacts shape the process. The study also uses both outside (etic) and inside (emic) perspectives to explore the gap between the researcher's analysis and how married couples see their own experiences, especially when situations that seem unfair in theory are seen as 'normal' or 'fair' by people in the village. The process aimed to develop a comprehensive understanding of the research context, key actors, and recurring experiential patterns. Second, the researcher conducted initial coding of relevant data segments, including statements related to "who is responsible," "who is offered contraception," "how decisions are made," "reasons for male non-use," and "physical and psychological impacts on women." These codes were generated inductively from data rather than imposed solely by theoretical categories.

Next, the researcher grouped the initial codes into broader themes. These themes were linked to Fakih's framework: (1) stereotyping in the FP program, such as labeling FP as women's responsibility, taboos about male contraception, and gender-biased encouragement; (2) subordination, including decision-making patterns, women's bargaining power, and spousal control; and (3) multiple burdens, like side effects, physical and psychological impacts, and ongoing domestic duties. The researcher then checked whether these themes were consistent across groups: women, men, and FP officers, and looked for any differences to avoid overgeneralization. Finally, each theme was connected to the local context of Fataatu Village and how the FP policy is put into practice, including how information is shared, how services are delivered, and the main reproductive health norms. This approach helped the analysis go beyond mere quotation and showed the social and policy factors shaping participants' experiences.

A. Stereotyping in Contraceptive Use

Stereotyping constitutes one form of gender inequality manifested through social labeling that assigns women and men to fixed and taken-for-granted roles. In the context of contraceptive use, the most dominant stereotype is the assumption that family planning is inherently a "women's issue." This stereotype operates at multiple levels: the ideational (beliefs and perceptions), practical (patterns of contraceptive use), and institutional (modes of socialization and health service delivery). It constructs a social normality in which contraception is attached to women's bodies because pregnancy and childbirth are biologically experienced by women. However, when this stereotype becomes the basis for allocating responsibility, gender relations become unequal: women are perceived as naturally responsible for bearing contraceptive risks, while men are viewed as legitimately uninvolved.

1) Perceptions of the Family Planning Program and Responsibility Allocation

According to Sondang P. Siagian (1989, cited in Soraya, 2018), perception is the process by which individuals organize and interpret impressions in order to assign meaning to their environment. Field findings indicate that community perceptions of the Family Planning (FP) program in Fataatu Village are generally positive. The program is considered beneficial for regulating the number of children, spacing births, and family planning. However, this positive perception coexists with a gender-biased understanding of responsibility.

Interviews with Mr. Xaverius Ra'i and Mrs. Monika Fitri on 14 May 2024 illustrate this dual perception. Mr. Ra'i stated: *"I think the family planning program is very good in helping families regulate the number of children. As for responsibility, I think it should be shared, but in practice, women use contraception more often. As husbands, we just support them, and if my wife wants to stop, that's fine"* (XR). Mrs. Fitri similarly noted: *"The family planning program helps my husband and me plan birth spacing and manage the family better. I think it's a shared responsibility, but mostly wives use contraception because it directly relates to women's bodies"* (MF).

Interviews with Mr. Antonius Kebhi and Mrs. Yuliana Mara on 14 May 2024 further confirm this pattern. Mr. Kebhi stated: *"The family planning program is good and helps couples manage birth spacing. It is the wife's responsibility because wives know more and often seek information or consult with FP officers"* (AK). Mrs. Mara added, *"The program has both positive and negative sides. It helps with planning and spacing births, but there are many side effects for women's health. Yes, it is my responsibility, because I am the one who chooses to use contraception"* (YM).

The analysis reveals two interrelated meanings. First, there is a normative acknowledgment that family planning is a shared responsibility. Second, this normative acknowledgment does not eliminate gender-biased social practices: women remain positioned as the "natural" and primary users of contraception. In other words, the discourse of "shared responsibility" operates as an idealized narrative, while everyday practices continue to be structured by norms that link contraception to women's bodies. This demonstrates that stereotyping functions not merely at the level of individual opinion, but as an unwritten social rule shaping concrete behavior.

Within the socio-cultural context of Fataatu Village, reproductive matters are firmly situated within the female domain. Mrs. Ance's reference to the "fear of disrupting household harmony" if husbands use contraception signals an important insight: male involvement in family planning is not only a medical issue but also a moral and social one. In many rural communities, condom use is often associated with extramarital sexual relations or marital distrust. Consequently, resistance to male contraception is not simply due to lack of knowledge, but is reinforced by social stigma. This represents a form of stereotyping that

operates as social control: women are "permitted" to use contraception, while men are considered "inappropriate" users.

Comparative studies from other locations reinforce this interpretation. Delia (2020) found low male involvement in Macanre Village due to strong beliefs that reproductive health is women's responsibility. Similarly, Kiswanto, Wardani, and Hapsari (2019) reported that the perception of family planning as a women's issue remains dominant and serves as a major barrier to male participation. The findings from Fataatu Village align with these studies but are more extreme, as there are no male contraceptive users at all. This indicates that stereotyping in Fataatu does not merely reduce male participation but effectively eliminates it.

2) Offers and Encouragement to Use Contraception

Stereotypes are embedded in community perceptions and reproduced through policy practices and service delivery. Interview data indicate that encouragement to use contraception is primarily directed toward women, while men are rarely, if ever, approached. This creates a gender-biased "policy pathway" in which women become the primary targets of socialization, consultation, and service provision, while men remain outside the scope of intervention.

Interviews with Mr. Servasius and Mrs. Maxima Songi on 14 May 2024 illustrate this clearly. Mr. Servasius stated: *"I was never offered contraception, and I didn't even know there was* contraception *for men because all I've ever known is women's contraception"* (SS). Mrs. Songi added, *"I used contraception because of encouragement and offers from health officers. I was willing because many women here also use contraception. Men don't want to use it, or it's very rare to find men who do"* (MS).

A similar pattern emerged in interviews with XR and MF. Mr. Ra'i noted: *"Both spouses could actually use contraception, but in most households, the wife uses it. Women are the ones encouraged to use contraception. I was never offered it, and I only recently learned that male* contraception *exists"* (XR). Mrs. Fitri echoed this experience: *"The encouragement to use contraception was directed at me, not my husband. Men here rarely use contraception. I was offered contraception by health workers, and I already intended to use it"* (MF).

Interviews with AK and YM further strengthen this finding. Mr. Kebhi stated: *"I was never offered contraception. I want to have many children, so I don't want to use contraception. I also just learned that there is contraception for men"* (AK). Mrs. Mara explained: *"I took the initiative to use contraception and was encouraged by my mother and health workers. Offers are mostly* directed *at women because it has become customary here that family planning is the wife's responsibility"* (YM).

The statement from the FP officer (Mrs. Filomena) on 17 May 2024 is particularly revealing regarding how policy bias operates in practice: *"As the data show, women dominate as contraceptive users here. Women consult more often about contraception. There are no male users in Fataatu Village. We encourage women more because they are more willing. For men, contraception is still considered taboo or embarrassing. We conduct socialization, but very few men want to participate. In this village, there are no male acceptors. There are two male acceptors in the sub-district, but they live in other villages. They chose a vasectomy because they felt sorry for their wives. We arranged the surgery and accompanied them to Ende, and it went smoothly."*

From a public policy perspective, this statement reveals two key issues. First, health workers tend to encourage women because they are perceived as "more willing," which may be pragmatic in the short term but ultimately reinforces structural bias by locking responsibility onto women. Second, although male participation barriers are acknowledged as stemming

from taboo and shame, existing interventions have been insufficient to transform these norms. Thus, stereotyping in Fataatu Village is not merely a cultural issue but also a policy capacity and design issue, raising critical questions about whether the FP program possesses specific strategies to challenge taboos and renegotiate masculinity norms in rural communities.

Comparative evidence from other studies further contextualizes these findings. Putra et al. (2020) emphasize the influence of economic factors on women's contraceptive choices, while Hartini (2011) highlights that primary healthcare services often focus on maternal and child health, thereby limiting access to male contraception. Rochimah et al. (2023) also identify low male participation in FP outreach as a significant barrier. Accordingly, the findings from Fataatu Village align with national patterns but demonstrate heightened intensity: limited offers to men combined with entrenched taboos have resulted in the complete absence of male contraceptive users.

B. Subordination

Subordination refers to a social valuation or assumption in which the roles performed by one gender are considered inferior to those of another. Social and cultural values have long structured gender roles in unequal ways, associating men primarily with public and productive roles, while women are more closely linked to domestic and reproductive responsibilities. Within the context of contraceptive use, subordination denotes situations in which women are positioned in relatively less empowered roles, particularly when their choices and responsibilities related to contraception are shaped or constrained by male authority or socially sanctioned expectations. This includes conditions in which women are more frequently expected to comply with decisions regarding contraceptive use or to bear responsibility without equivalent male participation.

This study examines subordination by focusing on how women within Couples of Reproductive Age (CRA) experience decision-making processes related to contraceptive use, as well as how cultural norms influence the formation and normalization of such power relations. Two analytical subthemes are explored: (1) decision-making dynamics in contraceptive use and (2) considerations underlying contraceptive choices.

1) *Decision-Making in Contraceptive Use and Reasons for Use*

Decision-making in contraceptive use concerns how couples determine who uses contraception and what considerations precede that decision. Interviews with several couples in Fataatu Village indicate that decisions are generally not made unilaterally but emerge through communication and mutual agreement within the household. This pattern initially appears in the narratives of Mr. Emanuel Edo and Mrs. Rosadelima Ance (25 May 2024), who emphasized the presence of consultation and consent prior to contraceptive use. Mr. Emanuel stated, "Before using contraception, my wife asked me first. I agreed that she should use it" (EE). Correspondingly, Mrs. Rosadelima emphasized that the decision arose from joint discussion: "I asked my husband for permission first, we discussed it, and he agreed. So I used contraception" (RA).

A similar pattern of discussion was evident in interviews with Mr. Ferdi Gado and Mrs. Dorotea (16 May 2024). After describing an exchange of opinions, Mr. Ferdi noted that his wife played an active role in selecting the method she considered suitable: "Before using contraception, my wife discussed it with me. She wanted to use it and chose the method that suited her" (FG). This was reinforced by Mrs. Dorotea, who framed the discussion as part of shared household interests: "Yes, my husband and I discussed it before using contraception, because this is for our mutual interest as a married couple" (DT).

Consistency in these findings also emerged from interviews with Mr. Servasius and Mrs. Maxima Songi (14 May 2024). While spousal approval remained significant, decisions were framed as deliberative rather than coercive: “My wife wanted to use contraception and asked for my approval as her husband. I agreed as long as she felt comfortable” (SS). Mrs. Maxima emphasized the consensual nature of the decision and the absence of external pressure: “If we decide to use contraception, I must ask my husband’s permission… before using it, we exchange opinions and decide together. It is purely a joint decision” (MS).
Taken together, these interviews indicate that contraceptive decision-making in Fataatu Village is largely conducted through spousal discussion and mutual agreement. This pattern reflects a relatively modern decision-making model, in which couples have space for negotiation and comparatively equal rights in determining choices (Hanifah et al., 2023). Although women often initiate contraceptive use due to their direct bodily involvement, husbands generally provide consent and support. Accordingly, explicit subordination does not appear prominently at the level of formal decision-making mechanisms, as decisions are reached through communication and consensus.

2) Considerations for Contraceptive Use

This study further explores why women tend to use contraception while men generally do not. Field findings reveal that such decisions are shaped not only by individual preferences but also by knowledge levels, social norms, and practical household experiences. This dynamic is clearly illustrated in interviews with Mr. Servasius and Mrs. Maxima Songi (14 May 2024). Mr. Servasius explained his refusal by referencing feelings of awkwardness and shame, alongside limited knowledge of male contraceptive methods: “I don’t want to use contraception because it feels strange for men to use it—it’s still rare. It’s embarrassing because women usually use it. I know about condoms, but I don’t use them because it’s not common, and since I have a wife, it’s fine not to use condoms. As for vasectomy, I only recently learned about it” (SS). This statement indicates that low male participation is not merely a matter of preference but is shaped by social stigma and limited literacy regarding male contraception.

Similar knowledge constraints were evident in interviews with Mr. Emanuel Edo and Mrs. Rosadelima Ance (15 May 2024). Mr. Emanuel stated, “I actually don’t know much about male contraception. I don’t use condoms because they’re uncomfortable, and I didn’t even know about vasectomy” (EE). In contrast, Mrs. Rosadelima articulated a more pragmatic rationale from a female perspective, grounded in economic and caregiving considerations: “Contraception helps space children. Given our living conditions, without contraception it would be difficult to manage childcare, expenses, and schooling. It’s better that I use contraception” (RA). This contrast illustrates how women’s decisions are often driven by calculations of household burden, while men’s non-participation is shaped by informational gaps and comfort considerations.

These patterns were reinforced by interviews with a younger couple, Mr. Antonius Kebhi and Mrs. Yuliana Mara (14 May 2024). Mr. Antonius reiterated that limited knowledge was the primary reason for his non-involvement: “The reason I don’t use contraception is that I don’t know much about male contraception. For family planning matters, my wife is the one who participates” (AK). Meanwhile, Mrs. Yuliana linked her contraceptive use to both the availability of options and early marriage: “There are more contraceptive options for women than for men, and because I married young, I use contraception to space births” (YM). Thus, women’s contraceptive use is closely connected to the structural reality that female methods are more varied and more accessible than male methods.

Based on the interviews, several key reasons explain women's dominance as contraceptive users. First, economic considerations and domestic burdens play a central role. Women's awareness of household economic conditions and caregiving responsibilities motivates them to adopt contraception as a strategy for managing reproductive and productive burdens. This finding aligns with Putra et al. (2020), who demonstrate that family economic status significantly influences contraceptive choices among women of reproductive age. Second, access and service availability strongly favor women. Women are more frequently encouraged to use contraception due to the wider range of available methods and health services that prioritize female reproductive health. Kusumaningrum (2009, cited in Hartini, 2011) notes that men's limited access to contraception is partly attributable to primary healthcare services that focus predominantly on maternal and child health, thereby marginalizing male contraceptive options.

Conversely, men's reluctance to use contraception converges around two reinforcing factors. First, male contraception remains socially taboo and associated with shame, resulting in low participation, particularly in the absence of strong encouragement from health services or social networks. Rochimah et al. (2023) identify low male participation in family planning outreach as a major barrier to the implementation of male contraception in Indonesia, contributing to limited knowledge and low social readiness. Second, practical discomfort, especially with condom use, is frequently cited by men as a deterrent. Dausu (2020) demonstrates that perceived discomfort is a significant factor reducing male participation in family planning programs, especially when prevailing social norms do not support male contraceptive use.

These findings can be interpreted through Bertrand's framework (as cited in Wijayanti, 2021), which emphasizes that contraceptive use is shaped by sociodemographic, sociopsychological, and health service factors. In Fataatu Village, sociodemographic factors such as household income intersect with sociopsychological factors, including attitudes, beliefs, and stigma surrounding male contraception. At the same time, health service factors, particularly limited information dissemination and minimal male engagement in outreach, reinforce gendered patterns of participation. Together, these factors explain why women disproportionately become contraceptive users, highlighting that participation gaps are not merely individual choices but the outcome of socially embedded norms and gender-biased service practices.

C. Reproductive Double Burden

Field evidence indicates that the burden of contraceptive use in the Family Planning (KB) program is disproportionately borne by women, particularly through physical side effects and constraints on everyday activities. This perception is articulated not only by women as contraceptive users but is also explicitly acknowledged by husbands, who recognize that wives are the primary parties affected by contraceptive-related health risks. This is evident in the statement of Mr. Xaverius Ra'i, who positioned his wife as the one carrying the health consequences: "I think it's my wife, because she is the contraceptive user, so the side effects must exist, and they disrupt her health" (XR). Such acknowledgment suggests that men may be aware of an unequal burden of care, even when this awareness does not translate into more balanced contraceptive participation.

This recognition is reinforced by women's first-hand accounts. Mrs. Monika Fitri, for instance, described how contraceptive use tangibly limited her physical capacity to work. She explained: "I feel it is somewhat a burden for me, because when I use contraception my menstruation becomes irregular, and I cannot do heavy work, such as lifting heavy things or

other physically demanding tasks" (MF). This indicates that side effects are not merely biological phenomena but also reshape women's productive roles and daily labor capacity, with potential implications for household welfare and gendered divisions of work.

A comparable pattern emerged in the narratives of Mr. Sarilus Kabhu and Mrs. Rosiana Mara (15 May 2024). From the husband's perspective, contraceptive burden again appeared as the wife's primary responsibility. Mr. Sarilus stated: "My wife bears most of the burden of contraceptive use" (SK). His view was elaborated by Mrs. Rosiana, who noted that although she did not frame the situation as emotionally burdensome, she nevertheless experienced significant physical consequences. She stated: "I do not feel burdened, but there are side effects from contraception that I have to experience. I get tired easily; after using contraception, I feel unwell, and I cannot do heavy work" (RM). This narrative illustrates how women may normalize health impacts as routine consequences of reproductive responsibility, even when those impacts constrain their bodily autonomy and everyday functioning.

Similar experiences were further reinforced by Mr. Antonius Kebhi and Mrs. Yuliana Mara (14 May 2024). From the husband's standpoint, the wife's health complaints were understood as an expected outcome of contraceptive use: "Yes, my wife often complains that her body hurts after using contraception" (AK). Meanwhile, Mrs. Yuliana provided a more comprehensive account of how contraceptive side effects intersected with ongoing domestic and caregiving responsibilities: "Sometimes I feel burdened when using contraception. My menstruation becomes irregular, my body feels weak, and I still have to take care of housework and the children. My body becomes weaker, I get tired easily, and my weight keeps decreasing" (YM). This statement highlights the core mechanism of a reproductive double burden: women continue to perform domestic labor and childcare while simultaneously absorbing the physical and psychological costs of reproductive regulation.

Taken together, the interviews suggest that women commonly experience negative effects associated with contraceptive use, such as irregular menstruation, fatigue, dizziness, and weight changes, while also carrying broader reproductive and social responsibilities, including pregnancy, childbirth, domestic labor, and childrearing. Glasier (2006, cited in Sosiologi, 2017) notes that family planning interventions can generate adverse health effects, including side effects that may compromise women's well-being. Nugroho and Musman (2018) further argue that state-centered family planning regimes may produce physical and psychological consequences that are frequently overlooked or normalized within everyday policy practice. In this sense, the empirical evidence from Fataatu Village can be read not merely as a matter of individual discomfort but as an institutionalized pattern of policy burden allocation that systematically concentrates reproductive risk on women.

From an etic standpoint, this pattern reflects gender bias in contraceptive practice. As Morisson (2019) explains, an etic perspective interprets cultural patterns using external theoretical concepts and scientific frameworks. Although KB regulations normatively emphasize shared responsibility between husbands and wives, the implementation context places women as the primary targets of outreach, consultation, and contraceptive uptake. Consequently, women disproportionately bear the health-related and social costs of contraceptive use, while men remain largely disengaged. The empirical situation, therefore, reveals an implementation gap between the formal equality embedded in policy texts and the unequal distribution of burdens produced by policy practice.

At the same time, an emic lens illuminates how such inequality is often not experienced as "unjust" by the couples themselves. Many women appear to accept, and in some cases willingly assume, a greater share of contraceptive responsibility due to cultural expectations, greater familiarity with reproductive health information, and the normalization of side effects

as tolerable. The emic perspective thus underscores that gender injustice in KB does not always appear as explicit conflict or resistance; rather, it can operate through internalized norms and socially stabilized meanings that present unequal arrangements as reasonable, moral, and socially appropriate. This finding is analytically significant because it suggests that gender inequality may persist not only through coercion or male control, but also through culturally produced consent and normalized expectations in intimate and community life.

Conclusion

Based on the analysis presented, this study concludes that gender injustice in contraceptive use within the Family Planning (KB) program is primarily manifested through the persistence of gender stereotypes. Contraception continues to be socially and culturally labeled as women's business and women's responsibility. This stigma positions women as the "appropriate" and "most responsible" actors in fertility regulation, thereby generating inequality in the distribution of reproductive roles and health risks between women and men.

The findings further indicate that overt subordination is not strongly evident in household decision-making processes regarding contraception, as decisions are typically reached through discussion and mutual agreement between husbands and wives. However, the absence of explicit subordination does not eliminate gender injustice. Women continue to carry a reproductive double burden in practice, as their reproductive roles are accompanied by physical and psychological side effects of contraceptive use, such as health disturbances and constraints on everyday activities. While women often interpret these consequences as normal and tolerable, such acceptance reflects a broader process of normalization through which unequal gender arrangements become embedded in household life and in the localized implementation of KB policy.

Theoretically, this study offers important implications for gender scholarship within public administration. It demonstrates that policies that are normatively framed as egalitarian, such as KB, can still produce gender-biased outcomes when implementation is mediated by unequal socio-cultural norms and institutional practices. Hence, gender analysis in public administration should not stop at formal policy design; it must examine implementation processes, the distribution of policy burdens, and the ways gender injustice is interpreted and normalized at the grassroots level. This study also strengthens public administration debates by illustrating the value of integrating etic and emic perspectives to understand gender justice, particularly in reproductive health policy.

This research has several limitations. First, it relies on a single case study site, limiting the generalizability of its findings across contexts with different socio-cultural configurations. Second, the study focuses primarily on couples of reproductive age and local KB officers, and therefore does not fully capture perspectives from higher-level policy actors involved in program design and governance. Third, as a qualitative descriptive study, it does not provide quantitative estimates of the magnitude of inequality or measure the effects of contraceptive burden on gendered welfare outcomes.

Given these limitations, future research should conduct comparative studies across regions with varied socio-cultural settings to examine how gender injustice in KB manifests differently. Subsequent studies should also more specifically investigate how policy design and reproductive health service systems reproduce, or potentially reduce, gender bias in program implementation. In addition, future research agendas should explore gender-inclusive policy strategies to increase men's participation in KB without undermining women's reproductive rights and health.

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